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Mental Health among Young People Experiencing Homelessness: The Role of Disability

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Abstract

Young people experiencing homelessness face substantial mental health challenges, yet inequalities within this population remain poorly understood. This study examines how homelessness and disability shape psychological distress and diagnosed mental health conditions among youth aged 15–24 in Australia, using longitudinal data from the *Journeys Home* Version 6.0.2 survey. Mental health burden is high, with 35.65% of observations classified as moderate or serious distress and 60.38% reporting at least one diagnosis. Substantial differences were observed by disability status, with serious distress more than three times higher among those with disability (29.52% vs. 9.28%) and diagnoses substantially more prevalent (81.87% vs. 52.93%). In regression models, disability showed strong associations with both outcomes (distress: OR = 4.16, 95% CI [3.11, 5.56]; diagnosis: OR = 3.90, 95% CI [2.71, 5.62]). Homelessness was associated with higher psychological distress (OR = 1.48, 95% CI [1.16, 1.88]) but not independently associated with diagnosis. No interaction between homelessness and disability was observed. Overall, the findings suggest that mental health inequalities among youth experiencing homelessness are not evenly distributed and may be strongly shaped by disability.

1 Introduction

Youth homelessness remains a persistent social and public health concern, with young people experiencing homelessness (YEH) facing disproportionately high levels of disadvantage. Beyond housing instability itself, YEH experience elevated rates of psychological distress and mental illness (AIHW, 2025; Flatau et al., 2015; Stewart & Townley, 2019), while simultaneously reporting high rates of unmet need for healthcare (Kozloff et al., 2016). Despite consistent evidence of poor mental health outcomes, YEH are often treated as a relatively homogeneous group, obscuring important within-population differences in vulnerability. Disability represents a key, yet underexamined dimension of this inequality. In Australia, nearly 10% of individuals accessing Specialist Homelessness Services (SHS) report a disability, with disability linked to limitations in daily functioning across domains such as education, employment, and social participation (AIHW, 2024a). These constraints suggest that disability may fundamentally shape how young people experience homelessness and its consequences. However, the intersection of homelessness, disability, and mental health remains insufficiently understood, particularly in longitudinal research capturing changes over time. To address this gap, the present study uses longitudinal data from the Journeys Home survey to examine whether disability is associated with psychological distress and diagnosed mental health conditions among YEH, and whether disability moderates the association between homelessness and mental health.

2 Theoretical Background

2.1 Youth Homelessness as Exposure to Mental Health Outcomes

Across international studies, individuals experiencing unstable housing show significantly elevated rates of a wide range of mental health problems compared with the general population (Chikwava et al., 2024; Flatau et al., 2015). Longitudinal evidence from Australia indicates that more than half of YEH report high or very high levels of psychological distress on the Kessler-10 scale, compared to around 15% in the general population (Flatau et al., 2015; Hail-Jares et al., 2023). Similarly, 53% of YEH have received a mental health diagnosis, approximately twice the prevalence observed in the general youth population, highlighting a substantial mental health burden associated with housing instability (Flatau et al., 2015). Evidence from service systems further reflects this pattern, with the share of SHS clients experiencing mental health issues increasing more rapidly than the overall SHS client population (AIHW, 2025).

A key mechanism linking homelessness to mental health is ongoing exposure to instability, insecurity, and loss of control. Temporary accommodation, social disconnection, and disrupted support systems are associated with psychological distress, learned helplessness, and reduced well-being (Bower et al., 2023; Clair & Baker, 2022; Stewart & Townley, 2019). Adolescence may represent a particularly vulnerable period, as housing instability often coincides with family conflict, transitions from care, and limited social support. Disruptions during this developmental period can have longer-term implications for educational participation, social relationships, and mental health trajectories into adulthood (Chikwava et al., 2024; Watson et al., 2016).

