Engaging Youth Experiencing Homelessness

Core Practices and Services

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

DISCLAIMER

ACKNOWLEDGEMENTS

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INTRODUCTION

The large numbers of young people experiencing homelessness in the United States each year are at significant risk of diseases, injuries and developmental delays that can impair their functioning, potentially for their entire lives. Moreover, engaging them in services can be difficult for a variety of legal, psychological, and practical reasons. Wanting to minimize the risks faced by these young people, to improve their health status, and to help them avoid a lifetime of homelessness, Health Care for the Homeless (HCH) and other service providers have developed various strategies for engaging homeless youth in systems of care.

This publication describes practices and services that HCH agencies have found to be helpful in engaging youth experiencing homelessness. It is not a guide on street outreach for youth experiencing homelessness[1]. It is not evaluative or, strictly speaking, a proven "best practices" document, but it captures elements deemed to be essential by practitioners in the field. The information presented here is derived from discussions of the Engaging Homeless Youth Advisory Work Group credited above, discussions in a daylong training during the 2014 National HCH Conference and Policy Symposium, responses to a survey of the field, detailed interviews with six HCH grantees, and a review of the literature. See Appendix A for a fuller description of the methodology and its results.

A substantial body of research findings and literature on homeless youth exists; the references in this publication and appendices; and United States Interagency Council on Homelessness' *Framework to End Youth Homelessness*[2] are worth the reader's attention. For context, however, we start with brief summaries of the various pathways into youth homelessness, the size of the population under consideration, types of youth homelessness, some challenges to engagement efforts, and – first – some definitions.

Definitions

Youth. Currently, there is no standard definition of *youth*, and laws and programs vary widely about the range of ages considered *youth* (e.g., 10-18, 12-21, 16-24, etc.)[3]. Inclusion of individuals who are legally adults (i.e. 18 and over) reflects scientific evidence establishing that the human brain is not fully mature until about the mid-twenties[4].

The working definition for purposes of this publication is ages 12-24, a range inclusive of the various age groups studied in the literature and served by the programs reviewed here.

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[1] For information on outreach, view Homelessness Resource Center's Webcast Resources: Effective Street Outreach: Why it's important, How YOU Can Do It Better! http://homeless.samhsa.gov/resource/hrc-webcast-resources-effective-street-outreach-why-its-important-how-you-can-do-it-better!-48319.aspx

[2] United States Interagency Council on Homelessness (2013). Framework to End Youth Homelessness. Retrieved from http://usich.gov/resources/uploads/asset_library/USICH_Youth_Framework__FINAL_02_13_131.pdf

[3] National Health Care for the Homeless Council. (2011). Children, Youth & Homelessness Policy Statement. Retrieved from http://www.nhchc.org/wp-content/uploads/2011/09/Children2011.pdf

[4] Johnson, S. B., Blum, R. W., Giedd, J. N. Journal of Adolescent Health (2009) Adolescent Maturity and the Brain: The Promise and Pitfalls of Neuroscience Research in Adolescent Health Policy. 45(3): 216-221

Instead of the shorthand term "homeless youth" we apply the term "youth experiencing homelessness" to both individuals and the population of concern. This usage reflects both a "people first" approach to nomenclature and the frequently temporary nature of homelessness.

Homelessness. We adhere to the broad definitions of homelessness used by the US Department of Health and Human Services[5] and the US Department of Education[6], which include persons who are not literally on the streets or in formal shelter programs, but who lack tenure in a variety of ad-hoc, temporary accommodations such as couch-surfing or doubling-up.

The information shared may also help communities develop prevention programs since services targeted to youth and individuals at risk of homelessness are highlighted[7].

Staff, clinicians, and providers. Because this publication is tailored to all levels of an agency, this document uses these terms interchangeably for people who interact with or have direct contact with youth.

Clients, patients, and consumers. The terms are used by different professions and agencies, and this publication uses these terms interchangeably to refer to the youth whom programs serve.

Agencies, organizations, and programs. These terms point to administrative-level functions, practices, and personnel.

Pathways into Homelessness: Adverse Childhood Experiences

As with other homeless sub-populations, a variety of social, economic, and health conditions drive youth homelessness. Some of these are unique to youth, such as parental homelessness, running away from home, being abandoned by parents, abuse, or aging out of foster care or juvenile justice systems. Service providers must assess how individuals' unique histories affect their here-and-now experience.

[5] Defined in section 330(h)(5)(A) as "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing." A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation. [Section 330 of the Public Health Service Act (42 U.S.C., 254b)] An individual may be considered to be homeless if that person is "doubled up," a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. In addition, previously homeless individuals who are to be released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. A recognition of the instability of an individual's living arrangements is critical to the definition of homelessness. (HRSA/Bureau of Primary Health Care, Program Assistance Letter 99-12, Health Care for the Homeless Principles of Practice)

[6] The McKinney-Vento Homeless Assistance Act (42 USC 11302) defines children and youth as homeless if they "lack a fixed, regular, and adequate nighttime residence," including sharing the housing of other persons due to loss of housing, economic hardship, or similar reasons; living in motels, hotels, trailer parks, or campgrounds due to lack of alternative accommodations; living in emergency or transitional shelters; and living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar places. https://www.nn4youth.org/wp-content/uploads/2015-What-Works-to-End-Youth-Homelessness.pdf

[7] The HEARTH Act passed May 2009 involved a revised definition of homeless for the United States Department of Housing and Urban Development (HUD) and its programs and included at-risk and unaccompanied youth within its definition.

Pathways into homelessness, and homelessness itself are commonly understood to be traumatic experiences, requiring that engagement efforts, treatment, and service responses be trauma-informed[8,9].

The Adverse Childhood Experiences (ACE) framework provides a unifying understanding of the personal factors that underlie youth homelessness. In the 1998 ACE Study, which examined the relationship between trauma experienced between ages 0-18 and health outcomes in adulthood, researchers found a relationship between the number of traumatic experiences in childhood and the increased number of risk factors for several leading causes of death in adulthood. More specifically this study reviewed the impact of abuse and household dysfunction during childhood on adulthood disease risk factors and incidence, quality of life, health care utilization, and mortality.[10]

The ACE Study categorized *abuse* as psychological, physical, or sexual abuse, and *household dysfunction* as substance abuse, mental illness, if the mother was treated violently, or criminal behavior in the household. The study considered ten disease risk factors in adulthood including smoking, severe obesity, physical inactivity, depressed mood, suicide attempts, alcoholism, any drug abuse, parenteral drug abuse, a high lifetime number of sexual partners (>50), and a history of having a sexually transmitted disease. The study looked at disease conditions including but not limited to chronic bronchitis, hepatitis, and skeletal fractures. The study found that the number of risk factors increased as the number of childhood exposures increased. The overall findings of the study suggest that the impact of traumatic and adverse childhood experiences on adult health status is significant and may be even stronger than the findings showed in the study.[11]

The seminal work of this study has implications for policy and practice for healthcare providers and child advocates. The ACE Study points to the behaviors used as coping strategies for the anxiety, anger, and depression experienced as a result of the trauma. These behaviors include smoking, alcohol or drug use, overeating, or sexual activity. These coping strategies link ACEs and adult risk behaviors and adult disease.

Prevention strategies for decreasing adult risk factors and diseases that were identified in the ACES include 1) prevention of adverse experiences in childhood, 2) prevention of the adoption of unhealthy coping strategies, and 3) changing these risk behaviors and decreasing the disease burden among adults[12].

Additional research on ACEs more specifically with homeless youth looked at the correlation between ACE scores and both Physician Trust Scale scores and Adult Attachment Scale scores. Faculty at the Oklahoma University School of Community Medicine conducted focus groups and

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[8]Network on Transitions to Adulthood. (2005) Policy Brief: Youth Aging Out of Foster Care. Retrieved from http://www.nhchc.org/wp-content/uploads/2011/10/agingoutoffostercare.pdf

[9] HCH Clinicians' Network Communications Committee. Healing Hands (2010) Delivering Trauma-Informed Services. 14(6) Retrieved from http://www.nhchc.org/wp-content/uploads/2011/09/DecHealingHandsWeb.pdf

[10] Vincent J. Felitti, et al. American Journal of Preventive Medicine (1998) Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. 14(4), pg 245-258.

[11] Ibid.

[12] Ibid.

individual interviews of 23 youth between the ages of 16-24. Common themes identified were 1) reported experiences of adult perpetrated trauma, 2) suspicion of health care providers, and 3) avoidance of health professionals. Results show that ACE scores are associated with lower trust in the medical profession, which is tied to less willingness to seek care, to share sensitive information, and to follow provider recommendations.[13]

The Numbers of Homeless Youth

The accurate number of homeless youth is unknown due to factors including the impermanent nature of homelessness, the varying definitions of youth homelessness, and forms of hidden homelessness such as couch-surfing and doubling-up. Although these enumerations are likely undercounts of the population, recent data provide an indication of a significant issue:

The US Department of Education reports that public schools served a total of 1.36M youth experiencing homelessness in 2013-2014[14].

The US Department of Housing and Urban Development (HUD) reports that there were 194,302 children and youth on a single night in 2014, representing 1/3 of all people experiencing homelessness[15].

The Health Care for the Homeless Program of the Health Resources and Services Administration, US Department of Health and Human Services, reported serving 111,723 youth ages 12-24 in 2014[16].

