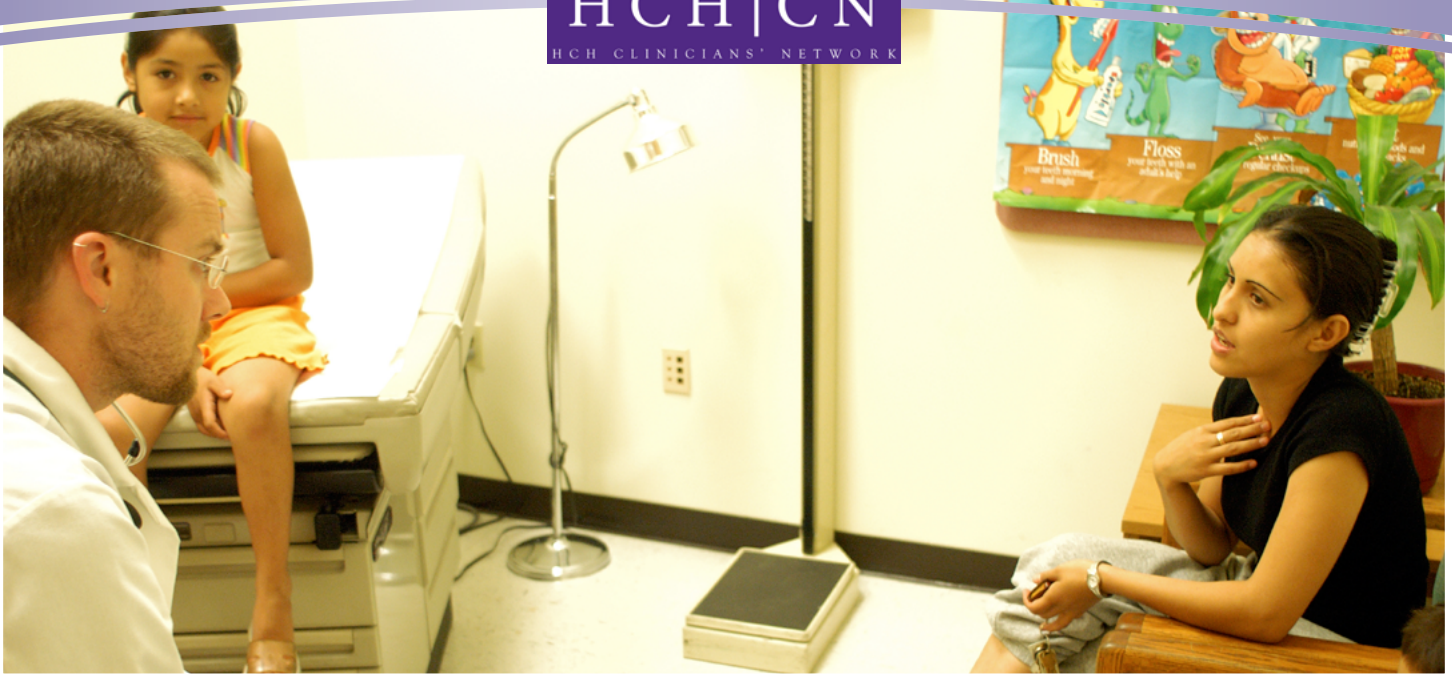


HEALING HANDS

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Substance Use Among Youth Experiencing Homelessness

Youth experiencing homelessness compose one of the largest sub-groups of the homeless population in the United States; estimates suggest that between 1 and 1.7 million youth experience homelessness every year.¹ One HUD study found that on a single night in January an estimated 194,302 children (under age 18) and youth (18-24) were homeless, 23.3% of whom were unaccompanied; HUD estimated that individuals up to age 24 made up one-third of all homeless people.² It is difficult to accurately assess these numbers, partly because the definition of “youth” varies between agencies and across the research. Some agencies define “youth” as ages 16-22 or 18-24; others consider individuals under the age of 18 to be children.³ This issue of *Healing Hands* will incorporate research and service providers’ perspectives on both teenagers and young adults between the ages of 12 and 24.