Importantly, the relationship between homelessness and mental health is bidirectional. Mental health problems increase the risk of housing instability, while homelessness exacerbates psychological distress through trauma, social isolation, and service disconnection (Chikwava et al., 2024; Elkins et al., 2024; Flatau et al., 2015).

This study distinguishes between psychological distress and diagnosed mental health conditions, as these represent related but conceptually distinct dimensions of mental health rather than a single continuum (Payton, 2009). Psychological distress reflects emotional suffering and stress responses, whereas diagnosed mental health conditions capture clinically recognised disorders that extend beyond immediate stress responses (Horwitz, 2007). While homelessness represents an important source of mental health stress, these outcomes may also be shaped by broader structural factors, including disability.

2.2 Disability as Structural Disadvantage

While homelessness represents an important mental health stressor, disability may function as a broader structural axis of inequality shaping how young people experience and respond to housing instability. The relationship between disability and homelessness is reciprocal: disability may increase the risk of homelessness through structural barriers such as low income, limited employment opportunities, and restricted access to housing, while homelessness itself may worsen impairments and functional limitations over time (Guillén et al., 2021). Within homeless populations, disability is associated with longer durations of homelessness, greater barriers to participation, and heightened exposure to victimisation and accidents (Guillén et al., 2021). Longitudinal evidence further indicates

that co-occurring conditions, particularly the combination of mental illness and cognitive disability, substantially reduce the likelihood of exiting homelessness (Nishio et al., 2017).

In Australia, 60% of SHS clients with disability had a current mental health issue compared to 36% of clients without disability, with substantially higher rates of anxiety (48% vs. 14%) and depression (41% vs. 7%; AIHW, 2024). Disability is typically defined in terms of limitations in daily activities that last longer than 6 months, while mental health issues capture current psychological conditions (AIHW, 2024b). Similar patterns are observed among YEH, with disability associated with higher rates of diagnosed mental health conditions and greater need for specialised mental health assistance (AIHW, 2024a; Mann & Duell, 2023). International evidence further indicates that disability-related mental health inequalities persist both within and beyond homelessness populations (Brown & McCann, 2021; Nishio et al., 2017; Okoro et al., 2014).

For YEH with disability, adverse mental health outcomes are further reinforced through institutional processes within the health system. One key mechanism is diagnostic overshadowing, whereby mental health symptoms are misattributed to a person's intellectual disability, leading to underdiagnosis or denial of appropriate care (Baker Collins et al., 2018; Thurman et al., 2023; Whittle et al., 2019). For YEH, this is particularly consequential, as they already navigate fragmented and resource-constrained service environments (Heerde & Patton, 2020; Watson et al., 2016). Consequently, the true prevalence of both disability and mental health issues among YEH is likely to be significantly higher than current figures suggest (Baker Collins et al., 2018; Thurman et al., 2023; Whittle et al., 2019).

Empirical evidence further indicated that disability is associated with higher levels of perceived discrimination, which in turn is significantly related to poorer mental health and higher psychological distress (Guillén et al., 2021; Narendorf et al., 2022). Exposure to discrimination and bullying has been consistently linked to worse self-reported health and well-being, reinforcing the role of stigma as a chronic social stressor within this population (Ditchman et al., 2016).

These patterns are consistent with the social model of disability, which emphasises that disadvantage arises not primarily from individual impairments, but from societal and institutional barriers that restrict participation and access to resources (Oliver, 1983). Similarly, the concept of *categorial disadvantage* suggests that intersecting social positions, such as disability and homelessness, may compound inequalities across multiple domains (Maroto et al., 2019). From this perspective, disability may function as a central axis of within-population inequality among YEH, shaping mental health outcomes beyond the immediate effects of homelessness.

2.3 Theoretical Framework: Capabilities and Minority Stress Theory

To conceptualise these dynamics, this study draws on an integrated framework combining the capabilities approach and minority stress theory. Together, these perspectives emphasise how structural

conditions and socially produced stressors shape mental health outcomes among YEH, particularly for those with disability.