Types of Youth Homelessness

Subgroups or subpopulations of youth experiencing homelessness can be defined by individuals' shared circumstances and characteristics. These identities have implications in both program development and individual treatment planning including engagement strategies. Examples of subgroups of homeless youth include:

- lesbian, gay, bisexual, transgender, or queer/questioning (LGBTQ) youth[17];
- unaccompanied youth as contrasted to youth who are accompanied by their families[18];

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[13] Mark D. Fox, Ricky T. Munoz, Nancy Brahm (2013) National Health Care for the Homeless Conference workshop presentation. http://www.nhchc.org/wp-content/uploads/2012/11/Adverse-Child-Experiences-Fox.pdf

[14] http://eddataexpress.ed.gov/data-element-explorer.cfm/tab/data/deid/5353/sort/idown/

[15] The U.S. Department of Housing and Urban Development (2014) The 2014 Annual Homeless Assessment Report to Congress. Retrieved from https://www.hudexchange.info/resources/documents/2014-AHAR-Part1.pdf

[16] Calculated from: 2014 Health Center Data: Health Care for the Homeless Grantees, US Department of Health and Human Services. http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2014&state=&fd=ho.

[17] Forty to None Project. Research & Report. (2012) Serving Our Youth: Findings from a National Survey of Service Providers Working with Lesbian, Gay, Bisexual and Transgender Youth Who Are Homeless or At Risk of Becoming Homeless. Retrieved from http://fortytonone.org/research-report/serving-our-youth-findings-from-a-national-survey-of-service-providers-working-with-lesbian-gay-bisexual-and-transgender-youth-who-are-homeless-or-at-risk-of-becoming-homeless/

- youth who are pregnant or parents of young children;
- local as contrasted to nomadic youth;
- youth involved with juvenile justice or foster care systems;
- victims of sexual trafficking and exploitation;
- refugees and immigrants; and
- rural youth.

The National Network for Youth provides additional categorizations within youth homelessness[19].

The United States Interagency Council on Homelessness's youth framework model suggests that organizations consider a young person's time experiencing homelessness, such as newly homeless or chronically homeless, because this correlates with *high and low risk factors* of problems and long-term outcomes[20].

Service providers also should recognize that many young people experiencing homelessness may not consider themselves "homeless" because they may not perceive couch-surfing or anything other than sleeping on the streets as homelessness[21]. This has marketing implications for programs that seek to engage youth who are unstably housed but not sleeping outdoors or on the streets.

Challenges to Engagement

Several factors are known to hinder engagement of youth experiencing homelessness. These include:

- **Rigid agency policies.** Unrealistic expectations about youths' ability to conform to expectations about acceptable behavior may in fact create barriers to care.

- **Legal issues.** In many states, parental permission is required for health care providers to treat unaccompanied youth, and youth may be unable or unwilling to secure permission. In many jurisdictions, a youth must have reached the age of 21 to sign a lease on a dwelling[22]. Many communities criminalize youth for committing "status offenses", behaviors that are considered illegal only when committed by a minor such as truancy, breaking curfew, or running away[23]. Lack of documentation and identification is another barrier faced by many individuals who are experiencing homelessness. Without a permanent address or a safe space to store belongings, documents often get lost, and

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[18] National Center for Homeless Education. (2013) Supporting the Education of Unaccompanied Homeless Students. Retrieved from http://center.serve.org/nche/downloads/briefs/youth.pdf
[19] https://www.nn4youth.org/learn/definitions/
[20] United States Interagency Council on Homelessness (2013). Framework to End Youth Homelessness. Retrieved from http://usich.gov/resources/uploads/asset_library/USICH_Youth_Framework__FINAL_02_13_131.pdf
[21] HCH Clinicians' Network Communications Committee. Healing Hands (2009) Engaging Adolescents Who Are Homeless in Care. 13(5) Retrieved from http://www.nhchc.org/wp-content/uploads/2011/10/HealingHandsOctweb.pdf
[22] National Health Care for the Homeless Council. (2011). Children, Youth & Homelessness Policy Statement. Retrieved from http://www.nhchc.org/wp-content/uploads/2011/09/Children2011.pdf
[23] Youth Today. (2012) Experts Address the Legal Problems Surrounding Homeless Youth Services. Retrieved from http://youthtoday.org/2012/09/experts-address-the-legal-problems-surrounding-homeless-youth-services/

people experiencing homelessness often don't have the money to replace them. We know this is a barrier to accessing supportive services, employment, education, and housing. This "outlaw" status may cause youth to avoid authority figures altogether. The 2012 report developed by the National Law Center on Homelessness & Poverty, *Alone Without A Home: A State-By-State Review of Law Affecting Unaccompanied Youth*[24] provides more information on these topics.

- **Substance use.** Research shows that substance use can influence service utilization because the youth may perceive their using as precluding access to programs and services such as emergency or transitional housing, so they may not even attempt or consider accessing available services[25]. Drug use can also impair judgment and decision-making, a critical consideration when youth have to make a decision about engaging with providers or accessing services. Shame and guilt are normal aspects of addiction, and some youth may have concerns about their rule-breaking, or not wanting to disappoint service providers with whom they had built a relationship[26]. Reviewing administrative policies and ensuring staff training to develop skills in working with youth who use substances, including a non-judgmental approach, motivational interviewing and harm reduction models of care are suggested[27].

- **Youth perception of available services.** Youths' perceptions of the health care system, service providers, and older adults can present a challenge to engagement. Youth may have been treated poorly in the past by medical staff so there may be anxiety around accessing medical care. One clinician recalled a young person saying, "I want to see someone that is not paid to care about us." Providers need to consider that other homeless youth outside of the care system may share this sentiment, and consider research previously mentioned on adverse childhood experiences and provider trust.

- **Youth knowledge of available services.** Youth, especially newly homeless individuals, may lack knowledge of available services and assistance. Vigorous campaigns of outreach and marketing, informed by the advice of youth themselves and the participation of community collaborators, are often necessary. Provision of tangible resources can be a helpful entry point with a potential client. Outreach workers can explain benefits and assist youth in determining eligibility and applying for insurance, disability, or income and food assistance[28], and can share general information that allow youth to make informed decisions about their options.

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[24] http://www.nlchp.org/Alone_Without_A_Home

[25] Staci Perlman and Joe Willard. (2013) Homeless Youth in Philadelphia: An innovative method for identifying youth who are homeless. Available at: http://works.bepress.com/staci_perlman/11

[26] Ibid.

[27] Denitza Bantchevsk et al. Social Work Research. (2011) Predictors of Drop-in Center Attendance among Substance-Abusing Homeless Adolescents. 35(1): pages 58-63.

[28] New policy guidance released in May 2013 by USDA aims to ensure that eligible homeless youth can get food through Supplemental Nutrition Assistance Program (SNAP). National Clearinghouse on Families and Youth. (2013) Homeless Youth Under 18 Can Apply for Food Assistance, and Other Clarifications of SNAP Regulations. Retrieved from http://ncfy.acf.hhs.gov/news/2013/08/homeless-youth-under-18-can-apply-food-assistance-and-other-clarifications-snap

- **Insufficient agency resources.** Effective engagement requires the consistent availability of well-trained staff that agencies may not be able to afford. Creating and maintaining safe physical settings for youth can be costly.

- **Rural settings.** Resource limitations may be particularly challenging in rural and sparsely populated areas. To address this challenges the National Alliance to End Homelessness suggests relying heavily on needs and asset assessments in planning for services and programs, and understanding that each community will present with its own unique set of challenges so conversations between community members and stakeholders are first steps in identifying possible solutions.[29]

- **Outcomes and Reimbursement.** Funders of all types increasingly require measurable outcomes. As discussed below, however, engagement is all about relationship, which can be difficult to measure. One clinician shared, "The majority of things that I talk with [youth clients] about are not specifically medical, and I'm banking on the fact that building that relationship will mean when things hit the fan, when things get bad, they're going to remember that I treated them like a person and was willing to talk with them when I didn't have anything specifically I needed from them. I found that that is the relationship that results in them calling me before they go to an emergency department." The section of this paper on Measuring Engagement explores this topic further.

THE CORE OF ENGAGEMENT: RELATIONSHIP

The following discussion is based on suggestions of the advisory work group, the literature review, and results and key findings from the study. The concepts and approaches discussed here are closely interrelated and should shape both individual interactions and program design.

Engagement means establishing a **relationship** and building upon it.

One clinician shared, "Engagement is not about what [products and services] we have to offer, what's in our backpack, or even the fliers that we have to hand out, it's really about connecting with the young person."

Practical suggestions for providers meeting homeless youth for the first time include[30]:

- Share what you do, and don't require anything of the young person.
- Give the young person an opportunity to choose to say *no* or decline what is being offered.

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[29] National Alliance to End Homelessness. (2012) Housing and Outreach Strategies for Rural Youth: Best Practices from the Rural Youth Survey. Retrieved from http://b.3cdn.net/naeh/3f100858fc52da907c_ctm6bhnhe.pdf
[30] HCH Clinicians' Network Communications Committee. Healing Hands (2009) Engaging Adolescents Who Are Homeless in Care. 13(5) Retrieved from http://www.nhchc.org/wp-content/uploads/2011/10/HealingHandsOctweb.pdf See page 5.

- If the client accepts or declines, make known the availability of the provider (location and times) that the young person can access if they would like to in the future.
- If the client accepts further engagement, the provider can share health information and information about accessible community resources.
- If the client accepts further engagement, the provider may begin to assess the young person's needs by asking and listening, sticking with basic attending and reflective listening skills[31].

To connect with a consumer, staff members first need to earn the **trust** of the youth. Trust is a complex phenomenon, involving personality characteristics, past experiences, cultural expectations, and the current situation and environment. It is gained through genuineness, consistency, dependability, and transparency. The experiences two people have with one another are a central factor in building trust, and may entail multiple encounters or exposures to the other person, conscious reflection on the evolving relationship, a willingness to admit mistakes, and time. As a clinician remarked, "It can take engaging, re-engaging, and not giving up on the young person." Many clinicians agree that it happens in baby steps. One clinician noted, "When we engage a youth client and build a trusting relationship with that individual, we are also helping them to see that there can be a positive relationship with systems, providers or with adults."