Estimates on the proportion of youth experiencing homelessness who use alcohol and/or drugs vary widely, ranging from 28% to 81%.⁴ Research has found that polysubstance use is common, and that youth without homes who use substances are more likely to have co-occurring mental health disorders such as depression, anxiety, and conduct disorders, and to engage in high-risk behaviors, including risky sex.⁵ This publication addresses the connections between substance use, trauma, mental health, and homelessness, with a lens on the experiences of young people. It considers some barriers to engagement of care for youth who

are using alcohol or drugs while experiencing homelessness, and provides practical, legal, and clinical perspectives on overcoming these barriers and assisting young people in accessing care through the use of concepts such as trauma-informed care, harm reduction, and building trusting relationships.

Links Between Substance Use, Trauma, Mental Health, and Homelessness

As with other 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.”⁶ Care providers seeking to provide assistance to youth experiencing homelessness should begin with an understanding of the patient’s history, the role of childhood trauma, the continuous trauma of homelessness itself, and connected health issues.

An overwhelming percentage of people experiencing homelessness have a history of trauma, which can be understood as “an experience that creates a sense of fear, helplessness, or horror,

and overwhelms a person's resources for coping. The impact of traumatic stress can be devastating and long-lasting, interfering with a person's sense of safety, ability to self-regulate, sense of self, perception of control and self-efficacy, and interpersonal relationships.⁷ Traumatic experiences include "neglect, psychological abuse, physical abuse, and sexual abuse during childhood; community violence; combat-related trauma; domestic violence; accidents; and disasters," and research has found that "early developmental trauma—including child abuse, neglect, and disrupted attachment—provides a subtext for the narrative of many people's pathways to homelessness."⁸

Moreover, homelessness itself involves an array of traumatic experiences and increases the risk of further victimization and continuous retraumatization.

"The overwhelming majority of young people experiencing homelessness have experienced a trauma if not years of traumas."

Mary Howe, Homeless Youth Alliance, San Francisco, CA

Mary Howe, Executive Director of the Homeless Youth Alliance (HYA), which works with a population of 5,000 youth in the Haight Ashbury district of San Francisco, explains what this process of traumatization and retraumatization may look like for youth:

The overwhelming majority of young people experiencing homelessness have experienced a trauma if not years of traumas. These early life experiences are not isolated, as simply living on the street is a continued daily trauma itself. Trauma affects every aspect of the young people's lives. These young people regularly are victims of violence, sexual assaults, discrimination, overdose, survival sex. They constantly experience loss and death. They experience constant criminalization by the police who should be protecting them, mistreatment by mental and medical health providers who should be helping them (not stigmatizing or shaming them), a media that addresses them as problems that need solving, and people who share sidewalks with them who ignore them or degrade them rather than acknowledging them.

A look at the sub-groups of youth experiencing homelessness reveals that some groups of young people are particularly vulnerable to trauma and connected homelessness; vulnerable groups include LGBTQ teens and youth, unaccompanied youth, pregnant youth or youth with children, victims of trafficking and exploitation, refugees and immigrants, rural youth, youth involved with the criminal justice system, and former foster kids.⁹ According to Ms. Howe, a survey of Homeless Youth Alliance clients revealed that:

- 46% of HYA participants are LGBTQ
- 57% deal with mental health issues, from PTSD to major depression to bipolar disorder and schizophrenia
- 34% spent time in the foster care system

- 19% have reported trading sex for food or a place to stay
- On average, youth left home at age 14; their self-reported reasons for leaving home included "I was in a group home, and being on the street is better," "There were too many mouths to feed," "I got emancipated from foster care," and "I didn't want to live with a rapist."

Other research also describes the vulnerability to homelessness amongst youth who are already marginalized based on their race, ethnicity, sexual orientation, or gender identity.

Jeffrey Scott, Counselor at Aunt Martha's Youth Service Center in Illinois, emphasizes

the relationship between economic conditions in impoverished areas, substance use, and youth homelessness. He explains that often, the young people who are referred to Aunt Martha's "had experienced some disruption in healthy relationships within their family dynamic; some were living house to house or sleeping out in a nearby forest... The common bond we found with youth who were living in the park is that they spent much of their time seeking ways to access substances." Acknowledgment of these complicated, interrelated, and individualized factors is a key first step; as **Katie Kirkman**, the Street RISE Team Lead Clinician at Outside In in Portland



JEFFREY SCOTT COUNSELS A YOUNG CLIENT AT AUNT MARTHA'S

notes, “youth experiencing homelessness tend to have experienced significant trauma in their life and often cope through substance use, and also experience other mental health issues, like depression, anxiety, and psychosis, which are all further complicated by substance use.”