In Sen's (1996) framework, *capabilities* refer to the real freedoms individuals have to achieve valued ways of being and doing, while *functionings* represent their realised outcomes, such as being housed, healthy, or able to access support. The translation of resources into these outcomes depends on *conversion factors*, including individual characteristics, social conditions, and institutional environments. Homelessness disrupts these capabilities by exposing young people to instability, loss of control, and social disconnection. Disability operates as a critical conversion factor by limiting access to resources and intensifying exposure to institutional barriers. As a result, stressors associated with homelessness are more likely to accumulate and translate into more severe mental health outcomes.

Minority stress theory complements this structural perspective by explaining how stigma operates as a chronic and socially produced stressor (Meyer, 2003). For YEH, particularly those with disability, stigma embedded in service systems and social interactions may therefore contribute to elevated distress and poorer mental health.

Together, these frameworks suggest that psychological distress may reflect more immediate responses to instability and stress, whereas diagnosed mental health conditions may reflect longer-term exposure to structural disadvantage and chronic stress. This framework guides the analysis by examining how homelessness and disability jointly shape these distinct dimensions of mental health.

3 Methods

3.1 Data and Sample

This study utilises longitudinal data from the *Journeys Home* survey, a nationally representative and publicly available panel study designed to examine housing instability, homelessness, and associated outcomes in Australia (Department of Social Services & Melbourne Institute of Applied Economic and Social Research, 2022). Structured interviews were conducted at approximately six-month intervals across six waves.

Participants were recruited using Centrelink administrative records identifying individuals experiencing or at risk of homelessness. The sample also included individuals facing significant housing vulnerability, resulting in a broad spectrum of housing insecurity experiences, with approximately 90% reporting some form of lifetime homelessness (Scutella et al., 2013). A total of 1,682 individuals were recruited at baseline and the data are structured as a person–wave panel. To align with the focus on youth homelessness, the study sample was restricted to respondents aged 15–24 years. Non-substantive responses (e.g., "refused", "not applicable", or invalid entries) were coded as missing, and analyses employ a wave-specific complete-case approach.

Ethics approval

for this study was waived by [Anonymized], as the analysis relied exclusively on secondary, de-identified data. The original study received approval from [Anonymized].

3.2 Measures

In order to maximise data availability while maintaining internal consistency, separate complete-case analytic samples were constructed for psychological distress (K6) and diagnosed mental health condition. As a result, sample size and composition vary slightly across models.

Psychological Distress

Psychological distress was measured using the Kessler Psychological Distress Scale (K6). Respondents were asked how often in the past four weeks they felt nervous, hopeless, restless, that everything was an effort, and that nothing could cheer them up. Each item was recorded on a five-point scale ranging from 1 = *All of the time* to 5 = *None of the time*. Items were summed and reverse-coded to produce a score from 0 to 24, with higher scores indicating higher distress. Following established cut-off scores, scores were categorised into low (0–7), moderate (8–12), and serious (≥ 13) distress for the main analysis (Okoro et al., 2014; Wang et al., 2007).

Diagnosed Mental Health Conditions

Diagnosed mental health conditions were measured using binary indicators capturing whether respondents had “ever been diagnosed with” bipolar affective disorder (manic depression), schizophrenia, depression, post-traumatic stress disorder, or anxiety disorder. Each condition was coded as 0 = *No* and 1 = *Yes*. A composite binary indicator was constructed reflecting the presence of at least one diagnosis. In the Journeys Home data, diagnoses remain coded as present in subsequent waves once reported.

Disability

Disability was measured using the Journeys Home survey question: “Do you have any long-term health condition or disability that restricts your daily activities?” Responses were coded as 0 = *No* and 1 = *Yes*, resulting in a binary indicator. This measure was specified as time-varying, capturing disability status at each survey wave.