Trust must be reciprocal. A clinician stated, "Engagement means both parties [are] willing to take a chance on each other." Both parties take risks. He goes on, "Continue to show good faith, and even if things don't go well, try to do it again. A lot of time my success has been with youth who multiple times have gone through the same process with me before it was a success, and for them seeing that I'm willing to continue to work for them is the thing that finally convinces them to work with me."

Trusting providers take risks, and trust in the ultimate outcomes. Providers accept clients as they say they are, and remove suspicion and doubt. Providers remove and reframe terms that can be damaging to the relationship. For example, the term *manipulative* behavior can be reframed and instead providers begin to see a person not as manipulative but as resourceful and creative in finding ways to get their needs met, or not *lazy* but reasonably exhausted or even experiencing symptoms of depression. Providers trust in the client's ability and capacity to adapt and change. These shifts in attitudes toward the young person will allow for trust to grow and deepen in the relationship.

Safety is a central component of trust. Does the youth feel safe? If a provider responds "They should feel safe. I'm not going to harm them. I'm a safe person" or "They're inside a clinic, and it's more safe than being on the street", this is not addressing the *feelings* of the individual. When a person is clear of danger, it does not necessarily cause that person to *feel* safe. Consider that feelings of safety can be altered in people who experience violence and trauma. Because of a past trauma a client may behave in a way that to an outsider's perspective seems *more* risky. For example, think of a person who when physically attacked at home and had difficulty trying to escape because the locks became a barrier and the person fumbled to remove all the locks to escape

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[31] Allen E. Ivey, Norma Gluckstern Packard, Mary Bradford Ivey. (2006) Basic Attending Skills. Fourth Edition.

being attacked. Now several months later this person only feels safe in her home if she doesn't have her doors locked. To an outsider this seems more dangerous, but to this traumatized person it *feels* right. The initial approach to individuals should not be to convince them that they are wrong, but to approach them with a desire to understand. Providers serving homeless youth need to be cognizant of how trauma affects the individual's behaviors and thinking, especially one's concept of safety.

When people feel safe they are more willing to trust, and in this interactional cycle, trust creates a sense of safety. When young people feel safe, they can open up and are more willing to communicate and reach out. They will feel safe to:

- Be emotional, have and express various emotions including fear and anger
- Form attachments
- Voice opinions without fear of repercussions
- Say no and set boundaries with others including adults, providers, and staff

Respect is central to engagement. As youth begin to trust providers and reveal themselves, it is crucial for providers to exhibit a respectful, accepting, non-judgmental attitude. One clinician remarked, "The young people we serve feel invisible ...even within programs that are there [to serve] them." The young people who walk through an agency's doors may be judged or looked down on by others for their age, hygiene, behavior, dress, the groups or crowds they associate with, or their housing status, and because of this, many youth are not hearing that they are seen, heard or cared for from adults, authority figures, or people working for the "system." A clinician was reminded of something one of her young consumers had expressed, "Why can't I be seen for more than a drug-abuser? Why can't I be seen for more than a trouble-maker?"

If providers don't respect someone it will be challenging for the provider to trust that person or gain the person's trust. What does respect look like between a provider and a youth client? Respect involves taking a non-judgmental stance, acceptance, valuing, and involving. Providers attempt to view whole individuals, their perspectives, their behaviors, expressed ideas, and experiences from a non-judgmental stance. People tend to have biases and judgments that may be benign to their lives outside of work but these biases can be damaging in a helping relationship, but proper training and supervision assists providers in identifying their own limitations and areas for growth that may be getting in the way of engagement and developing mutual respect with clients.

Respecting the whole person is conveying to the young person through words and behaviors the message *I see you. I hear you. And I care.* Reflective listening through Motivational Interviewing is one technique for helping youth feel accepted[32].

When youth are being respected, their **boundaries** are also being respected. People of all ages and backgrounds struggle with boundaries at times, whether that is setting boundaries, enforcing them, or understanding and respecting another person's boundaries that are different than their own. Identifying and remaining respectful of a client's boundaries is essential to the client's sense of

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[32] National Health Care for the Homeless Council. (2011). Motivational Interviewing online training. Retrieved from https://www.nhchc.org/wp-content/uploads/courses/mi/mod2/doc/mi_slide_transcript.pdf

safety. Providers should offer opportunities for open discussions about boundary issues, which can include aspects of personal histories, relationships and behaviors that the client does not wish to broach, understanding that as relationships evolve, boundaries change, and new opportunities to explore sensitive issues will open up. Providers should model appropriate boundary setting around their work, the time spent with consumers, and the helping relationship they have with the young person.

A relationship characterized by trust, safety and respect is built upon **cultural humility.** Culture can be defined as the set of beliefs, experiences, and expectations within which an individual exists, and the set of choices that that context provides for the individual. Providers should be alert to their own cultural frameworks and presuppositions, to the (often differing) cultures of their clients, and the ways in which the differences play out in the provider-client relationship. Non-judgmental acceptance of the client's culture is key to developing a strong and helpful relationship.

Cultural humility is not only the responsibility of the individual staff member but should also be addressed by the organization on a programmatic level. The Youth Development Institute recommends that an agency's mission align with program practices, activities, interactions between staff and youth, and staff's personal missions[33]. Culturally appropriate staff and mechanisms for engaging and working with youth should be addressed at all levels within an agency including program development, communications, advocacy and networking, assessments, community and family engagement, and interventions[34]. A checklist to assess youth centrism is provided by the [National Resource Center for Youth Services' Youth Friendly Checklist](#)[35].

To achieve a strong relationship, providers and agencies should work to remedy the inherent imbalance of **power** that exists in helping relationships with youth.

On an individual level, youth gain power when providers elicit information from consumers about their goals, actively listen to their opinions and concerns, view them as the expert on their lives, incorporate their input and respect their boundaries. Such youth involvement is attributed to increased feelings of self-efficacy and positive self-esteem in the youth[36]. Providers should be mindful of the urge to "rescue" youth, which is not supportive to youth self-efficacy and can lead to providers overstepping boundaries and even to burnout.

On an organizational level, youth are empowered and agencies are well-served by youth involvement in program planning, execution, evaluation and governance[37]. Such involvement is required for federally funded health centers[38] like Health Care for the Homeless grantees, and for other programs. Youth have the capacity and desire to have projects, create programs, be involved in key decisions, and create change in policy, but they often require guidance from experienced

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[33] Youth Development Institute. (2008) Core Competencies for Youth Work. Retrieved from http://fred.fcny.org/ydipubs/pubs/core.pdf
[34] Ibid.
[35] See pages 40-43.
[36] National Resource Center for Youth Service. (2008) Positive Youth Development Toolkit: Engaging Youth in Program Development, Design, Implementation, and Service Delivery. Retrieved from http://www.nrcyd.ou.edu/publication-db/documents/2008-positive-youth-development-toolkit.pdf
[37] Ibid., p. 11-12.
[38] http://bphc.hrsa.gov/about/requirements/

adults[39], requiring planning and a concerted effort on the part of organizations serving youth. Helpful guidance in this area is provided in the National Resource Center for Youth Services' Positive Youth Development Toolkit[40], but, for example, a program can involve youth through:

- Surveys
- Focus groups
- Advisory committees
- Board participation[41]
- Volunteer, or paid employment, and other professional development opportunities[42]
- Peer outreach or mentoring programs[43]

Summary: Three Essential Questions about Relationship

- Is the provider expressing trust and respect and considering safety?

- Is the provider considering the individual's culture, respecting boundaries, and attempting to involve youth in decision-making?

- Are providers expressing acceptance, appreciation, and the desire to work together with the client?

CONSIDERATIONS IN PHYSICAL ENVIRONMENT

The physical environment in which encounters with homeless youth occur can have a profound effect on the quality of those encounters. "Meeting clients where they are," an established strategy in harm reduction models of care[44], often has geographic as well as psychological importance. Many providers go out to meet clients where clients feel safe to meet. The young person might say, "If you want to meet with me, you can meet me at the XYZ store downtown. I'll be there if you want to meet me." Young people may be unsure of the provider and want to test the relationship to figure out if they are trustworthy.

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[39] National Resource Center for Youth Service. (2008) Positive Youth Development Toolkit: Engaging Youth in Program Development, Design, Implementation, and Service Delivery, p. 16. Retrieved from http://www.nrcyd.ou.edu/publication-db/documents/2008-positive-youth-development-toolkit.pdf

[40] Ibid., p. 16.

[41] Youth on Board. http://www.youthonboard.org/#!shop/c1ryn

[42] The National Health Care for the Homeless Council. (2014) Consumer Employment in the Health Care for the Homeless Setting: Promising Practices. Retrieved from http://www.nhchc.org/wp-content/uploads/2014/10/consumer-employment-in-the-health-care-for-the-homeless-setting.pdf

[43] http://www.youthmovenational.org/youth-peer-to-peer.html

[44] Harm Reduction Coalition. Principles of Harm Reduction. Retrieved from http://harmreduction.org/about-us/principles-of-harm-reduction/

Providers meet clients where they are and do the best with what they have. One clinician shared an experience of her supervisee, "Sometimes the youth would show up with a large group of friends. The clinician would have to figure out how to engage in a productive therapy session with this youth who is showing up with ten friends." These kinds of relationships take dedicated effort and time to build. Consumers want to know if they can trust the provider, if the provider is willing to make an effort, and -- again -- youth fundamentally need to feel safe. Providers find that youth experiencing homelessness sometimes find safety in staying within familiar surroundings or having their peers close by.

For many program administrators and clinicians interviewed, creating a youth-centric physical environment for the clinic or drop-in center is important for youth engagement. In creating such a space it is vital that administrators understand the youth populations they serve, obtain and use youths' perspectives, and attempt to create a space that feels safe to their consumers.