One framework that has been used to develop an understanding of the personal factors that may underlie youth homelessness is the Adverse Childhood Experiences (ACE) framework, which examines the relationship between childhood trauma and health outcomes in adulthood; in the original 1998 ACE Study, researchers found that abuse and household dysfunction during childhood were related to disease, quality of life, and mortality in adulthood.¹¹ In addition to categorizing the variety of disease outcomes of trauma during childhood, the ACE Study also identified some behaviors often used as coping strategies—such as smoking, alcohol, or drug use, or sexual activity—to deal with the anxiety, anger, and depression resultant from the trauma. These coping strategies represent one of the links between trauma, mental health outcomes, risky behaviors, and lifelong physical health outcomes.¹²

Ms. Kirkman describes the relationship between trauma and substance use as a coping strategy:

Most often the story is that they’ve lived in multiple foster homes, that they’ve experienced physical, sexual, or emotional abuse—all traumatic events that occurred early on in their life that impact people’s ability to be stable. Often young people, [as a result of] brain development... are in a period of experimentation, testing, taking risks—that is all part of normal adolescent brain development, but then when you have a lack of stability in your life those things are exacerbated. So using substances gives some kind of relief or comfort or escape to people who have experienced trauma, and then it becomes a pattern... Since being homeless is traumatic in itself, some of the people that we work with use meth to stay up all night because they’re not in a shelter and they don’t feel safe when they’re on the street all night by themselves. So they use meth to stay alert, or they use heroin to be numb to the scary experience of being outside...

Homelessness is itself traumatic, so in an effort to try to cope with that, substances become a part of this maladaptive coping strategy.

Use of alcohol and drugs as a coping strategy can contribute to myriad long-term health problems, and responding to substance use as a care provider requires attention to the interconnectedness of all of these factors.

Challenges to Engagement

The National Health Care for the Homeless Council has found that there are several key challenges that can hinder engaging youth without homes in services, such as:

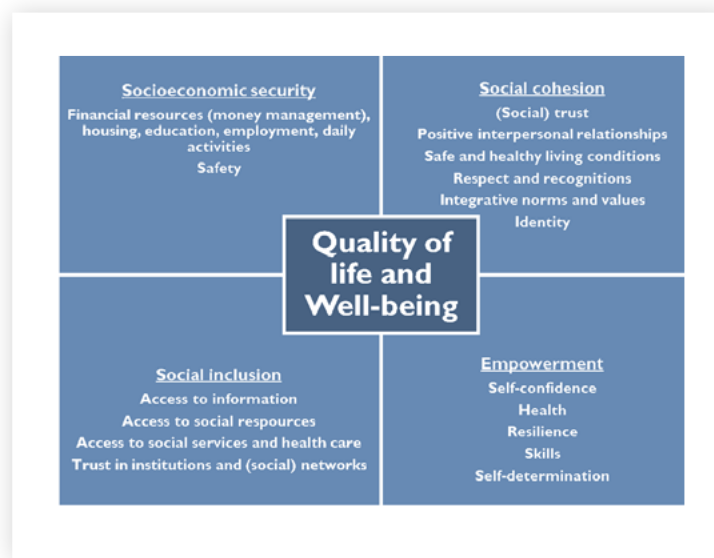
- Rigid agency policies that incorporate unrealistic expectations about youths’ behavior
- Legal issues, such as lack of parental permission, lack of documentation and identification, and the criminalization of “status offenses,” or behaviors which are only illegal when done by a minor, such as breaking curfew or truancy
- Youth perception of the availability of services and

trustworthiness of service providers and adults in general

- Youth knowledge of available services, particularly when networks of services are complicated or difficult to access or understand
- Insufficient agency resources for creating and maintaining safe spaces for youth; these resource limitations may be particularly challenging in rural or sparsely-populated areas¹³

Research has also shown that substance use has an effect on service utilization and engagement with care. In addition to the impairment of decision-making processes associated with drug use, the shame and stigma associated with drug use can

also inhibit young people’s attempts to access care and create a fear of disappointing adults with whom they have established relationships.¹⁴ Ms. Kirkman describes this as “internalized shame” and notes that “it is challenging to help youth overcome this sense of shame if they have been trained to view themselves as a bad person for being in a cycle of addiction.” When youth feel shamed for their drug use by care providers, it may inhibit them from seeking care.