Homelessness

Homelessness was assessed using the Journeys Home indicator “Experienced homelessness in the reference period”, coded as 0 = *No* and 1 = *Yes*. This variable is derived from the Melbourne Institute housing classification, which is based on the *cultural definition* of homelessness proposed by Chamberlain and MacKenzie (1992). Under this framework, homelessness is conceptualised along a continuum of housing instability, including primary homelessness (e.g., sleeping rough), secondary homelessness (e.g., temporary arrangements such as couch surfing or crisis accommodation), and

tertiary homelessness (e.g., insecure or inadequate boarding situations). The measure reflects homelessness exposure within the reference period rather than lifetime experience. A lifetime homelessness indicator was estimated separately as a robustness check, with results presented in Appendix C, Table C1, while additional robustness checks using lagged variable specifications for psychological distress (K6) are presented in Appendix C, Table C2.

Demographic Variables

All multivariate models adjusted for age, gender, and Indigenous status. Survey-wave fixed effects were included to account for time-specific variation across waves.

3.3 Data preparation

Negative values in the Journeys Home data indicate non-valid responses and were treated as missing, including the following responses: -1 (unknown), -2 (refused/non-response), -3 (not applicable), -4 (opt out), -5 (implausible value), and − 9 (not available in this dataset). Analytic samples were restricted to person-wave observations with valid data on the relevant outcome, predictors, and covariates.

3.4 Statistical analysis

First, descriptive statistics summarised sample characteristics, including the prevalence of disability and homelessness and the distribution of mental health outcomes. Cross-tabulations were used to examine differences in K6 distress categories and diagnosed mental health conditions by disability and homelessness status.

Second, associations between homelessness, disability, and psychological distress were estimated using nested ordinal logistic regression models with individual-level random intercepts and survey-wave fixed effects. The ordered K6 outcome (low, moderate, serious distress) was modelled as the odds of being in a higher distress category. Model 1 included covariates (age, gender, Indigenous status, and wave fixed effects); Model 2 added homelessness; Model 3 added disability; and Model 4 included the homelessness × disability interaction. Model fit was assessed using likelihood-ratio tests, AIC, and BIC. Results are reported as odds ratios (ORs) with 95% confidence intervals (CIs).

Third, for diagnosed mental health conditions, the same nested modelling structure was applied. However, due to limited within-person variation in diagnosis across waves, random-effects models showed instability, and conditional fixed-effects models relied on a small subset of individuals with changes in diagnosis. Therefore, pooled logistic regression models with wave fixed effects and cluster-robust standard errors at the individual level were estimated. The model sequence was identical to the K6 analyses.

4 Results

4.1 Psychological Distress Descriptives

The analytic sample for the psychological distress models included 616 individuals and 2,511 person-wave observations, with a mean age of 20.40 years (SD = 2.05), 56.65% female and 18.36% who identified as Indigenous or Torres Strait Islander. Disability was reported in 25.77% of observations, while homelessness was observed in 46.99% of person-waves. Psychological distress levels were elevated, with 14.50% of observations classified as experiencing serious distress and a further 21.15% as moderate distress.

Cross-tabulations showed a strong gradient in psychological distress by disability status, with higher levels of moderate and serious distress among young people with disability. A similar but less pronounced pattern was observed for homelessness (Table 1).

Table 1
Psychological distress (K6) by disability and homelessness status (%) among young people experiencing homelessness aged 15–24

Group	Low distress	Moderate distress	Serious distress
Disability			
No disability	72.05	18.67	9.28
Disability	42.19	28.28	29.52
Homelessness			
Not homeless	69.35	19.31	11.34
Homeless	58.73	23.22	18.05
Note. Values are percentages of person-wave observations.			

4.2 Psychological Distress Regression

Results from the nested ordinal regression models are presented in Table 2. In Model 1, age was not significantly associated with psychological distress. Females had higher odds of being in a higher distress category compared to males (OR = 1.70, 95% CI [1.08, 2.67]), while Indigenous status was associated with lower odds of distress (OR = 0.55, 95% CI [0.31, 0.98]).