In understanding the youth populations served, administrators can think in terms of sub-groups, sub-cultures, or sub-populations served, and have posters, images, symbols and other displays that are welcoming and considerate of these groups. For example, estimates suggest about 20 percent of the homeless youth population identifies as LGBTQ[45], so having a rainbow image displayed to represent that the clinic is welcoming of the LGBTQ community is a common best practice. Samples of health education posters tailored to youth were shared at the 2014 National Health Care for the Homeless Conference and Policy Symposium and are available upon request[46].

Trauma-informed organizations will take into consideration how youth are affected by trauma and how their worldview is shaped by the interactional relationship between developmental stage and the traumatic events, and take into account how the physical space of the clinic can trigger the youth and hinder engagement. One physician shared that some of his clients feared being behind closed doors with the clinician. In developing their new space for their youth clinic, they made sure to have large widows with blinds for privacy in the medical rooms. Another medical clinic that serves general adult populations was able to create a separate entrance/exit and private waiting room for the youth populations because several youth shared that they did not feel comfortable walking into the larger clinic. In these examples, the clinicians were not only able to get feedback from their youth clients but also incorporated what they had learned. Program administrators and clinicians are encouraged to collect feedback specifically about the environment where services are provided. Feedback can be given more formally in focus groups and questionnaires, or informally simply by listening while sitting with consumers during meals or during scheduled one-on-one appointments. Administrators need to create channels for this feedback to be shared back to the larger administration, possibly through a quality improvement committee. Consumer feedback is discussed in more detail in the section on *youth involvement*.

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[45] National Alliance to End Homelessness. (2012) National Policy Statement. *LGBTQ Youth*. Retrieved from http://www.endhomelessness.org/library/entry/lgbtq-youth-national-policy-statement
[46] Developed by Robert Power-Drutis from Outside In (Health Care for the Homeless grantee in Portland, OR) Request printable copies of health education posters on Cold & Flu; Scabies; Gonorrhea; Chlamydia; Syphilis; Hepatitis C by emailing jhishida@nhchc.org

Other suggested practices:

- Consider décor and colors of walls, moving away from standard, sterile colors.
- Remove physical barriers such as locks or gates that may seem unwelcoming and present as a barrier to youth.
- Have processes and policies in place to develop language on written materials so that the wording is not confusing or triggering, but inclusive. This can be done by having written material go through multiple stages of review that includes having an advisory group made up of the youth population served to review materials before it is posted or published by the agency.
- Display artwork and other designs created by the youth served.
- Open spaces are ideal.
- Allow and encourage youth to put things up that make it their own space.
- Programs need to be soliciting suggestions and available to receive concerns and complaints both in-person and anonymously.
- Offer snacks or food.
- If developing a clinic, consider locations adjacent or near drop-in centers or shelters. Clinics that are walking distance from youth drop-in centers and shelters can significantly increase walk-in traffic.
- One-stop shops, where clients can get a number of needs met in one place are ideal models to engage youth in more services. Generally evening and weekend hours are needed.
- Having support staff available in the open spaces, not just behind the front desk.
- Flexibility is key. Flexibility to increase opportunities for engagement whether that is through services offered, hours, or physical environment and other aspects. Consider the sub-populations served and the diversity of the youth population.

Some administrators and clinicians are mobile and provide services at shelters, various sites throughout the week, share space with a clinic that serves other general populations, or generally do not have total control of developing or changing the physical space. In these instances, administrators still made attempts to make available certain images and written language on fliers or pamphlets that were tailored to their youth population and welcoming of various sub-groups.

CONSIDERATIONS IN SERVICE DESIGN

Maintaining engagement with youth requires provision of services that are accessible and appropriate. The following **General Principles**, in large part reflective of the relationship issues discussed above, have proven to be important in the design of services for youth experiencing homelessness:

- <u>Multiple Points of Entry</u>: Various agency types and locations where programs and services are available and offered to young people will help increase the likelihood of engagement.

- Cultural Humility: This includes training providers to take a non-judgmental and accepting stance when working with youth from various backgrounds.

- Trauma-informed Care: Significant trauma is a near-universal experience for youth without homes; providers should learn to recognize and consider trauma when engaging with these youth.

- Multi-disciplinary, Holistic Care: The physical, psychological and social factors that effect youth are inseparable in practice and are best addressed by well-coordinated interdisciplinary teams.

- Consumer Involvement: Meaningfully involving consumers in the decisions that affect them – from treatment decisions to agency policies – is central to effective services.

- Housing: The reason to engage youth experiencing homelessness is to ensure their safety, health, and stability. This is best accomplished through permanent housing.

Medical Services: Youth experiencing homelessness are commonly seen for acute care for ailments such as cold and flu, bug bites, skin infections, lice and scabies, but youth seen at HCH clinics also receive treatment for chronic conditions like diabetes, hypertension, asthma and obesity. Many providers interviewed commented that missing follow-up appointments is a frequent occurrence, which can be due to many factors. People who are experiencing homelessness have competing priorities and keeping health care appointments may not be at the top of their list. Providers need to remain flexible and understanding. Motivational interviewing techniques are part of successful youth engagement, and once engaged young people can become more motivated to learn about healthy new ways and work toward change. Clinicians may be inclined to educate and inform, but if the consumer is not engaged and does not have that relationship with the clinician, the information will be cast aside. Providers need to identify what may get in the way of coming back to the client's next appointment and what is important to the client at the moment by asking questions like, "How can I get you to come back for another appointment?" or "How important is (state condition) to you?" Providers can then respond to youths' needs and connect them to the appropriate person, not convincing them to do something different or giving advice, but giving them options.

Providers commented on the lack of available funding and services for specialty medical care including oral health and vision services for their patients. The Department of Health and Human Services (HHS) offers suggestions for the integration of oral health services within primary care, and your state may be currently participating in HHS's Oral Health Initiatives to help expand the local oral health workforce[47,48]. Existing health centers are encouraged to apply for HHS Expanded

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[47] http://www.hrsa.gov/about/news/pressreleases/131030oralhealth.html
[48] http://www.hrsa.gov/publichealth/clinical/oralhealth/primarycare/integrationoforalhealth.pdf

Services grants when they are made available. These grants assist programs to expand services such as oral health, behavioral health, pharmacy, and/or vision services[49].

Programs can do more to facilitate changes in health conditions than just offering clinical services and working directly with clients. Programs can advocate for change at policy and programmatic levels to offer more health-conscious services and meals[50, 51]. Programs can network with peers; stay up to date with new research and treatment modalities[52]; and participate in research[53].

Sexual Health Services: Programs should identify consumers who may be at risk for sexually transmitted diseases and sex-related violence, and engage these youth as early as possible to reduce risk. Levels of risk for engaging in survival sex may be affected by whether the youth is living on the street or in shelter[54]. Lesbian, gay, transgender and bisexual homeless youth had significantly greater likelihood of reporting survival sex than their heterosexual and non-transgender counterparts, and both homeless and bisexual youths who engage in survival sex are at a high risk for HIV infection[55, 56]. Both males and females participate in survival sex and African American homeless youth were significantly more likely to engage in survival sex than white homeless youth[57]. Drug use plays a role in increasing sexual risk behaviors, especially among newly homeless youth, but current research is unclear about the exact relationship between substance use and survival sex[58]. Training providers to assess for risk and make services, education, and treatment available is important, but if the relationship hasn't been built, youth may not feel comfortable disclosing their sexual activities or symptoms or access treatment.

Rates of pregnancy correlate with housing status; data suggest about 50% of unaccompanied youth have had a pregnancy experience, and one study showed that both accompanied and unaccompanied young males experiencing homelessness were less likely to use contraception (30%) than their housed counterparts (60%)[59, 60]. Programs can offer services that may help limit the number of unplanned pregnancies including distribution or referrals for contraceptives and education. Special services and needs should be tailored for youth who are pregnant or already parents. The National Network for Youth suggests that services for pregnant and parenting youth include eligibility workers, health care providers including access to substance use treatment, parenting classes, educational support, child care, and transportation assistance[61]. In addition to

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[49] http://www.hrsa.gov/grants/apply/assistance/es/
[50] https://www.nhchc.org/resources/clinical/diseases-and-conditions/nutrition/
[51] https://www.nhchc.org/resources/clinical/tools-and-support/children-youth/
[52] Society for Adolescent Health and Medicine. https://www.adolescenthealth.org/Home.aspx
[53] Join the Council's HCH Practice-Based Research Network. https://www.nhchc.org/pbrn/
[54] Ibid.
[55] N. Eugene Walls & Stephanie Bell. Journal of Sex Research (2011) Correlates of Engaging in Survival Sex among Homeless Youth and Young Adults. 48(5), pg 423-436
[56] Shulamith Lala Ashenberg Straussner. (2004) Clinical Work with Substance-Abusing Clients. pg 405
[57] Ibid.
[58] Youth Today. (2008) Predictors of Sexual Risk Behaviors among Newly Homeless Youth. Retrieved from http://youthtoday.org/2008/02/predictors-of-sexual-risk-behaviors-among-newly-homeless-youth/
[59] Staci Perlman and Joe Willard. (2013) Homeless Youth in Philadelphia: An innovative method for identifying youth who are homeless. Available at: http://works.bepress.com/staci_perlman/11
[60] The National Network for Youth. (unknown) Issue Brief: Pregnant and Parenting Homeless Youth. https://www.nn4youth.org/wp-content/uploads/IssueBrief_Pregnancy_and_parenting.pdf
[61] Ibid.

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parenting classes, peer support groups for this population should be considered. Tips to engage and work with this subgroup are available[62, 63, 64, 65].

