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Barriers and Facilitators to Accessing and Utilizing Mental Health Services for Homeless Youth: A Systematic Review

by

Abbygail Lapinski

A thesis submitted in partial fulfillment of the requirements

for the degree of Bachelor of Science in Nursing

in the College of Nursing

at the University of Central Florida

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Abstract

Homelessness in the youth population is associated with elevated rates of mental illness, substance abuse, and suicidality compared to the housed population in the United States (Berdahl, Hoyt, and Whitbeck, 2005; Hodgson, Shelton, Van den Bree, 2014; Hughes et al., 2010). With a survival-focused perspective, exacerbating issues, stigmatization, and transience housing; homeless youth require special consideration to meet their diverse health needs. When barriers impede homeless youth's access to necessary health resources, their health concerns are left untreated and impound until emergency services are required. This review of literature is focused on identifying and synthesizing barriers and facilitators for homeless youth to access and utilize mental health care services.

When untreated mental illness reaches a crisis point, it becomes more expensive to treat (Taylor, Stuttaford, and Vostanis, 2006). For youth experiencing homelessness, various factors influence their decisions to wait until a crisis to reach out to emergency services. Within the literature, barriers and facilitators were bracketed into personal, social, and structural factors. These factors ranged from financial concerns, communication with health care providers and between health care service locations, stigmatization, lack of awareness, and administrative requirements. While further research is required, evidence from the literature shows promise in developing and altering interventions and communication to meet homeless youth's mental health and substance abuse needs.

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Dedication

This paper is dedicated to all those struggling with homelessness and the selfless individuals who come together to show them they deserve to be heard, cared for, and treated with dignity.

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Acknowledgments

I want to take a moment to highlight all those who have helped grow to the person I am today and reach this milestone in my academic studies. To my parents, thank you for your continual support and encouragement. I could not have achieved the things I have today without you. To the friends I met through Straight Street Orlando and Hearts for Homeless Orlando, you are all the inspiration behind my thesis and your compassion for others inspires me every day. Thank you to my committee chair, Ms. Luzincourt, for your insight and expertise. To Ms. Kimberly Dever, my thesis chair, thank you for believing in me and dedicating time and effort to see this come to fruition. Your guidance was instrumental over this journey, and I feel so fortunate to have you as a mentor. Finally, to the University of Central Florida Burnett Honors College and College of Nursing, thank you for placing value in research and providing students the opportunity to build their research skills as undergraduates.

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Introduction

In 2017, approximately 553,742 people were experiencing homelessness on a single night in the United States (Henry, Watt, Rosenthal, and Shivji, 2017). One-fifth or 114,829 of those individuals were children under the age of 18 (Henry et al., 2017). Even though the number of homeless children has declined by 5% since 2016, this progress does not offset the pressing public health concerns among homeless youth (Henry et al., 2017). Prior research corroborates homeless youth exhibit statistically heightened rates of mental health problems (Berdahl, Hoyt, and Whitbeck, 2005; Hodgson, Shelton, Van den Bree, 2014; Hughes et al., 2010). As a diverse population with various stressors, stigmatization, and transience housing; homeless youth have high rates of mental health problems indicating an imminent need for mental health care services. Though, current research confirms an apparent gap exists between mental health care needs and service utilization among homeless youth (Berdahl et al., 2005; Hodgson et al., 2014; and Hughes et al., 2010). This vast difference indicates merely having mental health care services available is not enough. Addressing this gap and effectively implementing interventions to meet this vulnerable population's health needs is important. Therefore, it is critical to understand the barriers and facilitators influencing service use. The purpose of this thesis is to: (1) Explore literature on homeless youth's accessibility to mental health care services, (2) Identify and synthesize barriers and facilitators to mental health care service use, and (3) Make recommendations regarding the development of effective interventions.

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Background

Homeless, as defined in the 2017 Annual Homeless Report to Congress, is a descriptive term for a person who lacks adequate permanent residence at night (Henry et al., 2017). This review will focus on a subset of this population: Homeless youth. Within the literature on homeless youth, descriptive terms and age designations of homeless youth lack consistency. For this review of research, the World Health Organization's age designated for youth, aged 15-24, will be utilized (SEARO, n.d.). The term homeless youth will encompass runaway youth, street-involved youth, systems youth, and sheltered youth. Runaway youth are youth who left home without parental permission for more than one night (Edidin, Ganim, Hunter, and Karnik, 2011; and Henry, Watt, Rosenthal, and Shivji, 2017). Street-involved youth who are youth living in nontraditional locations not intended for regular sleeping accommodations (Edidin, Ganim, Hunter, and Karnik, 2011; and Henry, Watt, Rosenthal, and Shivji, 2017). Systems youth which are youth with a history of involvement in governmental agencies; and sheltered youth who reside in emergency shelters, transitional housing programs, or safe havens (Edidin, Ganim, Hunter, and Karnik, 2011; and Henry, Watt, Rosenthal, and Shivji, 2017). Homeless youth is heterogeneous group characterized by various subpopulations including race, ethnicity, gender identity, and sexual orientation (National Health Care for the Homeless Council, 2015). For the intent of this review, the term homeless youth will encompass these sub-populations.

Mental Health and Homeless Youth

Homeless youth, when compared to the housed youth of similar age, exhibit higher rates of psychiatric disorders including depression, posttraumatic stress disorder, anxiety disorders,

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and substance abuse disorders (National Health Care for the Homeless Council, 2015). In a study of 60 homeless youth between the ages of 16 to 24 in Nova Scotia, clinical-level symptoms of psychological maladjustment were reported in nearly half of the participants (Hughes et al., 2010). Similarly, in another study of 428 homeless and runaway adolescents from eight Midwestern cities in the U.S indicated increased rates of five major mental disorders: Conduct Disorder, Major Depressive Episodes, Posttraumatic Stress Disorder (PTSD), and Alcohol or Drug Abuse (Whitbeck, Johnson, Hoyt, and Cauce, 2004). Of the participants interviewed, 89% meet the criteria for one mental disorder while 67.3% met the requirements for two or more (Whitbeck et al., 2004). When compared to a nationally represented sample of similarly aged youth, homeless adolescents were six times more likely to meet the criteria for lifetime comorbid mental disorders (Whitbeck et al., 2004). These results were replicated in a 2014 study, which found 88% and 73% prevalence of psychiatric disorder and psychiatric comorbidity respectfully in 90 homeless youth (Hodgson, Shelton, Van den Bree, 2014). In assessing the individual prevalence of mental disorders, results from the Midwest Longitudinal Study of Homeless Adolescents in the United States found the prevalence of major depressive disorder; lifetime alcohol abuse and drug abuse; and post-traumatic stress disorder exceeded estimated national averages as cited by Martin and Howe (2016).

Trauma, and Substance Abuse in Homeless Youth

A multitude of factors ranging from individual, familial, social, and environmental add to the complexity of mental health concerns for homeless youth. Alongside higher rates of psychiatric disorders, homeless youth have heightened rates of substance use, and trauma

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(Whitbeck et al., 2004; Martijn and Sharpe, 2006; Edidin, Ganim, Hunter, and Karnik, 2011; and Coates and McKenzie-Mohr, 2010).

A study of 100 homeless youth indicated trauma is evident both before and during homelessness (Coates, 2010). In a sample of youth from a homeless youth drop-in center in Los Angeles, California, 50% reported witnessing family verbal abuse, 39% saw family physical abuse, 50% were physically abused, 39% were sexually abused, and 68% were verbally abused (Ferguson, 2009). Many of these cases involved familial alcohol or substance use alongside abuse (Ferguson, 2009). Traumatic experiences of abuse can have severe adverse effects on youth's psychological adjustments (Ferguson, 2009). Youth who experienced abuse, rape, and assault before homelessness, may leave their homes only to experience other forms of victimization as homelessness may increase their risk for abuse (Edidin et al., 2,011).

Homeless youth have been noted to use substances more heavily and at an earlier onset then non-homeless peer (Nyamathi et al., 2010). In a study of 419 homeless youth in Los Angeles, 56.6% of traveling youth reported heavy drinking, 80.9% marijuana use, and 57.5% reported other forms of drug use (Martino et al., 2011). Substance use, among homeless youth and young adults, has been used as coping mechanisms for those experiencing mental health problems (Nyamathi et al., 2012). This form of coping mechanism has been termed a form of "self-medicating" (Nyamathi et al., 2012). Heightened substance use in this population may translate into substance abuse disorder which is noted in the literature to be increased in this demographic. A study in 2006 exploring pathways to youth homelessness found 70% of homeless youth interviewed reported drug and alcohol disorders while experiencing homelessness (Martijn et al., 2006).