The inclusion of homelessness in Model 2 significantly improved model fit ($\chi^2 = 8.56$, $p = .003$). Homelessness was associated with higher levels of psychological distress (OR = 1.44, 95% CI [1.13, 1.83]), with other coefficients remaining stable. Mean panel coverage was 4.08 waves per person (median = 5).

In Model 3, the inclusion of disability resulted in a substantial improvement in model fit ($\chi^2 = 92.87$, $p < .001$). Disability was strongly associated with higher psychological distress (OR = 4.16, 95% CI [3.11, 5.56]), indicating a substantially stronger association than homelessness. Homelessness remained a significant predictor of higher distress (OR = 1.48, 95% CI [1.16, 1.88]). After accounting for disability, Indigenous status was no longer statistically significant.

Model 4 included the homelessness × disability interaction; however, this did not improve model fit, and the interaction term was not statistically significant.

Table 2

Nested ordinal logistic regression results for psychological distress (K6) among young people experiencing homelessness aged 15–24

Variable	M1 OR [95% CI]	M2 OR [95% CI]	M3 OR [95% CI]	M4 OR [95% CI]
Age	1.05 [0.94, 1.16]	1.05 [0.95, 1.17]	1.04 [0.94, 1.14]	1.04 [0.94, 1.14]
Female	1.70 [1.08, 2.67] *	1.73 [1.11, 2.70] *	1.64 [1.08, 2.50] *	1.64 [1.08, 2.50] *
Indigenous	0.55 [0.31, 0.98] *	0.56 [0.31, 0.98] *	0.66 [0.39, 1.13]	0.66 [0.39, 1.13]
Homelessness (it)	—	1.44 [1.13, 1.83] **	1.48 [1.16, 1.88] **	1.44 [1.08, 1.91] *
Disability (it)	—	—	4.16 [3.11, 5.56] ***	3.98 [2.71, 5.85] ***
Homeless × Disability	—	—	—	1.09 [0.67, 1.77]

Note. Odds ratios (OR) with 95% confidence intervals (CI) are reported. Disability and homelessness are measured as time-varying indicators at the survey wave (it). Men serve as the reference category and models include survey-wave fixed effects and individual-level random intercepts. Model specifications are nested across columns. *p < .05, **p < .01, ***p < .001.

4.3 Diagnosis Descriptives

The analytic sample for diagnosed mental health conditions included 615 individuals and 2,529 person-wave observations and a mean age of 20.40 years (*SD* = 2.05). 54.57% were female and 18.39% identified as Aboriginal and/or Torres Strait Islander. Disability was observed in 25.74% of person-waves and homelessness in 47.09%. Overall, 60.38% of observations reported at least one diagnosed mental health condition. Mean panel coverage was 4.11 waves per individual (median = 5).

Cross-tabulations showed a strong gradient by disability, with 52.93% of observations without disability reporting a diagnosis compared to 81.87% among those with disability. Differences by homelessness were smaller (58.82% vs. 62.13%).

Supplementary descriptive analyses examining recent mental health professional contact showed similarly limited differences by homelessness status, with 14.7% of non-homeless observations and 14.9% of homeless observations reporting contact within the last six months (see Appendix A, Table A1). In contrast, contact differed substantially by disability status, with 30.5% of observations among young people with disability reporting recent contact compared to 9.37% among those without disability.

4.4 Pooled Logistic Regression

Results from the nested pooled logistic regression models are presented in Table 3. In Model 1, females had higher odds of reporting a diagnosis than males (OR = 2.01, 95% CI [1.42, 2.84]), while Indigenous status was associated with lower odds (OR = 0.50, 95% CI [0.33, 0.77]). Age was not significantly associated with diagnosis.

Adding homelessness in Model 2 resulted in a modest improvement in model fit (AIC = 3289 vs. 3293), with no independent significant association with diagnosis (OR = 1.23, 95% CI [0.99, 1.53]).