Youth experiencing homelessness are at increased risk for intimate partner violence (IPV) due to several potential factors including turning to survival sex, drugs, and other illegal activity, which increases their vulnerability to exploitive relationships and interpersonal abuse[66]. Assessing and addressing abuse and imminent danger is part of creating a safe space for youth. Programs also need to have materials and other means available to educate youth about abusive relationships as a prevention and awareness measure, and inform youth about protective services that are available to them if they are currently in an abusive relationship or if they find themselves in one in the future.

Mental and Behavioral Health services: Standard mental and behavioral health services for youth experiencing homelessness include regular screenings and treatment for depression, anxiety and other mood disorders, suicidality, post-traumatic stress disorder, and substance use. Using substances can in itself be harmful to one's overall health and wellness, but also it can act as a barrier to engagement and impede a person's ability to receive help and treatment. Providers should consider and utilize harm reduction and core concepts of motivational interviewing to approach youth so that if they are using, they are more inclined to feel accepted and welcomed to engage and receive services. Building healthy relationships could assist in diminishing negative consequences of substance use. Assessment and screening tools for substance use designed for adolescents are available[67]. Programs should offer support groups or at least be able to refer clients to local support groups. When planning for support groups consider the subgroups a program serves and tailor services accordingly. For mental health crises when clinics are closed and staff are not on-call or available, posting numbers to your local 24/7 crisis hotline and the National Suicide Prevention Lifeline[68] may be an option.

The Adverse Childhood Experiences Study (ACES) explains how traumatic childhood experiences place individuals at risk for negative health outcomes in adulthood. The study has significant implications for service provision and engagement strategies. Trauma-informed practices align with the prevention strategies outlined in the study and are vital for organizations and providers to address many of the serious negative consequences highlighted in the study. Trauma-informed practice includes (1) increasing awareness of the occurrence of trauma experienced during

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[62] The National Clearinghouse on Families and Youth. (unknown) 6 Tips for Connecting with Pregnant and Parenting Teens. Retrieved from http://ncfy.acf.hhs.gov/media-center/slideshows/6-tips-connecting-pregnant-and-parenting-teens

[63] The National Clearinghouse on Families and Youth. (unknown) Five Things to Know About Teen Parents and How to Help Them. Retrieved from http://ncfy.acf.hhs.gov/media-center/slideshows/five-things-know-about-teen-parents-and-how-help-them

[64] Christine Taylor et al. Contemporary Nurse. (2012) What Works to Engage Young Parents Into Services? Findings from an Appreciative Inquiry Workshop. 42(2): pages 258-271.

[65] Ammerman SD, Ensign J, Kirzner R, Meininger ET, Tornabene M, Warf CW, Zerger S, Post P. Homeless Young Adults Ages 18-24: Examining Service Delivery Adaptations. Nashville: National Health Care for the Homeless Council, Inc., 2004. (see pages 33-35). Retrieved from http://www.nhchc.org/wp-content/uploads/2011/10/younghomelessadult1.pdf

[66] Hollywood Homeless Youth Partnership. (2010) A Practical Guide for Service Providers: Addressing Intimate Partner Abuse in Runaway and Homeless Youth. Retrieved from: http://hhyp.org/wp-content/uploads/2012/02/HHYP_Addressing_Intimate_Partner.pdf

[67] The National Clearinghouse on Families and Youth. Assessment and Screening Tools for Measuring Mental Health, Substance Abuse, and Independent Living Skills in Adolescents. Retrieved from http://ncfy.acf.hhs.gov/publications/assessment-and-screening-tools-measuring-mental-health-substance-abuse-and-independent

[68] National Suicide Prevention Lifeline. 1-800-273-TALK. http://www.suicidepreventionlifeline.org/

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childhood (e.g. educating staff and clients, routine screenings for trauma and exposure to violence), and (2) an understanding by staff and clients of the behavioral coping strategies that individuals commonly utilize to mitigate the emotional impact of traumatic experiences. The ACE study also highlights the lack of psychosocial assessments and anticipatory guidance that are available and utilized in adolescent health care, and suggests an increase in physician training to best address trauma and its long-term health impact[69]. There are many proven effective treatment modalities for trauma such as narrative therapy, eye movement desensitization and reprocessing (EMDR) therapy, expressive arts, and acute therapy interventions. Mental health providers can assess the type of trauma and treatments that are appropriate for improving youth outcomes; additional reasons for integrating trauma-informed approaches in homeless youth programs include reducing staff burnout, increasing engagement, and increasing organizational effectiveness[70]. Other treatment considerations for trauma relevant for all providers are available[71].

Social and Support Services: A highly desirable goal of engaging youth experiencing homelessness is housing for the consumer. Programs should consider offering housing assistance either directly or through referral, and/or collaborating with local housing authorities, Runaway and Homeless Youth (RHY) grantees, supportive housing programs[72], and the local Continuum of Care[73]. Reviewing research on youth exiting homelessness and working with younger adults or youth who have been housed and who could speak to their experiences, even mentor currently homeless clients is recommended[74].

In addition to housing services and case management, common support social services include family reunification services, employment, GED and other educational services such as career counseling. Having staff or teams of staff dedicated to education and employment services is ideal. Programs should consider offering legal services for assistance with disability benefits, signing leases and getting housing, and youth coming out of incarceration or the juvenile justice system. The publication "Examining Service Delivery Adaptations" shares strategies for working with young people who are involved in the criminal justice system[75]. For programs that do not have a one-stop shop model, who refer youth to other agencies for services, or are asking youth to return back to the agency or program at a later date or time, it is best practice to have transportation support available, whether that is through bus tokens, taxi vouchers, or an agency's own shuttle or van services. Lastly, health and medication management or navigation services, including peer-led and community health worker models are support services that benefit the client and speak to

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[69] Ibid.

[70] Hollywood Homeless Youth Partnership. (2009) 10 Reasons for Integrating Trauma-Informed Approaches in Programs for Runaway and Homeless Youth. Retrieved from http://www.hhyp.org/downloads/HHYP_10Reasons_Flyer.pdf

[71] The National Child Traumatic Stress Network. (2007) Culture and Trauma Brief: Trauma Among Homeless Youth. Retrieved from http://www.nctsnet.org/nctsn_assets/pdfs/culture_and_trauma_brief_v2n1_HomelessYouth.pdf

[72] http://www.csh.org/resources/stable-homes-brighter-futures-evaluation-report-preliminary-findings-from-year-1/

[73] Rapid Rehousing Models for Homeless Youth. https://www.hudexchange.info/homelessness-assistance/resources-for-homeless-youth/rrh-models-for-homeless-youth/

[74] Paula Mayock, Eoin O'Sullivan, and Mary Louis Corr. Housing Studies. (2010) Young People Exiting Homelessness: An Exploration of Process, Meaning and Definition. 26(6): pages 803-826.

[75] Ammerman SD, Ensign J, Kirzner R, Meininger ET, Tornabene M, Warf CW, Zerger S, Post P. Homeless Young Adults Ages 18-24: Examining Service Delivery Adaptations. Nashville: National Health Care for the Homeless Council, Inc., 2004. (see pages 29-30) Retrieved from http://www.nhchc.org/wp-content/uploads/2011/10/younghomelessadult1.pdf

youth engagement. Learning from other programs and communities about their practices may offer solutions to meeting these needs of youth consumers[76].

Healing Arts and other Creative Interests: Youth are often engaged through the arts. One administrator shared, "Sometimes we have theatre production. Folks work with the kids for a number of weeks and put on a program...Understanding that the arts and healing arts play an important role in helping staff and kids, being able to offer a variety of options is one of our goals." All interviewees highlighted unique classes and services that are offered to their youth consumers. Interest and participation in the services varied, and may work better within some communities and certain populations than others. As always, program design should include input from the youth population and allow time for the special services to grow and become established. Continually assess for quality, obtain input from youth, and make changes accordingly. There are resources available with tips on how to engage youth through humanities and other interests[77, 78, 79] including:

- Technology, the internet and social media[80, 81, 82, 83]
- Visual and performing arts
- Civic activities and community
- Writing and Poetry
- Music
- Entrepreneurship
- Sports and Exercise, including Yoga
- Gardening
- Bodywork
- Crafts

Interdisciplinary Care and Community Partnerships: Given the multiple issues presented by youth experiencing homelessness, and despite the central importance of primary relationships, it is unrealistic to expect any one provider or agency to be able to meet all the needs in any situation. Within HCH and other health care programs, interdisciplinary teams respond to whole persons and their health care needs[84]. Individual engagement can happen at all program levels from front

[76] Patricia F. Julianelle. California Research Bureau. (2007) The Educational Success of Homeless Youth in California: Challenges and Solutions. Retrieved from https://www.library.ca.gov/crb/07/07-012.pdf

[77] National Resource Center for Youth Service. (2008) Positive Youth Development Toolkit: Engaging Youth in Program Development, Design, Implementation, and Service Delivery. (page 57-58). Retrieved from http://www.nrcyd.ou.edu/publication-db/documents/2008-positive-youth-development-toolkit.pdf

[78] Adeline Nyamathi et. al. Program Community Health Partnerships. (2011) Art Messaging as a Medium to Engage Homeless Young Adults and Youth. Spring 5(1), pages 9-18. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3792012/

[79] National Clearinghouse on Families and Youth. (2012) Bright Idea: Finding Creative Ways to Engage Homeless Youth. Retrieved from http://ncfy.acf.hhs.gov/news/2012/01/bright-idea-finding-creative-ways-engage-homeless-youth

[80] National Clearinghouse on Families and Youth. (unknown) Using Technology in Family and Youth Work . Retrieved from http://ncfy.acf.hhs.gov/book/export/html/462

[81] Sean D. Young and Eric Rice. AIDS and Behavior. (2010) Online Social Networking Technologies, HIV Knowledge, and Sexual Risk and Testing Behaviors Among Homeless Youth. 15: pages 253-260.