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Mental Health Care Service Utilization and Homeless Youth

Though research has established homeless youth disproportionately experience psychiatric disorders such as major depressive disorder, PTSD, and substance abuse, this does not translate into adequate mental health care utilization. Of 50 homeless youth between 16 and 24 years old interviewed in a study, only 35 percent of those with clinically elevated symptoms accessed specialty mental health services (Hughes et al., 2010). Similarly, in another study of 688 homeless youths, only 32% of youth who met the criteria for emotional distress used mental health services (Solorio et al., 2006).

Health Care Accessibility Barriers and Homelessness

As a marginalized group with limited access to resources and short-term survivability perspective, the homeless population faces a multitude of challenges in seeking out and attaining health care despite their high burden of illness. Barriers to care identified by homeless youth correspond with thoughts reflected by homeless adults. These barriers include lack of insurance, lack of financial means, stigmatization, service center policies, prior negative experiences, substance abuse, and complex health care systems (Christiani, Hudson, Nyamathi, Mutere, and Sweat, 2008; Martin et al., 2016). Moreover, some homeless youth may be hesitant to seek care due to fear of social service agency notification or legal intervention, and lack of knowledge on how to attain care (Hudson et al., 2010). As homeless youth experience a high burden of mental illness, it is pertinent to address personal, economic, and structural barriers impeding youth from seeking and attaining quality care.

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Significance

Addressing mental illness in youth homeless is imperative as transitioning from adolescence to young adulthood is a vital physical, social, and psychological developmental period for individuals (Narendorf et al., 2017). Psychiatric symptoms and homelessness add incremental challenges to this critical time. The experiences of homelessness, psychiatric disorders and substance abuse, have considerable influence on an individual's morbidity and mortality (SAMHSA, 2018; USICH, 2010).

The Centers for Disease Control and Prevention states "… suicide is the third leading cause of death among young people between the ages of 10 and 24…" (CDC, 2017). As cited by the United States Interagency Council on Homelessness, homeless youth are at a higher risk for suicide (2010). A study of 444 homeless youth found two-thirds reported thoughts of death or suicide and approximately 16% attempted suicide in the year leading to the interview (Yoder, Whitebeck, and Hoyt 2007). In another study of youth experiencing family homelessness, 29.1% reported self-injury, 21% suicidal ideation, and 9.3% reported suicide attempts (Barnes, Gilbertson, and Chatterjee, 2018).

Substance Abuse and Mental Health Services Administration noted mental health disorders are disabling and may present significant costs to families, employers, and publicly funded health centers (SAMHSA, 2018). Moreover, untreated mental health disorders among young people are more difficult and costlier to treat once a person meets a crisis point (Taylor, Stuttaford, and Vostanis, 2006). Using a cost-benefit ratio, investments of one-dollar into prevention and early intervention programs for addiction and mental illness can potentially save

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two to ten dollars in health, criminal and juvenile, education, and lost productivity costs (SAMHSA, 2018).

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Problem

Youth who experience homelessness demonstrate increased levels of mental health problems such as depression, post-traumatic stress disorder, substance abuse, and suicidality (Martin and Howe, 2016; Solorio et al., 2006). Evidence shows that approximately two-thirds of homeless youth face mental health problems and are in need of treatment (Martin et al., 2016; Solorio et al., 2006). However, the evidence also shows one-half to two-thirds of this population does not seek out mental health services (Martin et al., 2016; Solorio et al., 2006). The gap between population need and mental health service utilization exhibit real concern as 41% of homeless youth surveyed in the Midwest Longitudinal Study of Homeless Adolescents attempted suicide (Martin and Howe, 2016). Thus, it is imperative to identify potential barriers influencing the attainment of quality mental health care services for homeless youth. Moreover, identifying facilitators can aide in implementing interventions to impede the barriers to care, increase accessibility, and improve the mental health of this vulnerable population.

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Method

A review of the literature was conducted utilizing the databases: CINHAL Plus with Full Text, Health Source: Nursing/Academic Edition, MEDLINE, and PsychINFO. These databases were searched using the following search terms: (MH "Homeless Persons") OR (MH "Homelessness") OR "homeless"; youth or "young people" or teen* or "young adult*" or adolescent* AND "mental health" or "mental illness" or "mental disorder" or "psychiatric illness" or "psychiatric disorder" or psychiatric AND access* or "health services accessibility" or "service use" or barrier* or obstacle* or challenge* or facilitator* or motivator* or enabler* NPT HIV or AIDS or "acquired human immunodeficiency syndrome" or "human immunodeficiency virus". Inclusion criteria included scholarly peer-reviewed journals published within the last ten years and research articles written in the English language. Research articles obtained in the initial search (n=228) were assessed first through their titles and then their abstracts to determine relevancy to the topic. Articles not meeting the title (n=137) and abstract (n=42) search criteria were removed. Reviews of full-text (n=38) were orchestrated to determine final eligibility. Eleven articles were selected, evaluated and organized based on their strength of evidence. Both qualitative and quantitative data were examined for this review.

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Results

The literature review yielded 11 articles discussing the barriers and facilitators of the homeless youth service sector across three central locations: London, California, and Canada. Nine of the eleven articles collected their central data through focus groups sessions or personal interviews with semi-structured interview guides. A majority of the articles exclusively sampled from the local homeless youth population or street-involved youth population (n=9). Two articles incorporated the perspective of youth experiencing homelessness as well as service providers. One article strictly pooled its sample from community agency staff serving street-involved youth, health service providers, hospital administration, and hospital security. Even with variable sampling, overarching reoccurring themes were identified between the articles' results. With the exclusion of a few outlier data points, barriers and facilitators experienced in the homeless sector fell within one of the following brackets: personal, social, and structural and systematic factors.

Barriers to Accessing and Utilizing Care

Personal

Personal factors cited within literature ranged from personal beliefs and stigmatization held about mental health issues and treatment, lack of financial means, denial and fear, past experiences of seeking care, lack of knowledge or exposure to mental health services, and survival prioritization. Six articles addressed how the personal factors impeded youth's ability to access mental health services, and service sector resources (i.e., shelters, employment services, health services, crisis interventions).

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Surabhi Chaturvedi aimed to bridge the research gap by conducting face to face semi-structured interviews with six clients from homelessness charity in London, United Kingdom (Surabhi, 2016) The interview specifically addressed perceived facilitators and barriers to counseling service or psychological therapies. Following thematic analysis of transcribing verbatim interviews, five themes emerged on barriers: "resistance to opening up, stigma, past experiences of help-seeking, denial about needing help, and lack of familiarity with therapy" (Surabhi, 2016). Personal resistant to seeking out and accepting support through psychological therapies stemmed from "feeling overwhelmed" and the idea of "close interpersonal contact" with counselors (Surabhi, 2016). Stigmas discussed by the participants reflected an internalized stigmatization separate from societal views defined by negative perceptions about needing or being offered counseling (Surabhi, 2016). Beyond personalized stigmas, reluctance to seek help was influenced by past experiences of receiving substandard support or loss of trust consistent with the trauma and familial problems identified in this population (Surabhi, 2016). Denying the need for help and the generalized fear surrounding counseling due to lack of knowledge and exposure beyond media portrayal influences participants' propensity to accessing services (Surabhi, 2016).

In a 2008 study conducted by Christiani and colleagues, 54 homeless and drug-using youth participated in semi-structured focus groups sessions in the Hollywood and Santa Monic California areas (Christiani et al., 2008). The aim of the research was not specifically tailored towards psychological therapy and instead dealt with culturally sensitive quality health care (Christiani et al., 2008). Participants in this study described receiving prescription scrips they were unable to fill as they lacked the financial resources to afford the medication (Christiani et

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al., 2008). Like the Chaturvedi study, participants expressed fear of asking for help and a lack of knowledge on outreach services (Christiani et al., 2008). In this population of participants, drug use was identified as a barrier to care as it associated with social isolation (Christiani et al., 2008). However, drugs were seen as a necessity for street survival or treatment of mental health symptoms. Thus, leading to a personal resistance to substances use therapy (Christiani et al., 2008).