In Model 3, the inclusion of disability substantially improved model fit (AIC = 3124). Disability emerged as the strongest predictor of diagnosis (OR = 3.90, 95% CI [2.71, 5.62]), while homelessness remained non-significant.

Model 4 did not improve model fit (AIC = 3125), and the interaction between homelessness and disability was not statistically significant (OR = 0.81, 95% CI [0.51, 1.27]).

Table 3

Nested pooled logistic regression results for any mental health diagnosis among young people experiencing homelessness aged 15–24

Variable	M1 OR [95% CI]	M2 OR [95% CI]	M3 OR [95% CI]	M4 OR [95% CI]
Age	1.04 [0.96, 1.13]	1.04 [0.96, 1.13]	1.03 [0.95, 1.12]	1.03 [0.95, 1.12]
Female	2.01 [1.42, 2.84] ***	2.04 [1.44, 2.89] ***	2.04 [1.44, 2.91] ***	2.05 [1.44, 2.91] ***
Indigenous	0.50 [0.33, 0.77] **	0.50 [0.33, 0.77] **	0.54 [0.35, 0.84] **	0.54 [0.35, 0.84] **
Homelessness (it)	—	1.23 [0.99, 1.53]	1.22 [0.98, 1.51]	1.26 [1.00, 1.60]
Disability (it)	—	—	3.90 [2.71, 5.62] ***	4.32 [2.81, 6.65] ***
Homeless × Disability	—	—	—	0.81 [0.51, 1.27]

Note. Odds ratios (OR) with 95% confidence intervals (CI) are reported. Models were estimated using pooled logistic regression with cluster-robust standard errors at the individual level. Disability and homelessness are measured as time-varying indicators at the survey wave (it). Men serve as the reference category and models include survey-wave fixed effects. Model specifications are nested across columns. *p < .05, **p < .01, ***p < .001.

Supplementary descriptive analyses using the full youth sample show that diagnosed mental health conditions are consistently more prevalent among young people with disability across all conditions, including depression, anxiety, PTSD, bipolar disorder, and schizophrenia (see Appendix B, Table B1). In contrast, differences by homelessness status are smaller and less consistent across diagnoses.

5 Discussion

This study examined how homelessness and disability shape mental health among YEH, distinguishing between psychological distress and diagnosed mental health conditions. Three key findings emerged. First, homelessness was associated with elevated psychological distress, supporting the interpretation of homelessness as an important contemporaneous stress exposure. Second, disability was consistently associated with both higher psychological distress and greater likelihood of diagnosed mental health conditions, indicating persistent mental health inequalities within this population. Third, there was no evidence that homelessness and disability interacted multiplicatively, suggesting that these factors may operate through distinct rather than mutually reinforcing mechanisms. Together, these findings highlight the importance of distinguishing between different dimensions of mental health and demonstrate that homelessness and disability may shape mental health through different pathways.

Homelessness was associated with elevated levels of psychological distress, consistent with prior research identifying distress as a central mechanism linking homelessness-related stressors to broader mental health outcomes among YEH (Flatau et al., 2015; Hail-Jares et al., 2023; Stewart & Townley, 2019). Young people who were homeless in the reference period reported substantially higher levels of moderate and serious distress, indicating that mental health inequalities emerge even at relatively short-term or contemporaneous stages of housing instability.

At the same time, levels of *serious* psychological distress observed in the present study were lower than those reported in several earlier Australian studies of YEH (Flatau et al., 2015; Hail-Jares et al., 2023). This difference may partly reflect the use of the K6 rather than the Kessler-10 scale (K10), which operationalises distress differently and may capture severe distress at different thresholds. In addition, the analytic sample was drawn from the broader Journeys Home cohort, which captures a wider spectrum of housing instability than many service-based studies, including substantial levels of tertiary and less acute homelessness (Scutella et al., 2013). Nevertheless, distress levels remained substantially elevated, with more than one-third of person-wave observations classified as experiencing moderate or serious distress, consistent with broader Australian evidence documenting increasing mental health burden among SHS clients over time (AIHW, 2025).