CONDITIONAL FACTORS FOR QUALITY OF LIFE AND WELL-BEING AMONG HOMELESS YOUTH

Adopted from Altena et al. 2010.

Partly in an effort to mitigate this culture of internalized shame, many care providers are shifting away from language that tags substance-using young people as “service resistant” and toward an increased structural understanding of the complex histories and social contexts of teens and youth experiencing cycles of addiction and homelessness. Ms. Howe observes:

I hear a lot of the youth we work with referred to as “hard to reach” or “service resistant,” and I can’t disagree more with those statements. They are on our streets and in our parks; they are in plain view. How much easier can they be to reach? They want services, but the truth is they want services that accept them the way they are, provide them with the things they need by people that treat them as individuals with respect and dignity. I always reflect on my own experiences with medical providers, teachers, even probation officers, the ones I respected and built relationships with... [It was] because I could be honest with them and they wouldn’t shame me, punish me, or try to change me... [I]t is challenging to sit with a young person and bear witness to them, to their lives, their struggles, their heartbreak and their traumas; creating and holding that space for young person after young person is difficult.”

Ms. Kirkman explains that providers need to recognize that both homelessness and substance abuse represent “not moral failings, but a systemic failing;” she describes the ways in which structural forces, including slim housing markets, inadequate support for children transitioning out of foster care, and harsh economic realities, fail to create a context in which traumatized young people are nurtured and assisted. **Lauren Wiley**, Vice President of Community Health and Prevention at Aunt Martha’s, agrees, adding that care providers are “moving away from seeing substance abuse as a siloed affliction” while trying to cope with “inadequate services to support the multidimensional needs of young people,” including physical and mental health. She acknowledges that “substances are more accessible for some people than medical care... so developing a holistic view and coming to see that substances may be an act of self-medication for other issues...[allows us] multiple ports of entry into the reasons why people don’t have the degree of wellness that they deserve and that they need to have.” Improving mental and physical health services and “caring for physical health decreases the need to use substances to self-medicate,” she says.

Colleen, a young client at the Homeless Youth Alliance, describes some of the challenges she faced to accessing care and the ways in which HYA services have helped her overcome her reservations:

I hate doctors, and I hate hospitals. And when I was

high, I didn’t want to go to a doctor, because I was scared of it showing up on tests, and I didn’t know what the consequences of that would be. I always feel okay getting medical care at HYA. Even when I was using [heroin], it still felt like I could take steps to be safer, to not share needles, to prevent overdose, to have some responsibility. I’ve never gone anywhere else for services. I found out I was pregnant here and I am so glad I was here. I just always feel safe here, and that’s why I was able to get off heroin eventually. I get food here, they’ve gotten me glasses, they take messages for me from family, and I can talk to them about anything. Everyone here is just so supportive and so good. I love seeing them. I love coming here.

The following section will discuss some fruitful approaches to engaging traumatized and hesitant youth in care, and providing them with supportive treatment.

Clinical Perspectives and Approaches to Treatment and Engagement

Youth experiencing homelessness are typically in need of a variety of services related to both substance recovery and general health, and these needs may be amplified for youth who are using substances. Youth may be in need of medical care for both chronic and acute medical conditions, as well as specialty care such as dental and vision care. Some youth may be in need of sexual health services, and many require mental or behavioral health services. Social and support services may help youth access resources such as housing, employment, educational resources, or family reunification services. Substance abuse recovery can be particularly challenging for this population; Ms. Kirkman explains:

“Working with people who are experiencing complex trauma, using substances, and have unstable housing while in the adolescent stage really requires a paradigm shift...”