[82] HCH Clinicians' Network Communications Committee. Healing Hands (2009) Engaging Adolescents Who Are Homeless in Care. 13(5) Retrieved from http://www.nhchc.org/wp-content/uploads/2011/10/HealingHandsOctweb.pdf (see page 5).

[83] David E. Pollio, et al. Social Work. (2013). Technology Use among Emerging Adult Homeless in Two U.S. Cities. 58(2), pages 173-175.

desk staff, to outreach worker, to therapist, and physician. Interdisciplinary teams serve as a multiplier factor for engaging youth, because once engaged the individual is more likely to access additional services from other team members.

In most communities, a host of youth-serving agencies can complement each other and develop effective partnerships and collaborations. These include schools, education and employment programs, youth drop-in centers, and federally funded programs, any of which may provide initial opportunities for engagement with youth experiencing homelessness. A complete list of agencies with which homeless youth programs may partner is provided by the California Research Bureau[85]. Marketing services through the channels and partnerships listed below is a way to more broadly initiate engagement into the health or social services system. Embedding medical services in agencies that youth view as trusted spaces such as schools or drop-in centers is often an effective way to engage youth experiencing homelessness.

Schools: The leading causes of adult homelessness, as identified in the 2013 Philadelphia homeless youth study, were experiencing homelessness as a youth and the lack of a high school degree or GED[86]. Evidence shows that students experiencing homelessness do not perform as well academically as their housed counterparts and youth homelessness is associated with higher rates of truancy and lower rates of high school graduation[87]. Even if youth are housed but are not successful academically, their chances of homelessness as an adult increase[88]. Schools, local school district homeless liaisons, and other local education and vocational programs are important collaborators for programs serving youth experiencing homelessness, because they can offer support to current clients or can assist in referring youth to needed service. School systems can help identify at-risk and youth experiencing homelessness who are not currently being served by a program but who may benefit from its services. Local educational agencies carry out mandates from the McKinney-Vento Homeless Assistance Act and designate a homeless liaison who is responsible for working with homeless education issues in the area[89]. Each state is required to have a coordinator for homeless education. Agencies may contact the state coordinator (list is accessible through referenced footnote) to identify the local school district assigned liaison, or if the district does not have a liaison, the agency may need to advocate for one and inform the school district about available funding for this position[90]. The National Association for the Education of Homeless Children and Youth (NAEHCY) is a national resource for facilitating local, inter-agency collaborations, supporting youth experiencing homelessness, and assisting communities in preventing and ending youth homelessness[91].

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[84] National Health Care for the Homeless Council. (2011) Key Elements of Integrated Care for Persons Experiencing Homelessness. Retrieved from http://www.nhchc.org/wp-content/uploads/2011/10/Key-Elements-of-Integrated-Care.pdf

[85] Patricia F. Julianelle. California Research Bureau. (2007) The Educational Success of Homeless Youth in California: Challenges and Solutions. Retrieved from https://www.library.ca.gov/crb/07/07-012.pdf See pages 36-42.

[86] Staci Perlman and Joe Willard. (2013) Homeless Youth in Philadelphia: An innovative method for identifying youth who are homeless. Available at: http://works.bepress.com/staci_perlman/11

[87] Ibid.

[88] Ibid.

[89] National Center for Homeless Education. (2013). Homeless Liaison Toolkit. Retrieved from http://center.serve.org/nche/downloads/toolkit2/toolkit.pdf

[90] http://center.serve.org/nche/downloads/sccontact.pdf

[91] http://naehcy.org/legislation-and-policy/youth-task-forces

Some HCH programs also work within or in collaboration with school-based health centers, which presents benefits and unique challenges. Technical Assistance (TA) for collaborations between health centers and schools is available through the National HCH Council[92] and the School-Based Health Alliance[93].

YouthBuild is an international program targeted to unemployed young people who left high school without a diploma and attempts to help these individuals reclaim their education, gain skills for employment, and learn to be leaders. Local YouthBuild programs are possible collaborators for educational and vocational services.

Other Community Programs: Establishing relationships with community programs is a way to save on resources but also reach more youth. Drop-in centers are places where youth can rest, shower, eat and receive other social services. Providing health services at these sites and working with drop-in center staff is ideal to engage youth in health services and the larger health system. Having partnerships with shelters and transitional housing programs for adults can become great referral sources, and local centers that specialize in LGBTQ populations that offer tailored services to this group can also be valuable partners. Churches and other faith-based organizations are other great collaborators to market services and share resources[94].

Federal Programs with Local Presence: Other suggested collaborators are federally supported programs in your community, such as Health Care for the Homeless grantees which are part of the Health Resources and Services Administration's Health Center Program, and Runaway and Homeless Youth programs which are funded through the Family and Youth Services Bureau (FYSB). The Runaway and Homeless Youth (RHY) programs offer street outreach, emergency shelters and longer-term transitional living and maternity group home programs[95]. You can find a directory of RHY programs online through FYSB's grantees interactive mapping tool[96]. Local Health Care for the Homeless programs can be found using the National HCH Council's online HCH Directory[97].

Law Enforcement: Agencies may want to consider working with law enforcement agencies to learn about laws and policies that affect youth experiencing homelessness in the community and also train officers on serving, working, and engaging with this population. According to one survey with questions related to interactions with law enforcement, 75% of respondents reported regular negative interactions with police, including harassment and being ticketed, and not a single youth reported turning to police for assistance when victimized[98]. Officers can be trained on assessing the youth's safety and best practices to approach and engage these young people. The 10-question tool developed in collaboration with medical professionals, researchers and police officers, which is

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[92] https://www.nhchc.org/get-assistance/
[93] http://www.sbh4all.org/site/c.ckLQKbOVLkK6E/b.7453519/k.BEF2/Home.htm
[94] Gary Cook. Church & Society. (2001) How Churches Engage Homelessness. May/June. American Theological Library Association.
[95] http://www.acf.hhs.gov/programs/fysb/programs/runaway-homeless-youth
[96] http://www.acf.hhs.gov/programs/fysb/grants/fysb-grantees
[97] https://www.nhchc.org/resources/grantees/national-hch-grantee-directory/
[98] Youth Today. (2008) Voices from the Street: A Survey of Homeless Youth by their Peers. Retrieved from http://youthtoday.org/2008/04/voices-from-the-street-a-survey-of-homeless-youth-by-their-peers/

referenced in the footnote, is meant to help officers determine whether the minor needs medical attention or other community resources, and it can be used to essentially catch the young person before they fall through the cracks of the social services system[99].

Other state and local government programs such as Departments of Human Services, Family and Children Services, and health departments are common partners for youth programs. Transit authorities have worked with homeless programs and provide subsidized bus and other transportation tickets for their clients.

MEASURING ENGAGEMENT

Engagement may be measured at the individual or at the agency level.

At the **individual level,** engagement centers on interpersonal relationship, which is difficult to quantify and which may be seen as a process rather than an outcome. It is nonetheless useful for a provider or agency to look for concrete indications that a positive relationship is developing. One clinician remarked, "[After their first encounter] making use of services…calling on the clinician when they feel they are at risk, or they're in need of something that they don't know how to access like medication, transportation, or food in a safe way" is a particularly important measure of successful youth engagement. Other clinicians agree that a willingness to open up, communicate and ask for help can indicate successful individual or core-level engagement. A provider shared, "We document feedback from the young person that they've built a relationship with somebody at [our program]. Be it a case manager, a residential advisor, a security person, or the front desk person, if they build a relationship with anybody here they're more likely to come back."

Individuals' engagement can be assessed by examining their participation in programs or activities[100] or progress in service or treatment plans, which may be measured by multiple encounters, keeping follow-up appointments, or a measure of improved health.

At the **agency level,** the following questions may help an agency assess and measure its efforts to engage youth experiencing homelessness:

1. **Has the target population been defined and identified? Are eligibility for services and payment sources clearly established?**

2. **Have strategies for reaching and engaging youth been clearly established? What community partnerships are being employed?**

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[99] Youth Today. (2012) Runaway Youth Helped Using 10-Question Tool. Retrieved from http://youthtoday.org/2012/05/runaway-youth-helped-using-10-question-tool/
[100] Hollywood Homeless Youth Partnerships. (2013) Policy Brief: Measuring Success in Housing Programs for Homeless Youth: The Need for Youth-Specific Performance Measures. Retrieved from http://hhyp.org/wp-content/uploads/2013/02/HHYP_Outcomes-Policy-Brief_Final2.pdf

3. **Have staff throughout the agency been trained and equipped to respond appropriately to youth experiencing homelessness?**

4. **To what extent are young people experiencing homelessness utilizing the agency's service? Do the agency's data systems identify these clients?**

5. **What are the outcomes of services received by these clients? Is the satisfaction of the young clients included in outcome measurement?**

6. **How is the agency assessing core-level relationships?**

Engagement is part of the outreach that is classified as an "enabling service" by the Health Resources and Services Administration. Emerging strategies for defining and measuring outcomes are documented in the *2012 National Outreach Guidelines for Underserved Populations* developed by Health Outreach Partners.[101] An enabling services data collection tool[102] and related training curriculum for HCH programs to implement the tool[103, 104] are now available.

Programs may also want to consider tracking clients' hospital visits and emergency department (ED) utilization, using tools available through the National HCH Council.[105]

The following example suggests how an agency may operationalize these considerations for measuring engagement.