The strong and consistent association between disability and both psychological distress and diagnosed mental health conditions aligns with a substantial body of research demonstrating that people with disabilities experience poorer mental health outcomes, higher levels of unmet need, and greater exposure to structural disadvantage than their non-disabled peers (Aitken et al., 2022; Honey et al., 2011). Within homelessness populations, these disadvantages are often further compounded by intersecting barriers related to housing instability, service fragmentation, and comorbidity (Baker Collins et al., 2018; Brown & McCann, 2021; Guillén et al., 2021). Prior longitudinal research similarly finds that disability among people experiencing homelessness predicts poorer mental health and lower quality of life over time, with part of this relationship mediated through perceived discrimination and social exclusion (Guillén et al., 2021).

Importantly, these findings support the social model of disability by indicating that the relationship between disability and mental health is strongly shaped by social and structural conditions (Oliver, 1983). Prior research shows that mental health inequalities between young people with and without disability are substantially reduced under favourable social conditions characterised by lower financial hardship and stronger social support (Honey et al., 2011). Within contexts of homelessness, however, such protective conditions are often absent, potentially amplifying the effects of social exclusion, resource disadvantage, and institutional barriers. This interpretation is also consistent with broader Australian evidence showing substantially higher prevalence of anxiety and related mental health conditions among people with disability compared to those without disability (AIHW, 2024a).

At the same time, supplementary descriptive analyses showed that recent contact with a mental health professional was substantially more common among young people with disability, whereas differences by homelessness status were minimal. One possible explanation is that young people with disability may not only experience poorer mental health but may also have greater interaction with health and support systems, potentially increasing opportunities for diagnosis. Nevertheless, overall levels of recent mental health professional contact remained low across the sample, consistent with evidence documenting substantial unmet mental healthcare need among both YEH and people with disability (AIHW, 2025; Baker Collins et al., 2018; Brown & McCann, 2021; Whittle et al., 2019). Prior research further indicates that barriers to service engagement among homeless populations are often shaped by stigma, distrust of institutions, unstable service pathways, and fear of discrimination, all of which may reduce help-seeking and formal diagnosis despite high levels of psychological need (Guillén et al., 2021; Rea, 2023; Whittle et al., 2019).

Despite the independent associations of homelessness and disability with poorer mental health outcomes, there was no evidence that the relationship between homelessness and mental health differed by disability status. These findings suggest that these factors operate through distinct but additive mechanisms rather than reflecting a simple “double disadvantage”. One possible interpretation is that disability represents a more persistent and structurally embedded form of vulnerability, whereas recent homelessness functions more as an immediate stress exposure affecting emotional well-being. Consistent with this interpretation, homelessness was associated primarily with psychological distress, while disability showed strong and consistent associations across both distress and diagnosed mental health conditions. Previous research similarly links disability among people experiencing homelessness to more persistent and complex forms of disadvantage, including poorer mental health and greater service needs over time (Brown & McCann, 2021; Guillén et al., 2021). At the same time, the absence of a statistically significant interaction may partly reflect characteristics of the analytic sample, including the high prevalence of homelessness and the binary operationalisation of disability, which may obscure variation in disability type and severity. Taken together, the findings suggest that homelessness and disability may contribute to mental health inequality through overlapping but not necessarily synergistic mechanisms.

5.1 Policy Implications

These findings have important implications for policy. Responses to youth homelessness should move beyond a sole focus on housing and account for within-population inequalities, particularly disability. Although stable housing remains a critical foundation for improving well-being, policy responses should prioritise tailored mental health support that explicitly accounts for disability-related needs, including improved screening, integrated service provision, and targeted intervention strategies (Brown & McCann, 2021).