Katie Kirkman, Outside In, Portland, OR

Working with people who are experiencing complex trauma, using substances, and have unstable housing while in the adolescent stage of development really requires a paradigm shift from traditional recovery models. Sustained sobriety often doesn’t make sense when you consider the adolescent brain. In adolescent brains, the frontal lobe isn’t fully developed. This is the area that supports decision making and judgement. For this reason, young people are hard wired for reward seeking, risk taking, and impulsivity. The people we work with are often going to experience the benefits of our work together years down the line as the frontal cortex

is sometimes not fully developed until the late 20s. It can be really challenging on workers in a traditional framework where sobriety equals success. This can lead to burn out for workers supporting youth when sustained sobriety isn't developmentally appropriate. With high [staff] turnover, young people then have a continued cycle of fragmented relationships.

Regardless of whether programs offer multifaceted, holistic resources, or more specialized care, certain treatment and engagement approaches are advised when working with teenagers and young adults who use drugs and alcohol. This section will address legal considerations when working with this population, as well as Trauma-Informed Care, Harm Reduction, and practical advice for relationship-building.

Legal Considerations

Different jurisdictions have different legal frameworks that care providers working with teenagers and youth must research. These laws are especially important to understand when working with teenagers and children under the age of 18, as laws surrounding issues of consent and reporting vary from state to state. The report *Alone Without A Home: A State-By-State Review of Law Affecting Unaccompanied Youth* is a helpful resource for identifying relevant laws in each U.S. state; the report offers information about laws regarding youth in need of supervision statutes, status offenses, emancipation, rights of youth to enter into contracts, health care access for unaccompanied youth, consent and confidentiality statutes, discharge from the juvenile justice system, interstate compact for juveniles, federal benefits, rights of unaccompanied youth to education, harboring unaccompanied youth, and services and shelters for unaccompanied youth.¹⁵

Importantly, more than half of U.S. states allow people under the age of 18 to consent to substance use disorder treatment without seeking parental consent. Other states require parental consent before admitting adolescents into treatment programs. The U.S. Department of Health & Human Services reports that, "In States requiring parental notification, treatment may be provided to an adolescent when the adolescent is willing to have the program communicate with a parent," and adds that, "Histories of neglect or abuse may be revealed during the care of adolescent patients, and physicians must be aware of reporting requirements in their State. Mandatory child abuse reporting takes precedence over Federal addiction treatment confidentiality regulations, according to Title 42, Part 2 of the Code of Federal Relations (42 C.F.R. Part 2)."¹⁶ Because "some State statutes governing consent and parental notification specify consideration of a number of fact-based variables, including the adolescent's age and stage of cognitive, emotional, and social development, as well as issues concerning payment for treatment and rules for emancipated minors," health service and substance abuse treatment providers should always familiarize themselves with relevant statutes in their state.¹⁷

Guiding Principles for a Trauma-Informed Approach

- » **1. Safety:** Staff and the people they serve feel physically and psychologically safe—the physical setting is safe and the interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is high priority.
- » **2. Trustworthiness and Transparency:** Policies, system or organizational operations, and decisions are conducted with transparency with the goal of building and maintaining trust with clients, family members, among staff, and others involved.
- » **3. Peer Support:** Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing.
- » **4. Collaboration and Mutuality:** Importance is placed on partnering and the leveling of power differences between staff and clients as well as within and between system-level or organizational-level staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision making.
- » **5. Empowerment, Voice, and Choice:** Individuals' strengths and experiences are recognized and built upon. The system or organization understands that the experience of trauma may be a unifying aspect in the lives of those who lead the system, who run the organization, who provide the services, and/or who come into contact with the system or organization for assistance and support.
- » **6. Cultural, Historical, and Gender Issues:** The system or organization moves past cultural stereotypes and biases and offers access to gender-responsive services, leverages the healing value of traditional cultural connections, incorporates policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served, and recognizes and addresses historical trauma.

* Source: Adapted by Georgetown University National TA Center for Children's Mental Health and Youth MOVE National from Substance Abuse and Mental Health Services Administration. SAMHSA's *Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014 and the work of Roger Fallot and Maxine Harris.