Martin and Howe's 2016 study addressing attitudes of at-risk housed youth and homeless youth on mental health services surveyed 56 homeless youth and 97 matched at-risk housed youth as a comparison group. Barriers to accessing mental health services, identified by five participants, matched the items established by the prior two research articles including lack of openness, constrained finances, and lack of knowledge (Martin and Howe, 2016). About other services such as transportation, medical and dental, meals, government assistance, and education and employment services, mental health and substance abuse services were ranked last (Martin and Howe, 2016). Narendorf's mixed mode research studied a sample of 54 homeless youth with a qualifying diagnosis of serious mental illness who were eligible for outpatient services funded by the public fund and could provide informed consent (2017). Serious mental illness in the study is defined as major depression, bipolar disorder, or a psychotic disorder. As with prior studies, participants described the challenges with limited finances in obtaining care or treatment (Narendorf, 2017). For the participants, the circular nature made navigating systems difficult as participants who lack the financial means for medication attempted to get public funding (Narendorf, 2017). However, to get public funding one needed identification and to receive identification from the state one needed a residence (Narendorf, 2017). Kozloff and colleague's

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2013 research study interviewed 23 homeless youth with co-occurring disorders in a focus group format to identify influential factors in service use. As with Christiani's study, the research was more expansive to include other services while addressing substance abuse therapies (Kozloff et al., 2013). This study revealed an additional barrier: personal motivation and readiness for change. For youth to engage with services, the participants' felt they must first be motivated towards change (Kozloff et al., 2013).

Beyond a lack of finances, a study conducted in Santa Monica, California in 2010 with 24 homeless drug using young adults identified lack of insurance and identification as a barrier to care (Hudson et al.). To address specifically young homeless people's perceptions of mental health, O'Reilly, Taylor, and Vostanis interviewed 25 young people, 12 staff, and five mental health coordinators. Within their research, two themes emerged related to barriers: denial of mental health problems and negative perceptions of mental health (2009). Though participants may have used mental health services, participants did not associate themselves with having mental health concerns (O'Reilly, Taylor, and Vostanis, 2009). Further, negative connotations through the use of terms such as "nutter" and "psycho" were associated with mental health when interviewing youth (O'Reilly, Taylor, and Vostanis, 2009).

Social

Of the selected articles, four articles addressed the social factors influential inaccessibility to care or wiliness to seek out care. For this thesis, communications and quality of interactions between service providers and homeless youth are bracketed under social factors. In Kozloff and colleagues' research study, service providers were a source of stigmatization (2013). One participant described how challenging it was to seek out help as they didn't want to be labeled as

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"dirty," and "a prostitute," or being associated with using dirty needles (Kozloff et al., 2013). Hudson and colleagues research study in 2010 addressed health care seeking behavior among homeless drug-using youth through semi-structured interview guided focus groups. Discrimination by health care providers, law enforcement, and society was identified by the participants. Health care provider stigmatizing homeless youth was cited as a serious barrier to care (Hudson et al., 2010). One participates noted emergency service didn't adequately treat her pain due to her background (Hudson et al., 2010). Results revealed a prominent disconnect between young adults experiencing homelessness and local law enforcement (Hudson et al., 2010). A lack of understanding of available resources and challenges of homelessness along with pressures to remove youth from the street leads to participants receiving citations for minor offenses or being incarcerated (Hudson et al., 2010).

Hudson, Nyamathi, and Sweat's study focused on the therapeutic relationship between health care providers and homeless youth. The study obtained data through semi-structured focus groups with 54 substance-using homeless youth between the ages of 18-25 (2008). Following a constant comparative approach, three themes related to negative communication styles emerged: authoritative communication style, disrespect, and poor treatment, and one-way communication (Hudson, Nyamathi, and Sweat, 2008). To participants authoritative communication was perceived as noninformative, rushed, contradictive, and harsh (Hudson, Nyamathi, and Sweat, 2008). Some participants went on to the described provider's not believing the severity of their condition or being poorly treated in a disrespecting manner due to their lack of financial resources or health insurance (Hudson, Nyamathi, and Sweat, 2008). One-way communications styles by therapists were not therapeutic or engaging for the participants and therapists were

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often perceived as manipulative in conversation (Hudson, Nyamathi, and Sweat, 2008). When surmising the data, participants perceptions of poor communication involved a general feeling of disrespect, confusion, and lack of engagement with health care providers. These communication styles conveyed a lack of empathy and trust which is essential to developing engaging relationship pivotal to health-seeking behaviors (Hudson, Nyamathi, and Sweat, 2008).

Nicholas and colleagues aimed to explore service providers viewpoint on assisting street-involved youth in health care (2016). In total, 21 communication agency staff, 16 health care providers, and four hospital staff were interviewed as part of the research study. Street-involved youth were described by service providers as being treated as adults, especially by security guards (Nicholas et al., 2016). This form of treatment led to over-assumptions of the youth's capability, especially as a self-advocate (Nicholas et al., 2016). Moreover, the lack of responsiveness to challenges facing these youth by staff limited their continuity of care (Nicholas et al., 2016) Street-involved youth who did seek out care may have been subjected to stigmatization, prejudice, in compassionate care, insensitive communication negative or degrading terms, and general lack of understanding by staff in the emergency department (Nicholas et al., 2016).

Structural and Systematic Factors

Six articles in the literature review addressed systematic or structural barriers decreasing accessibility to care for this vulnerable population. Christiani and colleagues described how bureaucratic requirements of the community and formal agencies impaired continuity of care for homeless youth (2008). These rules such as requiring appointments to fill a prescription prescribed by another facility provide challenges for homeless youth whose transient and

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survival-based lifestyle does fit the mold to access these services (Christiani et al., 2008). Kozloff and colleagues described breaks in the continuity of care from the criminal justice systems failing to connect youth to services to gap periods between care and services encouraging relapse (2013). Homeless youth described difficulty accessing services due to the scarcity of service sites available to youth, long waiting time for services, and/or restricted accessibility times for youth (Kozloff et al., 2013). The defined limitations on services forced youth to prioritize shelter and basic needs over health-related disorders (Kozloff et al., 2013). An interplay of system requirements and lack of access to financial resources created a cycle, described by Narendorf, preventing youth from receiving medication (2017). As described earlier, homeless youth would value survival concerns over mental health in cases with long waiting times for services where they have the sole responsibility to monitor their waiting list status (Narendorf, 2017).

In the emergency department, concern for the involvement of child protective services and the rapid nature of the setting may dissuade homeless youth from providing health details (Nicholas et al., 2016). Lack of impulse control or generalized distrust combined with long wait times in the emergency department led to youth leaving before receiving treatment (Nicholas et al., 2016). Upon discharge, policies within the hospital required a responsible adult to be present in a population who often have guardianship issues or are not connected with family members (Nicholas et al., 2016). The available mental health services in the community were insufficient in meeting the homeless youth's specific needs leading to youth being turned award before or after seeing a psychiatric and receiving interventions (Nicholas et al., 2016). Some mental health

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services barred homeless youth who used substances from receiving care unless they became clean (Nicholas et al., 2016).

In a study conducted by Gharbaghi and Stuart, service providers, service sector stakeholders, and homeless youth were interviewed to describe the current challenges in the Central East Service Region of Ontario, Canada (Gharbaghi and Stuart, 2010). Service providers were first to note inadequate funding and staffing ratios in homeless youth shelters leading to an inability to provide safe supervision and care of youth with serious mental health concerns (Gharbaghi and Stuart, 2010). Thus, these youth were often excluded from receiving their services (Gharbaghi and Stuart, 2010). Inadequate staffing impaired meaningful accessibility to mental health services as more staffing would be required to help homeless youth with attending an appointment, and resources for travel (Gharbaghi and Stuart, 2010). The lack of sufficient staff and resources lead to inadequate transitional services for youth receiving independent housing (Gharbaghi and Stuart, 2010). As a result, homeless youth commonly relapsed leading to loss of housing, drug use, mental health episodes, and involvement with the criminal justice system (Gharbaghi and Stuart, 2010). Effective partnership and communication with formal service sector services were limited and service requirements such as scheduled appointments, and thorough intake processes limited engagement with homeless youth (Gharbaghi and Stuart, 2010). Meaningful access to community mental health services and appropriate follow-up care was proceeded by a lack of collaboration and understanding between informal and form sectors (Gharbaghi and Stuart, 2010). Age restriction on services in this area led to a prominent service gap for those aged 15 to 17 as they are too old for youth services but too young to access adult

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services (Gharbaghi and Stuart, 2010). In this area, long waiting lists or lack of knowledge on available substance use services limited their access to care (Gharbaghi and Stuart, 2010).