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[101] http://outreach-partners.org/?s=outreach+guidelines
[102] http://www.aapcho.org/projects/enabling-services-accountability-project/
[103] http://www.nhchc.org/wp-content/uploads/2012/12/CMMI-Module-14.mp4
[104] http://www.nhchc.org/wp-content/uploads/2014/08/enablingservices_berkeleytrng_slideshandouts.pdf
[105] http://www.nhchc.org/wp-content/uploads/2012/12/CMMICostWebinar.mp4

Example:

Agency XYZ plans to engage at-risk, low-income and currently homeless individuals ages 13-17 who reside in the three zip codes of their service area. The goal is to have the young person engaged **in community healthcare services and the larger health system.** In determining how to measure engagement practices the group considers individual outcomes for someone to be considered *engaged.* The agency comes up with the following:

The youth is engaged in the larger health system when the individual:

- **Knows accurate information about at least one available local community health service that they are eligible for.**
- **Applies for health insurance or disability benefits**
- **Attempts to access a service at any of the community health programs twice a year.**

The agency can determine if they want to use one or all three of these measures. Then practices, services, and quality improvement strategies are developed.

The agency chooses to define successful engagement as "the client knows accurate information about at least one available local community health service for which the client is eligible". The agency decides one method to engage youth at this level is educating the target population and **other agencies and providers that serve the target population about services available in the community.** This level of engagement can happen at health fairs and through other outreach and marketing practices.

The agency determines that the skills and knowledge the person attempting to engage youth in the larger health system will need to possess may include:

- **Knowledge about the services and programs in the community**

- **Knowledge about their audience (Are they speaking to representatives from the school system or a youth consumer who is part of an identified subgroup?)**

- **Ability to capture the audience's interest and share information in a way that is tailored to the audience.**

APPENDIX A

METHODOLOGY, INTERVIEW RESULTS & KEY FINDINGS

1. METHODOLOGY

In the fall of 2013 Council staff established an Engaging Homeless Youth advisory workgroup consisting of a total of 14 members which included program administrators, direct service providers, policy, and advocacy staff, trainers and researcher with varied experience in working with the youth population. An informal literature review was conducted by Council staff. The information gathered provided the basis for the core principles identified for engaging youth as well as the subjects highlighted during the daylong training that was conducted during the 2014 National Health Care for the Homeless Conference and Policy Symposium in New Orleans with invited speakers from both inside and outside the workgroup including a youth consumer. A result of planning the training was the development of a comprehensive youth experiencing homelessness resource list which was shared at the event[106]. The advisory group also developed an interview guide to identify and learn best practices for engaging youth. The guide was developed with foundational elements and themes identified from the literature review.

The interview guide consisted of 17 questions that probed for information about individual youth programs and services, best practices for engaging homeless youth, knowledge gaps and needs related to training, and policy and advocacy issues. To identify interviewees for this research study, research staff at the Council used data from the Bureau of Primary Care's Uniform Data System to select Health Care for the Homeless (HCH) grantees based on one of two criteria. The first included those that in 2012 served the highest percentage of youth of their total consumer population; the top six highest percentages ranged from 34%-82%. The second included grantees that served over 3000 youth in 2012, which ranged from 3,072 to 4,852 clients. These HCH grantees were invited to participate in a structured 60-minute interview using the interview guide developed by the advisory workgroup. Of the 12 HCH grantees that were invited for an interview, six grantees scheduled and participated in the interview. All interviews were transcribed to identify recurring themes and qualitative data to include in this publication.

2. INTERVIEW RESULTS

Youth Served

The six representatives from identified programs stated they provided services to a range of youth in various demographics such as race, gender, sexual identities, sexual orientation and age. This variation was dependent on several factors such as location and types of services offered. Some

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[106] http://www.nhchc.org/wp-content/uploads/2014/06/ehy-pci-resource-list.pdf

programs saw families especially if their youth services targeted ages 0-24, therefore, in some cases some youth experiencing homelessness were serviced with their immediate family.

In describing their client base, grantees shared how they integrated pathways to homelessness into treatment planning. Several different pathways to homelessness were identified including:

- Mental and behavioral health issues including substance use
- Participation or aging out of foster care
- Familial and social issues related to being lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ)
- Intergenerational experiences where poverty, homelessness, or drug use was involved

Grantees interviewed also shared general information about their client base and highlighted the greatest medical needs of their youth clients, which included:

- Sexual health needs
- Respiratory issues
- Pharmacy/ medications
- Dental and Vision care
- Mental/behavioral health and substance use treatment

In responding to questions about the clients' greatest medical needs, interviewees stated that the most pressing needs and greatest health needs were *enabling services*[107] and basic necessities such as *housing* and *food*.

Programs and Services

In sharing about programs and services offered at their sites, providers stated they offer services that meet the needs of the community or population being served, but also have an array of services which is a means to engage clients into other parts of the safety-net system. One interviewee highlighted the importance of granting young people the right to choose where they receive care based on their needs, personality, preference and comfort level.

When interviewed about programs and services targeted to youth, grantees commented on a variety of services their programs offer, such as:

- Testing and assessments (e.g. trauma, sexually transmitted diseases or infections, depression, tuberculosis, and pregnancy)
- Routine physicals and immunizations

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[107] The Health Resources and Services Administration defines enabling services as non-clinical services that do not include direct patient services that enable individuals to access health care and improve health outcomes. Enabling services include case management, referrals, translation/interpretation, transportation, eligibility assistance, health education, environmental health risk reduction, health literacy, and outreach.

- Treatment for acute issues such as flu/cold, lice, injury
- Treatment for chronic condition such as diabetes and asthma
- Dental care
- Mental/behavioral health care
- Treatment and programs dedicated to co-occurring disorders
- Therapy groups, and support groups including Alcoholics Anonymous
- Naturopathic care such as acupuncture, yoga, and massage
- Social services and enabling services to promote and support health care, such as:
  - Transportation
  - Housing assistance
  - Case management
  - Employment and education including internship programs
  - Eligibility assistance
- Health care navigation and assistance with health literacy
- Legal services related to housing, incarceration, or eligibility enrollment
- Services and programs for pregnant youth or new mothers
- Outreach and marketing practices varied and included word of mouth, fliers, and health fairs
- Physical activities, and opportunities for exercise by providing gym space or yoga classes
- Arts and creative outlets such as music, theatre, and crafts
- Meals, snacks

Interviewees represented a myriad of health center models and service delivery locations including:

- School-based health centers
- Local health department or *public center* grantees
- Multi-service sites
- Youth services co-located with programs that served the entire lifespan
- Programs that use the medical home model. In one case, a social worker sits in with the provider during each medical visit.
- Mobile medical care provided on the streets, in shelters, or at drop-in centers.
- Youth clinics in stand-alone sites, dedicated solely to at-risk and homeless youth
- Clinics co-located with a drop-in center or shelter.

Providers also commented on the varied times services are offered which addressed certain access barriers to care; services are provided during the day, night, and on weekends. Some programs offered drop-in services and meals, other programs had staff readily available to respond to crisis including mental health providers, and programs were able to offer same-day/ walk-in appointments as well as referrals. Other access barriers identified included lack of funding, lack of transportation, and competing priorities commonly faced by people experiencing homelessness.

Engagement Practices

Interviewees were asked to share their definition of engagement and describe promising practices. All interviewees commented on the relationship or "core-level" aspect of engagement. A few interviewed looked at engagement on a systems or *agency* level and tied it into the services and programs mentioned above. One interviewee shared the following about their services, "We are always looking for [the young person] being ready to buy in into something, and buy into something that we can support them doing."

When highlighting promising practices to engage youth who are homeless, providers mentioned the following:

- Be cognizant of the time and effort it takes to build relationships
- Understand how relationships and change can happen in baby steps
- Understand the role culture plays in developing the relationship
- Consider the young person's psychological, social, emotional developmental level
- Utilize harm reduction concepts and techniques
- Utilize motivational interviewing concepts and techniques
- Meet youth where they are
- Build service plans that are client-driven
- Use a strength-based approach
- Provide information and education so clients can make an informed choice
- See the "big picture" of engagement or the greater purpose of engagement
- Employ young people or former consumers at the program
- Provide peer-outreach and peer-mentoring programs
- Involve consumers and value their input in decision-making
- Assess the environment and physical space to be more culturally appropriate and engaging
- Have food available during meetings or other open settings

Collaborations

As part of the interview, grantees were directly asked about the quality and types of collaborations, relationships and other partnerships with agencies in their community. Entire interview transcripts were also analyzed to identify collaborators. Lastly grantees shared how they worked with other organizations to meet the needs of their clients. The following information was shared:

- Universities and college students may provide services such as mental health and legal services.
- Volunteers can provide naturopathic care and other services.
- Potential collaborators include churches or other religious organizations, food banks, public schools, local shelters and transitional housing programs, and the child welfare system.
- Employees who are well-networked within the community can assist an agency in building collaborations.

- Feelings of competition (for funding) may get in the way of healthy partnerships.
- Memorandum of Understanding and Agreements are used to formalize partnerships.
- Direct service providers may have the most contact with collaborating agencies and visit these sites or speak to staff weekly or daily, whereas administrators may only meet once a month.
- Mobile care providers or youth clinics may need to refer clients back to the main HCH site for certain services.
- Good collaborations help communities to not "reinvent the wheel" in service provision.
- It's easy to collaborate between services and programs, such as shelters/transitional living programs, outreach and other services, if they are part of the same agency.
- Collaborating agencies are places to engage current or potential consumers.
- If two agencies provide the same services near the same location, the idea is to work together with the understanding that it is better to have more options for the young person to choose where they get their needs met.

Effects of Federal and Local Policy

Interviewees were asked to identify how policies and laws affect the engagement or service provision to young people experiencing homelessness. The questions in this section of the interview guide broadly asked if the interviewee was aware of any laws or other federal or local policy issues that affected the young person's experience. If interviewees were not able to respond to these questions, they were at least able to identify someone on their staff who may best respond to this question. The following was identified:

- Youth may avoid law enforcement or have had bad experiences with law enforcement.
- Generally there may be legal issues in providing care to young people under the age of 18 who are unaccompanied.
- Some programs offer legal services onsite.
- Legal services may help a client obtain housing. One interviewee shared, "Nobody wants to rent or provide housing to an 18 year old or let them sign a lease, so the hardest part is finding them permanent housing."
- Legal services can help clients get identification cards. An interviewee shared, "Typically where they've left, they had to leave in a hurry and they left their identification. It's hard to get an identification when you don't have any kind of identification."
- Legal services can help young people involved in the juvenile justice system. Criminal backgrounds may prevent someone from getting employment, even for minor infractions such as jumping turnstiles.