Despite elevated levels of psychological distress, recent contact with mental health professionals remained low across the sample, suggesting substantial unmet mental healthcare need among YEH. Although contact with mental health professionals was more common among young people with disability, barriers related to stigma, fragmented service systems, and difficulties navigating support pathways may continue to limit access to appropriate care (Baker Collins et al., 2018; Whittle et al., 2019). Strengthening early intervention, accessibility, and integration across homelessness, disability, and mental health services may therefore be critical for reducing longer-term mental health inequalities.

5.2 Strengths and Limitations

This study contributes longitudinal evidence on the relationship between homelessness, disability, and mental health among YEH. Several limitations should nevertheless be acknowledged.

First, disability was measured as a binary indicator without information on duration, severity, or disability type, limiting the ability to capture differences within this population. Second, the analyses were restricted to complete-case person–wave observations, which may introduce bias if missingness is systematically related to mental health, disability, or housing instability. However, the consistency of results across models suggests that the main findings are unlikely to be driven solely by sample selection. Third, although the longitudinal design improves temporal ordering, the results cannot be interpreted causally due to potential unobserved confounding and bidirectional relationships. Nevertheless, the analyses provide robust evidence of contemporaneous associations. Finally, mental health outcomes were based on self-reported measures, which may be subject to reporting bias or misclassification. However, the use of both distress and diagnosis measures strengthens confidence that the observed patterns are not dependent on a single indicator.

5.3 Future Research

Future research should differentiate between different forms of disability as they might be associated with distinct mental health needs and trajectories. Second, better understanding the factors that shape help-seeking, service engagement, and barriers to care may help clarify why substantial unmet mental healthcare need persists among YEH. Third, qualitative research could provide deeper insight into the mechanisms underlying mental health inequality that may not be fully captured through self-reported survey indicators. Longitudinal research tracking individuals over time would further help clarify to what extent observed associations reflect causal processes. Additionally, testing the role of potential protective factors, such as social support and service engagement, would allow for a more comprehensive understanding of not only risk, but also resilience within this population.

Conclusion

In conclusion, the findings show that mental health inequalities among YEH are not evenly distributed and appear to be strongly shaped by disability. While homelessness was associated primarily with elevated psychological distress, disability showed broader associations across both distress and diagnosed mental health conditions, consistent with more persistent patterns of inequality within this population. These findings highlight the importance of distinguishing between different dimensions of mental health and recognising the heterogeneity of vulnerability among YEH. Overall, the study contributes a more differentiated understanding of mental health inequality and suggests that policy responses should account for the distinct needs of young people with disability within homelessness contexts.

Declarations

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Conflict of Interest Statement:

The authors declare no conflict of interest.

Ethical Statement:

Ethics approval for this study was waived by the Griffith University Human Research Ethics Committee, as the analysis relied exclusively on secondary, de-identified data. The original study received approval from the University of Melbourne's Behavioural and Social Sciences Human Ethics Sub-Committee.

Consent Statement:

Patient consent statement is not applicable for this study as the analyses were based on secondary de-identified survey data.

Data Availability Statement:

The data that support the findings of this study are openly available in ADA Dataverse at https://dataverse.ada.edu.au/dataset.xhtml?persistentId=doi:10.26193/I5QEWZ, reference number DOI:10.26193/I5QEWZ.

Author Contribution

Kira Jaechel contributed to the conceptualisation of the study, data curation, formal analysis, methodology, interpretation of findings, and writing of the manuscript. Christopher Ambrey and Katie

Hail-Jares contributed to study supervision, methodological guidance, interpretation of findings, and critical revision of the manuscript. All authors reviewed and approved the final submitted version.

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Data Availability

The data that support the findings of this study are openly available in ADA Dataverse at https://dataverse.ada.edu.au/dataset.xhtml?persistentId=doi:10.26193/I5QEWZ, reference number DOI:10.26193/I5QEWZ.

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