Facilitators to Accessing and Utilizing Care

Personal

In Martin and Howe's study of attitudes towards mental health services among both homeless and matched housed youth, a correlation was postulated between a total number of supportive individuals and positive attitudes towards mental health services, lower concern in stigmatization, and increased help-seeking behaviors (2016). Participants in Gharbaghi and Stuart's research shared similar sentiments as homeless youth were more likely to seek out help if their friends sought out help (2010). Kozloff and colleagues and Gharbaghi and Stuart noted engagement with services required personal motivator and readiness for change (Kozloff et al., 2013; Gharbaghi and Stuart, 2010). Like Martin and Howe's study, a personal support system increased help-seeking propensity (Kozloff et al., 2013). For participants in Narendorf's study, homelessness was associated with help-seeking propensity as a facilitator and barrier (2017). Homelessness for some of the participants exacerbated symptoms to a crisis point where they or others decided to connect them with crisis interventions (Narendorf, 2017). However, in effect, homelessness was associated with a disconnect from services (Narendorf, 2017). Past experiences and familial experiences with health care services can function as both a barrier and facilitator. Positive family experiences were associated with homeless youth being more open to the experience including wait times (Nicholas et al. 2016).

Social

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Social factors which facilitated access mainly focused in on communication and relationship building between service providers and homeless youth, reduction in stigmatization, confidentiality, peer mentoring. For homeless youth, the quality of communication they have with service providers is essential. Through thematic analysis and inductive approach of the data, Chaturvedi identified three facilitating themes related to communication: "patience and consistency to offer, simple explanations, and demystifying and normalizing counseling" (2016). Homeless youth preferred an informal communication style, explanations and promotional material to presented in a simplified manner to minimize professional medical jargon, and for mental health service providers to be patient (Chaturvedi, 2016). Empowerment and a sense of control in the intervention process while reducing stigmatization associated with treatment was important to the participants (Chaturvedi, 2016). Building upon Chaturvedi's results, participants in Christiani's and colleagues' study found nonjudgmental, and confidential health care services were important factors in care (2008). In addition to these factors, homeless youth valued building a relationship over time, relatability, and persistence with health care providers (Kozloff et al., 2013). Peer advising, mentoring, and or education was cited by homeless youth in three articles within the literature (Gharbaghi and Stuart, 2010; Hudson, Nyamathi, and Sweat, 2010; Kozloff et al., 2013). Emphasis on peer mentoring in the literature is consistent with homeless youth's preference for empathetic service providers and those who have shared similar experiences (Hudoson, Nyamathi, and Sweat, 2008).

Structural and Systematic Factors

Six of the articles outlined specific factors which facilitated access to health care and mental health services. Comprehensive, flexible, timely, and streamlined are some key

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descriptive of facilitator factors found within the literature. Through her research, Chaturvedi identified consistency to offer a service and having it always open to homeless youth as a facilitator (Chaturvedi, 2016). Christiani and colleagues revealed multiple facilitators through the data including the inclusion of mentors in the system to help guide youth in accessing services (2008). Participants in the study valued free accessible services that are competent, confidential, timely, and nonjudgmental (Christiani et al., 2008). As transportation is a concern in this population, participants identified on-site health care delivery at a location frequented by homeless youth or the inclusion of transportation assistance for referrals as facilitating factors (Christiani et al. 2008). Additionally, to increase access to medications, direct pharmacological services or a building a strong pathway between receiving health services and receiving prescription medication (Christiani, 2008).

Kozloff and colleagues' research data emphasized the importance of program flexibility in treating the homeless youth population (2013). Mirroring the results of prior literature, timely access and comprehensive services which meet both health and basic needs were cited as a facilitating actor (Kozloff et al. 2013). For homeless youth who utilize substance use, recreational activities and vocational services provided a form of engagement associated with a reduction in substance use (Kozloff et al., 2013). In this research study, abstinence and harm reduction services were seen both as a barrier and facilitator (Kozloff et al., 2013). For some, harm reduction services were seen as helpful while others believed it encouraged substance use in the program. On the other end, abstinence programs were seen as having too many restrictions on accessing substance abuse treatment but did not encourage the continual use of substances (Kozloff et al., 2013).

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In the emergency service setting, advocates for homeless youth was seen as beneficial as long as the person was in a position of authority. Health care professionals were more open to conversing with adult advocates while advocates serving as a source of medical history for the youth and decreased their anger in the setting (Nicholas et al., 2016). The caveat to youth advocates is some community workers in the study were denied the ability to be the youth's advocate in the hospital (Nicholas et al., 2016). Service providers in Ontario Canada described adopting rules and regulations in service programs to allow long term engagement, continual access after repeated failures, and easing accessibility for homeless youth (Gharbaghi, and Stuart, 2010). In the research varying strategies in program structures were discussed to alleviated barriers to accessing meaningful care. One proposed though was providing formal service sector health care in the informal setting through a "one-stop shop concept" (Gharbaghi, and Stuart, 2010). This concept would allow homeless youth to access basic needs while receiving health care. However, the concern is low financial support, and lack of qualified, trained staff (Gharbaghi and Stuart, 2010). A counterplan to the plan was to promote sharing of team members and knowledge resources between the two systems as well as providing formal section training to develop cultural competence of homeless youth (Gharbaghi and Stuart, 2010). Alongside these programs, early intervention and services which are developmentally and culturally specific (Gharbaghi and Stuart, 2010). Homeless youth participants highlighted the need for programs which provided safe and clean housing accommodations before considering mental health service (Gharbaghi and Stuart, 2010).

Moreover, transitional services are needed to ensure homeless youth are prepared to move from one service site to the next without increasing the risk for relapse (Gharbaghi, and

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Stuart, 2010). Martin and Howe's recommendations following their research matched those described in the literature (2016). They suggested the importance of changing service programs to meet the services homeless youth value first, and utilizing positive youth developmental practices (Martin and Howe, 2016).

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Discussion

As a population with a high burden of mental illness, traumatic experience, and substance abuse, it is imperative homeless youth have access to mental health care services and resources required to utilize these resources. Simply having services open to homeless youth is not enough to foster utilization. The literature reveals meaningful access is essential to encouraging help-seeking behaviors and connecting homeless youth to mental health care. To promote meaningful access among this population, it requires reducing barriers and encouraging facilitators defined by both homeless youth and services providers. Through the literature, barrier and facilitators were define under three themes: personal, social, and structural and systematic factors. Each is playing a pertinent role in accessibility and utilization. Though the literature ranges in sample populations and locations, commonalities occurred between the responses by both homeless youth and service providers.

The personal propensity to seek out mental health care stems from personal beliefs and motivation, stigmatization on mental health, substance use, financial means, denial and fear, past experiences of seeking care, lack of awareness or knowledge, and survival prioritization. The central underlying notes of personal barriers in the literature was the youth had first to identify they were struggling with mental illness, overcome negative associations with mental health, treatment, and past mistrust, value mental health care, and want to seek out care. Overcoming these roadblocks requires an intersection of personal factors with social and structural and systematic facilitating factors. To appeal to homeless youth's personal needs; interventions should focus on establishing positive support systems, increasing awareness of mental health to reduce stigmatization, and providing continual, consistent outreach to homeless youth. Services

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should be designed to be low-cost or free to homeless youth to reduce the financial barrier to care.

Social barriers to accessing and utilizing care stem from the quality of relationships and communication between homeless youth, service providers, and law enforcement. Lack of understanding, stigmatization, and prejudice impairs the quality of care homeless youth receive and influences their help-seeking propensity. To eliminate these barriers, it requires health care providers to alter their communication style to convey, empathy, and respect without judgment. Providers should be persistent in outreach and provide instruction which meets the population's health literacy. Educational training on how to provide culturally sensitive care and utilizing providers who are trained is an important intervention to reduce barrier and provide homeless youth with a positive experience. Additionally, services should incorporate relatable peer mentors and a source of positive support.

In addition to meeting the personal and social needs of homeless youth, homeless youth face multiple structural and systematic barriers to accessing care. Continuity of care is key to mental health and substance abuse. Lack of communication between facilities, follow-up care, free prescriptions, open appointment times, and/or free transportation impeded homeless youth's abilities to manage their health care. To counteract these barriers, interventions need to focus on providing comprehensive services at locations accessible to homeless youth or instill transportation and case management to ensure homeless youth can follow-up with flexible, timely care. Early interventions should be emphasized for at-risk youth and connections with shelters, and follow-up care should be provided upon discharge from crisis services, emergency services, or youth exiting the criminal system. Educational training for providers on the struggles

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of homelessness and connecting with services can help improve discharge processes between medical care and community resources. Depending on the structure of pre-existing resources, new comprehensive services locations should operate in conjunction with formal services or effective communication will be required between sites with assistive support for homeless youth.