Trauma-Informed Care

Given the complex and far-reaching relationships between trauma, mental health, homelessness, and substance use, care providers who are seeking to assist young people who are using substances and experiencing homelessness may seek to extend trauma-informed care (TIC) practices to clients. Basic principles of TIC, according to a review by Hopper, Bassik, & Olivet, include:

- Trauma awareness, based on an accurate understanding of the meaning and effects of trauma;
- Emphasis on safety and the creation of physically and emotionally safe spaces for both consumers and providers;
- Opportunities to rebuild control and emphasize choice for consumers;
- Strengths-based approaches that emphasize strengths and skills of consumers rather than being deficit-oriented.

Based on these combined principles, the researchers developed this consensus-based definition of TIC: “Trauma-informed care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.”¹⁸

Ms. Wiley notes that part of creating a practice of trauma-informed care for clients also needs to involve accounting for “the needs of the service providers in trauma-saturated environments given the secondary or vicarious trauma they experience.” She notes that in her work she often uses concepts from the book *Trauma Stewardship* by Laura van Dernoot Lipsky, and works to implement some of these strategies in order to simultaneously “create a culture that also cares for the caregiver.”

Harm Reduction

According to the Harm Reduction Coalition,

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. Harm reduction incorporates a spectrum of strategies from safer use to managed use to abstinence to meet drug users “where they’re at,” addressing conditions of use along with the use itself.¹⁹

Though harm reduction practices vary, they are based on the idea that people use drugs and it is important to minimize their harmful effects while respecting the autonomy of drug users as the primary agents of their own lives and empowering them to make changes without being coerced.

In practice, harm reduction interventions may include needle

Trauma-Informed Substance Abuse Treatment Models

- » **Adolescent Community Reinforcement Approach (A-CRA)** is a behavioral intervention that seeks to replace environmental contingencies that have supported alcohol or drug use with pro-social activities and behaviors that support recovery. This model of care has been adapted for use in a drop-in center for youth without homes.
- » **Trauma, Addiction, Mental Health, and Recovery (TAMAR)** was developed as part of the first phase of the SAMHSA Women, Co-Occurring Disorders and Violence Study, and is a structured, manualized 10-week intervention designed for residential systems that combines psycho-educational approaches with expressive therapies.
- » **Addiction and Trauma Recovery Integration Model (ATRIUM)** is a 12-session recovery model designed for groups as well as for individuals and their therapists and counselors.
- » **Risking Connection** is a trauma-informed model aimed at mental health, public health, and substance abuse staff and includes adaptations for clergy, domestic violence advocates, and agencies serving children.
- » **The Sanctuary Model** is designed to help children who have been victims of violence, abuse, and trauma. It may be used in a variety of settings, including shelters, institutions, substance abuse programs, schools, parenting support centers, acute care centers, and juvenile justice programs, among others.
- » **Seeking Safety** targets the co-occurrence of post-traumatic stress disorder (PTSD) and substance abuse, and is suitable for a range of settings.
- » **Trauma Affect Regulation: Guide for Education and Therapy (TARGET)** is an educational and therapeutic approach for the prevention and treatment of complex Post-Traumatic Stress Disorder, suitable for use with children and adults.
- » **Trauma Recovery and Empowerment Model (TREM and M-TREM)** is intended for use with trauma survivors, especially physical or sexual violence. This model is gender-specific: TREM for women and M-TREM for men.

* For more information on these and other trauma-informed substance use treatment models, see *Engaging Youth Experiencing Homelessness: Core Practices and Services* (<http://www.nhchc.org>) and SAMHSA's inventory of Trauma-Informed Interventions (<http://www.samhsa.gov/nctic/trauma-interventions>).

exchange programs, drug replacement and maintenance therapies, safe injection sites or supervised injection facilities, overdose prevention programs, and other strategies to minimize the amount of harm caused to drug users who are not yet willing to commit to abstinence. The philosophy behind harm reduction can also inform psychotherapeutic interventions; for example, motivational interviewing (MI) is a therapeutic approach that aims to engage individuals in considering and articulating reasons for changing their behavior. In motivational interviewing, “the general plan for every client is to identify and develop motivation for change, in order to move the individual in the direction of healthier behavior. MI assumes that individuals who act self-destructively... are not self-destructive, but rather, just like everyone else, interested in being healthier and happier.”²⁰ The aim of all of these tactics and techniques is to improve the quality of life and well-being of people who use drugs and alcohol, and, when applied to youth experiencing homelessness, of vulnerable young people.