Training Needs

Interviewees were also asked about their training needs on the topic of homeless youth. The following information was captured:

- Train physicians to dispense medications according to state pharmacy requirements when no on-site pharmacy is available.
- Train young people/consumers to develop advocacy skills.
- Develop a peer-outreach network.
- Allow young people/consumers to co-present or assist in teaching classes whether the class is for physicians providing health care or other providers working with the population.
- Train providers on the topic of homeless youth.
- Educate providers about how working with youth is not about rescuing.
- Providers should be trained in Trauma-informed Care, Motivational Interviewing, and models of care such as Attachment, Self-Regulation and Competency (ARC), Seeking Safety, and the Sanctuary Model.
- Identify training programs and internships within HCHs and clinics for marriage and family therapist, psychology, social work, and other disciplines.
- Training on youth homelessness should include cultural humility as it relates to LGBTQ populations.
- Training for providers is asking youth about their experience, and having more trainings with actual interactions with homeless or formerly homeless young people.
- There are challenges to train people on the services while operating a clinic fulltime. One interviewee shared, "It's difficult to shut down the clinic for a time to do trainings."
- Grantees are currently receiving a mix of online, in-person / in-house trainings, and attending offsite training including conferences.

3. KEY FINDINGS

Upon analysis of all the information retrieved from these interviews, there were consistencies across all interviews, which were identified as key findings for this study. These themes were found in the following areas: consumer involvement, trauma, services, staff and environment, and the "big picture".

Consumer Involvement

In nearly all of the interviews, respondents indicated that consumer involvement was a crucial aspect of engaging homeless youth. Consumer involvement was said to be important on both the individual and systems levels. Individually, such as working directly with the youth in developing treatment plans and participating in activities; and on the systems level which included youth involved in quality improvement activities-- incorporating the consumer's input and involving them in relevant aspects of the planning process.

Administrators stated that consumer input should affect the types of services offered as well as the mode of delivery. Interviewees commented on their program's ability to receive input including concerns or complaints from consumers both in-person and anonymously. Programs also provided examples of how they were able to utilize and put into practice the thoughts and suggestions shared by their young clients. In thinking about consumer involvement on an individual level,

respect and belief in the young person is essential. One administrator and clinician noted, "There is a team [of providers] that help the young person, and the team leader is always the young person."

Trauma

The other pervasive theme in all the interviews was the role of trauma. Interviewees commented on understanding the young person's perspective and how trauma may affect their behavior toward and perception of adults, service providers, people who work for the "system" and other peers. Interviewees commented on how an individual provider and whole agency can strive to become more trauma-informed. See Appendix B for Guiding Principles of Trauma-Informed Care.

Services

The National Network for Youth's fact sheet on consequences of youth homelessness provides details about the various physical and mental health, legal, and educational and vocational ramifications of homelessness for youth[108]. Offering services tailored to address these issues and more generally the needs of the consumer population is part and parcel to engagement. In speaking about services for this population one clinician shared, "*Appropriate* meaning something that feels appropriate to them, not what we think is appropriate or useful or helpful, but making use of their voices and making use of what they say their needs are and meeting them there." Interviewees also commented on the importance of allowing young people to have choices and to choose which place or provider best suits their needs.

Clinicians and administrators interviewed shared their experiences with medical, social, and therapeutic services, and the most common noted medical service utilized by youth populations in all communities were those related to sexual health. One recurring service was treatment and screening for sexually-transmitted diseases (STD) and infections (STI), sexual health education and STD/STI prevention, and other reproductive health needs. Reported numbers for consumers receiving STD/STI testing were as high as 60% of youth consumers. Interviewees also commented on the unusually high percentage of number of services in contraceptive management. Not only is this developmentally a critical time for an individual due to puberty and increased sexual activity and exploration, but also studies show that youth experiencing homelessness are more likely to engage in risky sexual behaviors including survival sex[109]. Survival sex is defined to mean the exchange of sex for food, money, shelter, drugs, and other needs and wants[110].

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[108] The National Network for Youth. (unknown) Issue Brief: Consequences of Youth Homelessness. http://www.nn4youth.org/wp-content/uploads/IssueBrief_Youth_Homelessness.pdf
[109] HCH Clinicians' Network Communications Committee. Healing Hands (2009) Engaging Adolescents Who Are Homeless in Care. 13(5) Retrieved from http://www.nhchc.org/wp-content/uploads/2011/10/HealingHandsOctweb.pdf
[110] N. Eugene Walls and Stephanie Bell. Journal of Sex Research (2011) Correlates of Engaging in Survival Sex among Homeless Youth and Young Adults. 48(5), pg 423-436

Interviewees also commented on the high number of testing and assessments more generally for this population. Assessment and testing for young clients ranged from physical health issues to mental and behavioral health concerns to educational and vocational topics, and when compared to older adult populations testing and assessments were more routinized.

Multiple interviewees commented that dental, vision and mental health care were high need areas where the current resources did not meet the demand for services. Another interesting comment was on the large percentage of clients in need of substance use and co-occurring disorder treatment, and yet many clients were not interested or not in a place where they could participate.

Another commonly expressed sentiment was on the practice of psycho-education or providing other educational information on treatment and diseases. One common area of education where providers noticed a high occurrence was around nutrition. Education on nutrition and exercise was common for young clients and particularly those receiving treatment for diabetes and those at-risk of diabetes as well as those who were suffering from obesity.

Many programs interviewed provided legal services and shared creative ways to offer these services. One of the most robust programs had a legal department with four attorneys.

Of importance was the comment targeted to outreach services and marketing practices that addressed hidden homelessness. Many young people who do not consider themselves homeless, who are couch surfing, and who are not connected with any safety-net programs, may not be aware of services that are available to them. Many young people at-risk of homelessness may not be aware of support and resources until they are in dire situations, living on the streets or in shelters.

Staff and Environment

All youth programs interviewed were part of a larger organization that receives Health Care for the Homeless (HCH) funding through the federal health center program. The programs interviewed came from a variety of service models and were not necessarily physically connected to the main HCH site. Sites shared how their program models, such as school-based programs or mobile medical care, contributed to their engagement and outreach strategies. For all locations and types of program models, interviewees shared common sentiments about expectations for staff and how they interact with the youth clients. The following practices were noted to bring positive results for engagement:

- Having staff available and interacting with clients in the common space or the waiting room. Programs have staff and volunteers out in the waiting room, not only behind the reception desk, working but ready to assist the young clients.
- Interviewees mentioned not only the staff's attitude and how one communicated but also having administrative paperwork that is respectful of the young person's identity, such as using not only legal but preferred names.
- Having staff who respected and appreciated "youth culture" was highly encouraged.

- Staff were encouraged to develop an understanding of street culture and more generally on homelessness and its affect on healthcare. Interviewees shared these examples:

  o Healthcare appointments may not be a priority for people who are experiencing homelessness.
  o It may not be easy to contact an individual due to lack of access to cell phones that are always in service.
  o People experiencing homelessness may have a more difficult time than housed counterparts to maintain whatever regimen their provider has prescribed for them.

Cultural humility was a common theme throughout all interviews. Providers also agreed that understanding pathways to homelessness helps to understand the social context of the young person's treatment plan. Interviewees also placed importance on understanding developmental stages and how behaviors like impulse control were influenced by development. Programs also addressed special subpopulations among youth experiencing homelessness, such as LGBTQ populations, young people involved in juvenile justice or foster care, and refugees and immigrants. Interviewees suggested that going out and spending time in the client's environment (where they physically are) is a good way to learn about the population. Having staff who identify as LGBTQ or other subcultures were seen as beneficial toward engagement as well as having a youth peer outreach worker.

Flexibility was another identified common theme. Flexibility goes hand in hand with understanding and cultural humility. Several interviewees commented on giving the young client multiple chances. Many programs see high recidivism rates for people who have dropped out of their programs, and continue to see clients who miss appointments. In working with youth, the interviewees have seen a number of young people who have "burned bridges" with other local programs and are no longer welcome to receive their services, so the interviewees work to create policies that are flexible, understanding, and do not involve punishment. One interviewee commented on giving multiple chances to their clients saying, "We do have to exclude people sometimes and it's for a brief amount of time. The focus is not on punishing but mainly on managing behavior. We've had people throw garbage cans through windows in the clinic. They were not kicked out of services but did have an exclusion time." Administrators and clinicians who have worked within youth programs for several years commented on the ability to deescalate situations without punishment and how it is an extremely rare occurrence to involve police or the authorities for behavioral issues.

Being considerate of culture when developing materials shared with clients and the layout of the space is a common practice. Programs display and promote only materials that offer services targeted and relevant to youth especially if those materials are used for outreach or shared during mobile health visits. Trauma is part of cultural humility and competency, and creating safe environments and considering past trauma experienced was acknowledged in developing the staff as well as the physical space.

The "Big Picture"

The "big picture" of youth engagement was alluded to in several instances. The "big picture" not only included housing but also the complete wellness of the individual. Wellness included all areas of psychological, emotional, social, physical and financial functioning. Addressing self-esteem, building self-efficacy and empowering clients were underlying themes. Interviewees commented on the desire and approach some providers have of "rescuing" their young clients and that this is not only unhelpful in the long run for clients but also leads to burnout for the provider. No matter the type of service being provided, youth programs interviewed were able to describe engagement on individual levels with the greater purpose of health and wellness in mind.