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Limitations

First and foremost, definitions of homeless youth and the age ranges which fall within this definition vary in the current research on homeless youth populations. The lack of strict definitions limits the generality of the research as some research may exclude the perspectives of the homeless youth population. Within the literature review, the articles chosen had a broad age range definition with some inclusion criteria being 18 or over while others included participants as young as 12. As homeless youth have different developmental concerns then the generalized population, many studies will include an upward of 25 to 26-year-old under the bracket of homeless youth or homeless young people. Beyond age ranges, research addresses in this literature review were limited in sample size and location. The largest sample size was 60 homeless youth, and the smallest sample size was six homeless youth clients. With a smaller sample size, one should be cautious about generalizing the research to the entire homeless youth population.

Much of the research sampled their participants from service-oriented organizations such as a homeless youth drop-in center, temporary shelter, or residential shelter. These locations may provide various services or referrals to homeless youth. Thus, allowing some youth to have access to mental health services as compared to others. Recruiting at these location limits engagement with street-involved youth who are often difficult to engage due to their living situation. Of the research studied, only five studies were conducted in the United States with the other two sites being England and Canada. As the United State' health system differs from Canada and England, the depth of challenges in accessing meaningful services may be different. Additionally, most studies primarily collect qualitative data through semi-structured focus

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groups or semi-structured interviews. Of the literature studied, only three structured their research aims to include quantitative data.

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Conclusion

Homelessness in the youth population is associated with heightened rates of trauma, substance use, and mental health issues. These factors combined with the various stressors, stigmatization, and transience housing associated with homelessness requires special considerations to meet this vulnerable population's mental health needs. Based on current research, having available mental health care services for the homeless youth population is not enough and deficits in care still exist. The focus of these services and interventions should be on provided meaningful access by tailoring services to address homeless youths' population needs. Meaningful access can be promoted by reducing the personal, social, and structural and system barriers and providing interventions facilitating ease of access and utilization. To achieve this, services should focus first on increasing awareness of mental health issues and free or reduced cost mental health services available in the area. Mental health services provided at these locations should be flexible, confidential, relatable, culturally sensitive, and timely while ensuring continuity of care. If possible, mental health services should be made accessible at sites where homeless youth receive resources such as shelter, food, water, and socialization. For homeless youth, the development of positive peer relationship should be promoted through peer mentorship, positive recreational activities, and awareness of mental health issues. Comprehensive services, case management, and transitional support should be funded at service locations to reduce the risk of relapse of substance use, mental health crisis, or criminalization among the youth. Implementing and altering current mental health services to promote meaningful access to homeless youth is a cost-effective solution for reducing health, criminal and juveniles, education, and lost productivity costs (SAMHSA, 2018).

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Further research should focus on collecting both quantitative and qualitative data with a large sampled population of homeless youth to determine accessibility to meaningful mental health services. Additionally, research should focus on the importance of peer relationship and mentorship on the homeless youth's mental health, substance use, and service use.

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Appendix A: Literature Review Article Chart

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Title	Citation	Purpose	Sample Population	Methods	Major Findings	Limitations
Accessing psychological therapies: Homeless young people's views on barriers and facilitators	Chaturvedi, S. (2016). Accessing psychological therapies: Homeless young people's views on barriers and facilitators. *Counselling & Psychotherapy Research, 16*(1), 54–63. https://doi-org.ezproxy.net.ucf.edu/10.1002/capr.12058	Bridge the gap in research by interviewing young homeless people about perceived barriers and facilitators to accessing counseling services.	A sample population of six clients, four females and two males, was obtained through purposeful sampling. Inclusion criteria included those who accessed the organization's counseling services between April 2013 and June 2014, attended at minimum two therapy sessions and where currently not in therapy.	Face to face semi-structured interviews lasting 45-60 minutes was utilized to obtain qualitative data. Interviews were audio-recorded and transcribed verbatim with the use of pseudonyms. Thematic analysis was utilized to analyze the transcripts. Following the analysis, themes were derived by inductive reasoning. Phase I: Transcripts Read Phase II: open-coding Phase III: similar codes were combined into overarching concepts Phase IV: Conceptually Clustered Matrix The British Association for Counseling and Psychotherapy's guidelines for ethical research were followed and the researchers obtained the informed consent from participants.	The research identified five barrier themes and three facilitator themes. The five barrier themes identified included resistance to opening up, stigma, past experiences of help-seeking, denial about need help, and lack of familiarity with therapy. The three themes identified under facilitators included patience and consistency to offer, simple explanations, and demystifying and normalizing counseling. Participants expressed resistance to accepting support, internalization of negative perceptions on counseling, and reluctance to seeking out care due to prior negative experiences of support. Participants preferred services being consistently available, communication styles portraying personal empowerment, explanations without professional medical terminology and more information on services. In this population, it is important to note the impact of homelessness on barriers and facilitators to counseling services.	The results of this research are limited by small sample size, lack of quantitative data, and one sample location. Due to the data being obtained from a larger research study, the results were limited to the study's focus.
Attitudes of homeless and	Christiani, A., Hudson, A. L., Nyamathi, A.,	The study aimed to understand the	The study sampled 54 youth, ages 18-25	Qualitative data were obtained from semi-structured focus group sessions	Participants identified the following items as their current health care needs: pregnancy,	Limitations included small

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drug-using youth regarding barriers and facilitators in the delivery of quality and culturally sensitive health care	Mutere, M., & Sweat, J. (2008). Attitudes of homeless and drug-using youth regarding barriers and facilitators in the delivery of quality and culturally sensitive health care. *Journal of Child and Adolescent Psychiatric Nursing 21*(3), 154-63. doi: 10.1111/j.1744-6171.2008.00139.x.	perspective of homeless youth on barriers and facilitators to health care and their health care needs.	years old, experiencing homelessness and were drug-using. Participants learned about the study through recruitment flyers posted at both sites Inclusion criteria included reported drug use within the past six months and age. The participants were recruited from youth drop-in center in Santa Monica, California and a residential youth shelter in Hollywood, California. Demographic Characteristics: 44% African American, 24% Anglo-Americans, and 22% Hispanic Americans; Two-thirds or 37	of five to ten participants. Sessions were approximately an hour in length. The Community Advisory Board developed the interview guide, drug screening, and research material to ensure it was culturally sensitive, age-appropriate, and nonjudgmental. All focus sessions were tape recorded, and a constant comparative method was used to analyze the data. Line by line coding using Atlas.ti created sentences and phrases. Concurrent coding was used until data saturation. The University of California, Los Angeles IRB Committee for the Protection of Research Subjects approved the study, and informed consent was obtained.	acute trauma, mental health, dermatologic conditions, dental disorders, chronic conditions, STDs, and drug-use complications. Participants used free and mobile clinics for non-urgent health needs and the local emergency department for urgent needs. Dental care, chronic conditions management, mental health services, and culturally appropriate nonjudgement drug use treatment were identified as lacking. Participants described financial barriers to obtaining prescription medications and an inability to pay for emergency room services. Administrative requirements such as additional appointments were identified as a barrier. Participants feared negative experiences when seeking health care and lack of confidentiality at shelter clinics. Illicit drug use was associated with survivability on the streets and social isolation impeding desire and ability to seek out treatment services. Facilitators to care included free accessible services which are competent, confidential, timely, non-judgment, and relatable. Increases inaccessibility can be done by providing on-site care, transportation services to appointments and allowing ease of transferring medical information between medical sites.	sample size and limited recruitment sites.