Mindful Programming and Relationship Building

A crucial component in engaging adolescents and young adults in care is to build trusting, authentic relationships with them. Ms. Howe explains that HYA believes that:

it is unrealistic to expect a young person experiencing homelessness who is hungry, sleep-deprived, and exposed to constant traumas to readily follow through on decisions that result in lasting behavior changes. The most significant and important thing we do is build supportive and consistent relationships free of judgment with youth exactly where they are... to create multiple outlets for youth to engage with us, get their basic needs met, and have some reprieve from the daily pressures of living on the street.

Mr. Scott emphasizes the importance of building relationships with youth that acknowledge that “they come with a variety of problems that need to be holistically met,” meriting a client-centered approach. Such an approach enables care providers, says Ms. Wiley, to have conversations with youth about the long-term nature of their future and the importance of problem-solving skills: “How can we help them understand that the decisions they make today will impact them and will shape their future?”

This commitment to relationship-building can be reflected in the therapeutic models used as well as in the physical and service

structures described in the National Health Care for the Homeless Council’s recent report entitled *Engaging Youth Experiencing Homelessness: Core Practices and Services*. The report offers practical suggestions for care providers invested in creating spaces that are physically and emotionally safe for youth seeking care or pursuing recovery.²¹ Ms. Kirkman notes that individualized programs, which are able to let young people set their own goals and proceed at a pace that makes sense for their life, often feel safer and more accessible for young people experiencing homelessness:

“Youth are resilient and smart and know what’s best for them, and they have a lot of ideas about what will help them in their journey to gain periods of sobriety.”

Katie Kirkman, Outside In, Portland, OR

The recovery journey for a young person without a home can be at their own pace, and this program in particular was designed with that idea. We understand that relapse is part of the process and we can support people to learn from those

experiences. What is really relevant for this population is having lots of options: groups, individual counseling, formal closed-office sessions, going on a walk around the block. Maybe every program isn’t able to do that but I think especially with young people that are in this identity period formation of their life, it’s important for us to give them lots of options so that they can explore the varieties of support that they need and figure out what works for them.

Mindful attention to the specificities of the homeless experience for young people, and an emphasis on developing secure and trusting relationships with youth who use substances, are pathways to enhancing program efficacy and improving the long-term physical and mental health of vulnerable young people.

Conclusions

In order to understand the lives of young people who use substances and experience homelessness, it’s critical to plumb the connections between substance use, trauma, mental health, and homelessness. Though difficulties may exist in engaging these young people in mental and physical health care as well as substance abuse programs, there are approaches that provide for the physical and emotional safety of vulnerable youth and support them as they work toward improved health outcomes.

A common thread of these approaches has to do with the importance of valuing youth as experts in their own lives and engaging in mutual, respectful relationships with them. Ms. Kirkman notes that this philosophy is a cornerstone of her work with the RISE program: “Youth are resilient and smart and know what’s best for them, and they have a lot of ideas about what will help them in their journey to gain periods of sobriety.”

When young people are supported on this journey, they are able to find what **Joey**, a former client with the Homeless Youth Alliance, describes as “direction and moral responsibility, to my community, to myself, and the world at large. I went on in that direction discovering a healthy life I never knew existed.” “Now,” says Joey, “[that I am] out of the darkness... I have a very nice apartment, a business of my own and so much time clean and sober that I stopped keeping track.”