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			participants were male.			
Attitudes toward mental health services among homeless and matched housed youth	Martin, J. K., & Howe, T. R. (2016). Attitudes toward mental health services among homeless and matched housed youth. *Child & Youth Services, 37*(1), pp. 49-64. doi:10.1080/0145935X.2015.1052135	Survey population of homeless youth and at-risk housed youth on their attitudes toward mental health services, while determining the link between social support and attitudes.	Recruitment occurred at a temporary shelter for homeless youth without families and with at-risk youth. Comparison group data was collected by surveys distributed at community sites in Northern California and alternative schools by school officials. Demographic characteristics: 56 homeless youth (29 females, 27 males) between the ages of 12 and 21 and 97 matched at-risk housed youth (37 females, 56 males) Inclusion criteria: Under the age of 21, parental or guardian consent from the comparison group,	Chi-square analysis was used to match demographic factors between both groups. Measures: Street Victimization scale: 5 items Parental Maltreatment: 11-item scale Accessing mental health service: 4-point Likert Scale and open-ended item Subjective needs assessment through 4-point scale assessment. Inventory of Attitude Toward Seeking Mental Health Service Scale: 24-items with three subscales Multidimensional Scale of Perceived Social Support: 12 items with three domains: significant other, friends, and family	Chi-square analysis revealed homeless youth received more mental health services than housed youth and a trend of homeless youth report more satisfaction with their mental health service compared to housed youth. Housed youth perceived less difficulty accessing mental health services than homeless youth. Of the 25 youth who identified mental health services is difficult or very difficult to access, all youth had accessed mental health service previously. Cited reasons for difficulty accessing health services included lack of openness to discussing psychological problems, limited financial resource, lack of knowledge on how to access these services. Services were ranked in the following order of frequencies of use if available: transportation series, medical/dental, free meals, government assistance, educational service, job training/placement. Mental health services and alcohol/drug treatment services were listed as the least potentially used services if available. Inferential Results Homeless youth and housed youth shared similar attitudes towards mental health services. Data revealed a trend of LGBQ youth having more positive attitudes to these services and less concern on stigma.	Ecological factors and limited geographic location may have skewed results. The sample of homeless youth participated in programs which encouraged and assisted in accessing mental health care. A majority of youth were satisfied with their experiences while receiving mental health care services. This could explain the trend of homeless youth reporting higher satisfaction with their mental health services. Service providers in this area utilized practice referred to as “positive youth development.” Additionally,

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			youth assent from the drop-in center.		Homeless youth reported lower amounts of total available social, family, and significant other support then housed youth. Moreover, they identified fewer supportive individuals available. Housed youth revealed an association between reduced concern for mental health stigma and perceived friend support. The total number of supportive individuals related to more positive attitudes towards mental health services, increased help-seeking propensity, and lower concern for mental health stigma. Barriers identified by the 5 participants from the homeless youth who responded to the subjective question was consistent with current research. Results suggested mental health services were not viewed as a priority.	recruitment was solely at service provider sites, and the results had low alpha reliability.
Factors influencing service use among homeless youths with co-occurring disorders	Kozloff, N., Cheung, A. H., Ross, L. E., Winer, H., Ierfino, D., Bullock, H., & Bennett, K. J. (2013). Factors influencing service use among homeless youths with co-occurring disorders. *Psychiatric*	To explore factors influencing service use among homeless youths with co-occurring disorders.	The study sampled 23 youths ages 18 to 26 with co-occurring disorders. Twenty participants were males (approximately 87%). The mean, standard	Focus groups were conducted across Ontario with youth with co-occurring disorders, their families, and service providers. This is a subproject aimed at homeless youth and only considered interviewed youths' perspective.	The following factors were perceived as influencing the initiation and ongoing use of services for co-occurring disorders. Individual (motivation, support, and therapeutic relationship) Personal motivation and readiness for changes is a requirement for engagement. Supportive	The research is limited by convenience sampling recruitment at local agencies. Participants in the study may have received better

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	Services, *64*(9), 925–928. https://doi-org.ezproxy.net.ucf.edu/10.1176/appi.ps.201200257		deviation age was 22.2 years give or take 2.1 years. Eight had not completed high school Five completed high school Seven attended some college or university 14 identified as white Four identified as Asian Two identified as African American 1 Identified as Aboriginal North American Indian	Four agencies providing a wide range of services including mental health and addiction services on site in the Toronto area were invited and agreed to participate. Mental health workers identified clients who met the criteria for co-occurring disorders. All 26 agreed and three did not attend on the day of the focus groups. Four focus groups lasting 60 minutes with five to seven youths were conducted at the recruitment sites. A semi-structured interview preceded the focus groups session. Written informed consent obtained Sessions digitally audio-recorded and transcribed verbatim. The data were coded separately by two authors. Results were discussed, and themes and broad categories were identified. Data was reread and coded by identified themes, and categories.	figures/advocates and support network were an encouragement for seeking treatment. Participants valued confidentiality, building relationship with a practitioner over time, relatability, and persistence in a therapeutic relationship. Program (flexibility, and comprehensives of services and availability of harm reduction services) Program flexibility (i.e., services without ID requirements) facilitated use. Comprehensive services and services which meet basic needs were important. Further, recreational activities and vocational services engaged youth and helped reduce substance use. Harm reduction services received mixed support. Abstinence was cited as creating too many barriers. Harm reduction services were described as encouraging substance use and providing temptation. Systemic (stigma and accessibility) Location of services and service providers were a source of stigmatization. Timely access to resources was important to participants. Youth described not being connected to services through related sectors such as the criminal justice system. Gaps between care (withdrawal management and	services and been less ill then youth experience homelessness with co-occurring disorders who do not have access to services.

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					residential treatment) encouraged relapse among the population. Peers in role modeling, peer-led education strategies, help-seeking behavior, and suggesting resources were seen as important by the participants.	
Health-seeking challenges among homeless youth	Hudson, A.L., Nyamathi, A., Greengold, B., Slagle, A., Koniak-Griffin, D., Khalilifard, F., and Getzoff, D., (2010). Health-seeking challenges among homeless youth. *Nursing Research*, *59*(3), 212-218. doi:10.1080/01612840802498235.	The study aimed to explore homeless young adults' perspective on barriers and facilitators of health-care seeking behavior and their perspectives on improving existing programs for individuals experiencing homelessness	The study utilized a purposeful sample of 24 homeless drug using young adults Participants frequented services of drop-in site in Santa Monica, California. Eligibility: aged 18 to 25 years, self-reported street youth, reported drug use over the last 30 days. Demographic Characteristics: 75% were men and 63% identified themselves as white. 21% identified as African American and 13% as Hispanic.	The method of the research study was based on comprehensive health seeking and coping paradigm The research study was part of a larger study exploring the effects of an arts program. Community advisory board was formed to guide design, implementation, and assessment of Phase I qualitative segment. Recruitment based flyers were utilized, and consent forms on being presented with study information were signed. Five focus groups session lasting 60 minutes were conducted with four to six participants Focused codes were first created by initial line by line coding, and then the researchers used theoretical coding. Categories were presented to	Within the data analysis, the following themes were identified: failing access to health care, needing more help, perceiving stigma, and making it work. Failing Access to Health Care Barriers identified by the participants included scarcity of service sites, long waiting times for services, few drop-in sites providing free medical services for general health care, and difficulty accessing available service sites for youth. Times restriction and survival prioritization constrained homeless youth's ability to access services. Additionally, lack of insurance and lack of identification were identified as barriers. Participants described discrimination from health care providers towards young adults who used illegal drugs or were homeless. One community agency included the length of homelessness as a required factor to access services. Needing more help	The study pooled participants from one geographic location and data were obtained in narrative format limiting generalization capability. Participants may have altered statements to be more positively perceived as they received services at the site of research.

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			A quarter had attended or completed college and nearly half completed high school. Five participants had children who did not live with them.	the community advisory board and reviewed by two research staff and an experienced qualitative researcher.	Hygienic and dental care was an unmet need for participants. Lack of services and not realizing they were mentally ill was a barrier to mental health treatment as cited by one participant. Increased outreach needed for mental health treatment was described as a need. Perceiving Stigma Participants described discrimination from the public and law enforcement. Police in Los Angeles wanted to move homeless youth regardless of the accessibility of services leaving the participants feeling misunderstood by the police. Making it Work Peer advising on available services and location was helpful. Implications made from the research included symptom management education, receiving care based on priority condition, health care providers become more aware of community resources to make necessary referrals. More street outreach and drop in centers needed	
Homeless youths' interpersonal perspectives of health care providers.	Hudson, A.L., Nyamathi, A., & Sweat, J. (2008). Homeless youths' interpersonal perspectives of health	The focus of the research was to explore homeless youth's perspectives on	54 substance using youth experience homelessness between the ages of 18 and 25 were	IRB approved flyers were posted by staff for recruitment purposes. Informed consent was obtained from all participants.	Themes emerged related to poor communication styles with health care providers. These forms of communication were viewed as disrespectful, confusing, or nonengaging. The following themes were	The study was limited by small sample size and similar geographic location. The

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	care providers. *Issues in Mental Health Nursing, 29*(12), 1277-1289. doi:10.1080/01612840802498235.	barriers and facilitators of the therapeutic relationship	sampled. The average age was 20.5 years old. Demographic characteristics: 44% African American 24% Anglo-Americans 22% Hispanic-Americans 2 Native Americans 1 Asian/Pacific Islander 2 Other 2/3 or 27 participants were male All street youth reported chronic homelessness, of 2 years or more. Sheltered participants reported during last from 2 days to 6 years.	Drug screener and sociodemographic data were collected by a structured questionnaire. Focus groups were conducted with two research staff in large private rooms in the facilities Sessions were audiotaped and transcribed using the constant comparative method, with line by line coding by Atlas.ti to create sentences and phrases. Themes were determined when comparing focus group sessions.	identified and used to structure the major findings: authoritative communication style, disrespectful and poor treatment, and one-way communication. Authoritative Communication Style Several participants disliked this style as it was harsh, noninformative, hurried, and contradictive. Disrespectful and Poor Treatment Participants felt the provider would not take their perception of condition seriously. Participants felt their lack of financial resources led to poor treatment or disrespect from providers. One-way communication Participants felt mental health providers manipulated the conversation and were not mutually engaging or therapeutic. Participants preferred providers who portrayed empathy or shared similar experiences.	research featured the viewpoint of the homeless youth population without the additional perspective of service providers.
"Nuts, schiz, psycho": An exploration of young homeless people's	O'Reilly, M., Taylor, H.C., Vostanis, P. (2009). "Nuts, schiz, psycho": An exploration of young homeless	Explore the term "mental health" in the framework of a group of young people in	Sample: Purposeful sampling Frame. All young people living in a homeless shelter and had engaged with	Interviews were conducted with 25 young people, 12 staff, and five mental health coordinators	The data revealed the following four key themes: Denial of mental health problems, negative perception of mental health, the value of having someone to talk to, and prejudice challenged through engagement with services.	The sample is limited by location and sample size. The perspective of youth experience

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perceptions and dilemmas of defining mental health	people's perceptions and dilemmas of defining mental health. Social *Science & Medicine, 68*(9), 1737-1744. doi:10.1016/j.socscimed .2009.02.033.	homeless shelters utilizing staff in mental health service	the five mental health coordinators were invited. Twenty-five young people (15-22 years old) participated.	Approved by NHS Multi-Centre Research Ethics Committee Jefferson system of prosodic notation was used for transcription. Discourse analysis was used.	Participants were put off by the terminology used to refer to mental health coordinators and felt the term counseling might be more open and agreeable. Young people definition and opinions of mental health created a dilemma when determining to engage with mental health services. Based on the data, establishing a shared understanding of key terms between public and professionals would be helpful for this population.	homelessness who do not have access to mental health services could provide more data on this subject matter.
Youth Homelessness: The Relationships among Mental Health, Hope, and Service Satisfaction	Hughes, J. R., Clark, S. E., Wood, W., Cakmak, S., Cox, A., MacInnis, M., . . . Broom, B. (2010). Youth homelessness: The relationships among mental health, hope, and service satisfaction. *Journal of the Canadian Academy of Child and Adolescent Psychiatry /Journal de l'Académie Canadienne de Psychiatrie de L'Enfant et de l'adolescent, 19*(4), 274-283. Retrieved from http://www.cacap-	The purpose of the study was to determine the association between mental health, hope, and service satisfaction in a population of homeless youth.	The researchers used a convenience sample of 60 youth, aged 16 to 24 years old. Inclusion Criteria: Spent at least one night in the youth shelter in Halifax, Nova Scotia Demographic Characteristics: 43 males, and 17 females 67% identified as being Caucasian	Data was obtained from the developed questionnaire (29-term developed for the study); the Youth Self-Report: 120-item self-report; and adult Self Report: 126 items Quantitative data were analyzed with descriptive and inferential statistics. Qualitative data was analyzed through thematic analysis	22% of the youth fell in the clinical range on the internalizing symptoms scale, and 40% fell in the clinical range on externalizing symptom scale. 48% currently fell in the clinical range for both scales. 75% reported good physical health and over 2/3 reported good, very good, or exceptional mental health. Service Use and Satisfaction In the previous 6-months, half of the youth had used emergency services, 44% visited family doctors, 20% accessed a community health clinic, and 22% reported using mental health services.	The results from this study were limited by not included a section on the history of abuse, using on a single question to assess for hope, and the questions on time spent on the streets and level of service satisfaction for each service did not adequately cover each topic. The study was cross-sectional, so

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	acpea.org/fr/cacap/Journal_p828.html		60% completed grade 10. 47% reported learning difficulties and/or special needs 7% had education beyond high school 18% were employed 29% were raised outside the family home 61% stated a family conflict was a triggering factor to leave home 88% still had family contact		Youth with clinically elevated symptoms reported accessing significantly more mental health services. The youth with the most clinical elevated symptoms had not accessed any specialty mental health services 84% indicated they were satisfied with the services they access over the past 6-months. Youth with clinically elevated symptoms were less satisfied with accessed services. Hope for the future 97% hoped first that basic needs would be meet and allow them to live productively Clinically elevated mental health symptoms were directly related to hopefulness in the future. Health ratings and service satisfaction were directly related to hopefulness Service Satisfaction Youth felt less satisfied with services had less hope for the future. Youth who were less satisfied with services reported higher levels of internalizing symptoms.	long-term changes could not be assessed. The results can only be applied to homeless youth who sought out shelters.

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Intersection of homelessness and mental health: A mixed methods study of young adults who accessed psychiatric emergency services.	Narendorf, S.C. (2017). Intersection of homelessness and mental health: A mixed methods study of young adults who accessed psychiatric emergency services. *Children & Youth Services Review, 81*, 54-62. doi:10.1016/j.childyouth.2017.07.024.	The focus of the research was to examine homelessness within a broader population of young adults that recently experienced a psychiatric crisis and received a diagnosis of serious mental illness requiring short term inpatient hospitalization	The research study sample 54 young adults between the ages of 18-25. Inclusion criteria included: Qualifying diagnosis of a serious mental illness, and eligible for publicly funded outpatient services A psychiatrist determined whether each participant was stable enough to provide informed consent. Sample Characteristics: 26 participants were currently living in a shelter, or on the streets and positive for being homeless in the last month 28 participants were classified as stably housed youth	Data were obtained from a larger mixed-methods research project utilizing a structured survey instrument Chi-square tests examined differences between groups Grounded theory methods were used for qualitative analysis. A constant comparative approach was utilized after the coding of the first ten interviews.	Factors influencing becoming homeless identified in the research included: housing instability, disrupted social support, challenging behaviors and fragile family systems, and foster care system Housing instability and homelessness were associated with disrupted social support networks. Extreme behaviors and being kicked out were associated and acknowledged by participants. Challenging behaviors were often occurring in conjunction with fragile family relationships. Childhood trauma and homelessness often led to involvement in the foster care system. The system failed at provided stability in the participants' lives. Homeless and mental health was seen in a circular relationship where homelessness was a cause or contributor. Substance use was cited as a contributor to homelessness and mental health problems. Substances as a substitute for treatment for mental health problems were common in this population. Homelessness and other experiences contributed to the mental health problem. Homelessness led to victimization which contributed to mental health problems	The sample came from one service site that was available to uninsured patients who were not acute enough to have longer hospitalizations. The research did not address extreme psychiatric symptoms, private insurance, or more resources. The sample did not account for the range of experiences typical to those who access the public mental health system in a large urban area. Self-report homeless may lead to the exclusion of persons who experiences homelessness but do not consider themselves

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			Demographic Characteristics: 28% African American 20% Bi-Racial 26% White 20% Hispanic 6% other		An intersection between homelessness and seeking help behaviors was identified where it was both facilitator and barrier. As a facilitator, homelessness escalated their symptoms to a point where others intervened to get them help, they were admitted due to the crisis, or they sought out care after realizing the need for these services. Due to mental illness, one participant was denied shelter services which led to seeking crisis intervention. Homelessness was a barrier as it led to a disconnection from services. Participants also faced financial and logistical barriers. Waiting times for services and being responsible for their status was a barrier as survival concerns outweighed mental health. Developmental aspects: how the transitional period from adolescents to adulthood influenced homelessness and mental health services. Coming to the age of 18 allowed a few participants to seek out treatment for themselves. Some noted fewer resources were available to adults compared to adolescents. Young age influenced them to seek services, so they didn't stay homeless	homeless. Identified themes in research but did not report definitively on relationships. Thus, further research will be required for explanations.
The experiences of emergency department use by street-involved	Nicholas, D. B., Newton, A. S., Kilmer, C., Calhoun, A., DeJong-Berg, M. A.,	The research aimed to explore the experiences and perceptions	The study sampled 21 community agency staff serving SI youth,	The researchers utilized grounded theory to guide their methodology.	Communication was identified as a key proponent in the quality of the experience in the emergency department.	The research is limited by the sole reliance on professional