Tips On Building Relationships With Youth

With **Mary Howe**, Executive Director of the Homeless Youth Alliance

1. *Check your language.* “At HYA we use the word ‘participant’ when we talk about people we have the honor to work with. We call them this because we feel it is more accurate and respectful; they are in fact actively participating in their own care and well-being. It removes hierarchical dynamics from our relationships—the us and them. Words as simple as ‘good’ or ‘bad’ actually imply judgement. If collectively we are mindful about this perhaps someday the media and policy makers will follow.”
2. *Be yourself and allow them to be themselves.* “Youth...want a sense of safety and confidentiality. Basing our opinion or approach off someone else’s experience will harm the relationship you are trying to build. We never know; we might be the one they first tell the truth to.”
3. *Accept your role as care provider in the healing process.* “Nobody saves anybody else. People save themselves. Dignity and self-worth are not things we are going to give them. Self-esteem is a result of their own skills and resilience. By treating them with respect and dignity it helps create opportunities for those qualities to grow.”
4. *Understand the connection between trauma and coping mechanisms.* “Every behavior has a reason behind it. Although in a way it doesn’t really matter why they are making the choices they are making, what matters is that it’s happening. Accepting the behavior doesn’t condone it, but it allows us to move beyond it, beyond our judgement, and do the real work. If and when our relationship with these young people grows and they have moments of having their basic needs met, there may come a time when looking at the root causes of their behavior could be beneficial.”
5. *Create opportunities for young people to share, teach, and contribute.* “Most people, especially young adults, love to teach things to people (remember they are the experts in their own lives and experiences), and especially to people who are in positions of authority. Youth who are homeless, who use drugs, who have mental health issues, historically are never given the opportunity to talk to someone who listens. When meeting with youth either on outreach, groups, medical, or one-on-one settings, ask questions and listen to their responses... Think of ways to incorporate some sense of this into your work environments. If you are a medical provider, allow youth if they are comfortable to present to staff: what their experiences getting medical care are like, or how services should be different for them, or what an average day for them is like, or have them talk about what the injection process is like. Something that can help you provide them with informed and more thoughtful care. Some youth are not organized enough or aren’t outgoing enough to present in front of a group; suggest they write a “zine,” or informal publication, with the same type of information. Perhaps there is a health concern that is common with their population such as abscesses, overdose, boot rot, scabies, or MRSA; have them help you design a pamphlet using their own language and images, something just for them.”
6. *Earn trust with patience and consistency.* “Young adults experiencing homelessness have been let down by almost every system and person that was supposed to protect them. If they are on the streets as young adults, this means that their family, their schools, the justice system, and the child welfare system most likely failed them. They have no reason to believe that their experience with us or our agency will be any different. Be patient; we may feel useless, disconnected, and not trusted for months. Remain consistent, patient, and open, and before we know it we’ll have built rapport with some of the youth. Every request a youth has—whether it is for food, socks, sleeping bags, or to help navigate some [complex] care system—is an opportunity to meet a need they have identified and prove that we are worthy of their trust.”
7. *Honor their priorities and decisions; don’t get attached to an outcome.* “We may have ideas and priorities of things we want to address with youth, and we do this with the best intentions. We have these tendencies because these youths’ lives are complex and chaotic beyond our comprehension. What is important for them is where we need to focus our efforts. Their goals are for them to set... At times their goals change day to day. Do not take their changing goals personally; it is NOT about you. Part of our role is to help them accurately assess a situation, minimize the harm, and to reinforce their agency, and another part is simply bearing witness. We have to learn to sit with our own discomfort and accept our lack of power. With youth it is more important to focus on the process, not necessarily the result.”
8. *Provide immediate treatment and realistic follow-up care.* “Let’s say a young person who injects heroin comes to the clinic we work at with an abscess on their neck. It is natural to want that person to stop using drugs so they don’t get life-threatening abscesses. What they want is to not be in pain and to not have this noticeable abscess in plain sight. Not using is not even on their radar. Instead of suggesting Buprenorphine/Naloxone or Methadone, think about other ways to reduce harm. Ask them to show you how they are injecting and be educated enough to make small suggestions about how to inject more safely. Maybe they are using the

wrong size needle or not using an alcohol wipe or are nicking an artery. Ask why they are injecting in their neck. Help them find veins right then and there, sharpie them so they can find them later. Ask them in a curious and non-judgmental way why they waited so long to come see you.”

9. *Never assume you're done learning or that you are still effective as a provider.* “Never assume what you learned the last time you saw a young person is still relevant; their lives, stations, and behaviors can change rapidly. We need to consistently take inventory and be aware of our strengths and limitations. We must, if we are lucky enough to have supportive and capable places of employment, ask for more training, and if not, take the initiative to educate ourselves.”

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