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youth: Perspectives of health care and community service providers.	Dong, K., … Smyth, P. (2016). The experiences of emergency department use by street-involved youth: Perspectives of health care and community service providers. *Social Work in Health Care, 55*(7), 531–544. https://doi-org.ezproxy.net.ucf.edu/10.1080/00981389.2016.1183553	of the service providers who assist these youth with health care related issues.	16 health service providers, 2 hospital administration, and 2 hospital security personnel Theoretical sampling approach was used for participants from the emergency department and community service providers. Email notices were utilized for recruitment Of the sampled service providers, half worked in the emergency department and the remainder worked in SI youth service community-based organization	Fourteen participants were interviewed individually, and the remainder took part in seven group interviews. All interviews were audio recorded and transcribed verbatim. NVivo 10 computer software was used to transcript data. Incremental evolvement occurred until saturation was achieved. Recruitment was adapted due to results from earlier interviews. Line by line coding was followed by axial and selective coding.	Community agency staff stated past experiences with ED influenced youths' attitudes and actions regarding seeking care. If the youth's family had a positive experience, they would more in likely accept their experience (i.e. wait times). Youth described as only having access to ED with no alternative health care or believing they would only end up in the ED if they used other services Health care providers (HCP) stated street-involved (SI) youth don't come until the situation was extreme and in crisis. This can lead to immediate and long-term health consequences. SI youth will walk out before receiving care or the entire treatment. Agency workers described difficulty in getting youth to access health services. SI youth were treated as adults especially in the eyes of security personnel and providers would make assumptions about youth's abilities (i.e self-advocacy, follow up care instruction, dealing with long wait times). SI youth's lack of money that impeded ED care and prescriptions were too expensive. Culturally related differences between SI youth and providers included paranoia due to past abuse, discrimination, mistrust. Young street-involved mothers feared child protective services being involved so they do not share	perspective without the inclusion of street-involved youth.

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					details. The quick nature of ED may dissuade youth from sharing important information, and youth often don't expect to be taken seriously closing opportunities for connection with staff. Community worker noted street-involved youth were automatically stigmatized for being homeless. ED staff noted hospital processes and culture might cause problems for SI youth. Stigma and prejudice from ED staff were mentioned. High workloads at service locations reinforced a lack of attention from staff. Hospital policy requiring the discharge of underage individual with a responsible adult created challenges as they struggle to determine who is a responsible adult. This is especially challenging when there are uninvolved family members or exploitive adults in the youth's life. The mental health services system was described as turnstile as a youth were turned away from care, admitted for brief interventions before being turned away, or told there was nothing to be done. Some services would decline youth due to the use of substances.	
Voices from the periphery: Prospects and	Gharabaghi, K., & Stuart, C. (2010). Voices from the	The study aimed to listen to the multiple	The study included the perspective of service providers,	Interviews and focus groups were audiotaped with the consent of participants. The recordings were	Service providers noted the staffing was not enough to meet needs and allow for safe supervision and care of youth with mental	The study is limited by small sample size.

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challenges for the homeless youth service sector	periphery: prospects and challenges for the homeless youth service sector. *Children & Youth Services Review, 32*(12), 1683–1689. https://doi-org.ezproxy.net.ucf.edu/10.1016/j.childyouth.2010.07.011	perspectives of service providers, stakeholders, and youth to identify current challenges and prospects facing the Central East Service Region.	stakeholders, and youth experiencing homelessness. Participants were recruited with a snowball sampling technique The sample included three executive leaders of services, four stakeholders, and 22 youth over the age of 18. Through the time the research was conducted, six more interview invitations were extended, and one was completed Demographic characteristics of youth participants: 6 Newmarket, 9 Richmond Hill, 6 Oshawa; Six females, 16 males	reviewed independently to determine themes. Collective reviewing of the themes was conducted to identify similarities. The research was approved by Ryerson University's Research Ethics Board	health concerns. As a result, services would turn away youth with severe mental health care needs. They noted mental health services might be available, but accessibility is limited due to travel costs, time, and lack of staffing to facilitate follow-up. Lack of resources extended to the transfer of youth from residential areas to independent housing and lead to relapses of loss of financial resources, housing, involvement with the criminal justice system, drug use, and mental health crisis episodes. In this area, a gap in services existed for those aged 15-17. To facilitate services for this population, service providers noted the need for advocates, and adjustment of rules and regulations in service delivery to meet the homeless and street-involved youth's needs. Though limited, formal sector partnership is important especially for assessing the youth's mental health concerns. Stakeholders held the same sentiments as service providers. In addition to service providers thoughts, they noted the disconnection between formal and informal services leading to lack of a plan for homeless youth and lack of follow up access to continued mental health services following jail or inpatient mental health services. The formal system from their eye did not understand the needs of homeless youth. The strategies they noted to counteract the barriers included the informal system developing a location which	

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					provides comprehensive services, sharing staff and knowledge between the informal and formal sectors, and cultural competence training. Housing should also be provided to facilitate mental health treatment. Youth in the study noted they prioritized safe and clean housing over their health. They noted how being in a shelter limited employment opportunity and how employment connected them with safe sleeping accommodations. Youth relied on peer mentoring to navigated through the system to get identification, and health cards. The youth noted how substances were used to cope with mental illness, family violence, poverty, and parental mental illness. Lack of awareness of services available, and long waiting time limited connection with services. The youth noted peer mentorships, flexibility in counseling relationships, voluntary commission for substance abuse and mental health services, and transitional support helped facilitate use.	

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Appendix B: Selection Method for Literature

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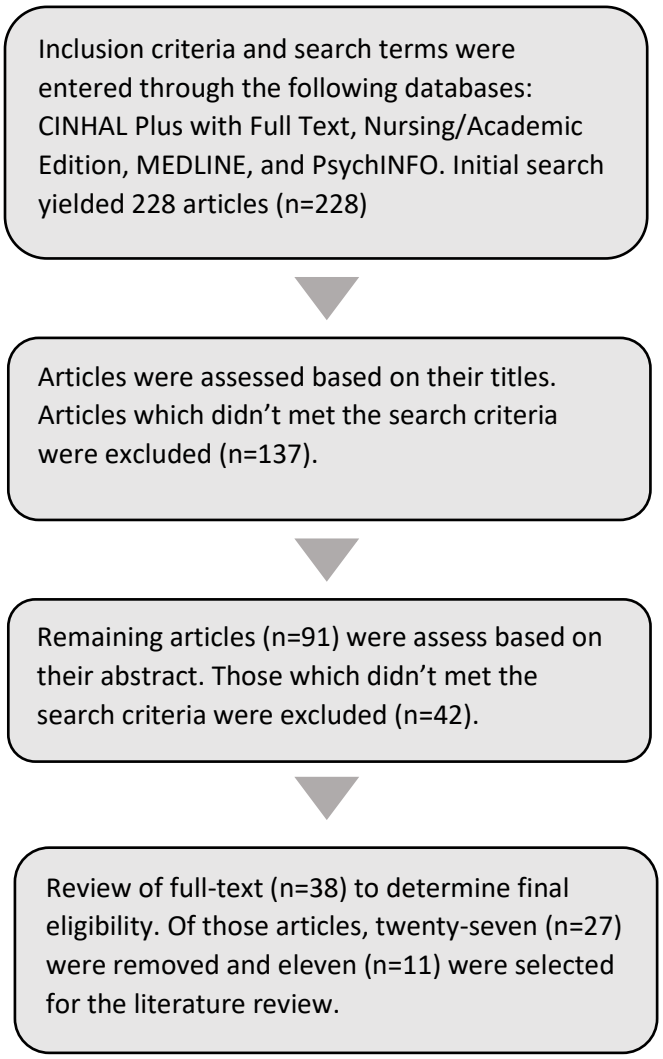
Search Terms: (MH "Homeless Persons") OR (MH "Homelessness") OR "homeless" AND youth or "young people" or teen* or "young adult*" or adolescent* AND "mental health" or "mental illness" or "mental disorder" or "psychiatric illness" or "psychiatric disorder" or psychiatric AND access* or "health services accessibility" or "service use" or barrier* or obstacle* or challenge* or facilitator* or motivator* or enabler* NOT HIV or AIDS or "acquired human immunodeficiency syndrome" or "human immunodeficiency virus"



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