Engagement with health and social care services: perceptions of homeless young people with mental health problems

Philip Darbyshire RNMH RSCN DipN RNT MN PhD[1], **Eimear Muir-Cochrane** BSc (Hons) RN RMN Grad Dip Adult Education MNS PhD[2], **Jennifer Fereday** RN RM Dip App Sci (Nsg) BN Med (Mgt) PhD[1], **Jon Jureidini** BS MB PhD FRANZCP[3] and **Andrew Drummond** Narrative Family Therapist Certificate

[1]Department of Nursing and Midwifery Research and Practice Development, Children, Youth and Women's Health Service, University of South Australia, and Flinders University, Adelaide, [2]School of Nursing and Midwifery, University of South Australia, Adelaide, [3]Department of Psychological Medicine, Children, Youth and Women's Health Service, University of Adelaide, Adelaide and [4]Streetlink Youth Health Service, Uniting Care Wesley Adelaide Inc., Adelaide, South Australia, Australia

Correspondence
Philip Darbyshire
Department of Nursing and Midwifery
Research and Practice Development
Children, Youth and Women's Health
Service
University of South Australia
Level 2
Samuel Way Building
72 King William Road
North Adelaide
South Australia 5006
Australia
E-mail:
philip.darbyshire@adelaide.edu.au

Abstract

The present qualitative study describes and discusses the perspectives and experiences of young homeless people with mental health problems in relation to their interactions with health and social care services. Working in partnership with Streetlink, a supported accommodation assistance programme in Adelaide, Australia, the authors interviewed 10 homeless young people, aged from 16 to 24 years of age, who had experienced mental health problems. In-depth interviews elicited accounts of the best and worst of the participants' experiences of health and social care services. Access to services was not identified as being a significant problem in comparison with the participants' concerns regarding the quality of the services encountered. The central findings stress the importance of a respectful and supportive climate in relation to the qualities of service provision that the young people identified as valuable for their continuing treatment or consultation.

Keywords: homelessness, mental health problem, service engagement, young people

Accepted for publication 11 May 2006

Introduction

Youth homelessness is a growing problem in Australia, as it is world-wide. Homelessness means more than not having a home to live in; it is characterised by accommodation transience, uncertainty, lack of safety and security, and 'contrasting spaces of connection and disconnection' (Robinson 2002, p. 33). Thus, it is difficult to determine exactly how many young Australians are homeless at any one time. However, on census night in 2001, the homeless population in Australia was calculated to be 99 900 (Chamberlain & MacKenzie 2003). Almost half of these people (46%) were under 25 years of age, and those aged 12–18 years comprised 26% of all homeless people (Chamberlain & MacKenzie 2003). The

present paper reports findings from a wider study that explored the perceptions and experiences of a small group of homeless young people who had experienced mental health problems. It specifically describes their engagement with a range of healthcare services and the experiences which either encouraged or hindered their relationships with healthcare personnel.

Homelessness, young people and mental health problems

Homeless young people experience considerable health disadvantage, and are at risk of particular health problems such as respiratory illnesses, hepatitis B and C, and mental illness (Chung & Tesoriero 1997). An Australian

study of 210 homeless people aged 17–87 years (Hodder *et al.* 1998) found that 75% of the sample had at least one mental disorder. The authors commented that:

[T]he disabilities associated with mental disorders are compounded by the deprivations of living in a homeless state. It is likely that homeless people with a mental disorder are one of the most disabled groups in Australia. (Hodder *et al.* 1998, p. 11).

A comparative review of the literature from 1989 to 1998, which has explored the prevalence of psychological distress and psychiatric disorders among homeless youth in Australia (Kamieniecki 2001), highlights the extent and seriousness of mental health problems for these young people. The results of the review indicate that homeless young people in Australia experience significantly higher rates of psychological distress, psychiatric disorders and suicidal behaviour than their domiciled counterparts. This finding is similar to research conducted in the UK, where comprehensive studies have also found that mental health problems are significantly greater for people who are homeless, or who have been homeless, in comparison to domiciled populations (Commander & Odell 2001, Commander *et al.* 2002).

Mental health services and young homeless people

The prevalence of mental health problems among young homeless people highlights the importance of providing healthcare services which are 'accessible, acceptable and appropriate' (Clark & George 1993, p. 28). The difficulties involved in providing such a service are well recognised, and the UK experience shows that '[y]oung homeless people appear particularly unlikely to access healthcare services' (Centre for Economic and Social Inclusion 2005, p. 43). Homeless young people often fail to engage with a mental health service, or terminate treatment prematurely (French *et al.* 2003).

A recent, quantitative evaluation of healthcare programmes for homeless people found that a person who was homeless for longer than one year was less likely to seek regular healthcare (O'Toole *et al.* 1999). Client engagement with healthcare services has often been measured using survey instruments to evaluate client satisfaction levels, and this purports to represent the extent to which services meet the respondents' expectations (Jimmieson & Griffin 1998, Chan & Twinn 2003, Alden *et al.* 2004). However, because of problems inherent in instrument design, surveys share a range of possible limitations in the assessment of reliability and validity, and in the ability and/or willingness of people to complete the survey critically and honestly (Powell *et al.* 2004).

Health and social services which aim to maximise access and support have been developed world-wide to help young people who are homeless. These include flexible delivery using mobile intervention services (Guo *et al.* 2001), the employment of community mental health nurses (Wood *et al.* 2001), co-locating and integrating multiple services (Randolph *et al.* 2002), and involving people in service planning and delivery who have experienced similar problems (Buck *et al.* 2004). However, evaluation of such services has shown that these new initiatives may not meet the needs of clients after all (Goldman *et al.* 2002), and that there may still be marked differences in perspective and priorities between clients and their service providers (Rosenheck & Lam 1997).

Qualitative research has been conducted with staff from several homeless shelters to ascertain their views of the problems experienced by homeless people when accessing healthcare services (Hatton *et al.* 2001). In Hatton *et al.*'s (2001) study, focus-group discussions revealed staff perceptions of the problems their clients encountered when seeking healthcare services. These included the clients' lack of communication skills when contacting healthcare services (including the ability to be assertive), the scattered geographical location of services, and the lack of services for clients who experienced difficulties speaking English.

If both service provision and support staff practices are to become more responsive to the needs of young people who are homeless and who experience mental health problems, then it would seem crucial that these young people's experiences and perspective should be sought and understood. Thus, the need for more qualitative research in this area has been widely expressed (Power *et al.* 1999, Rosenfeld *et al.* 2000, Barry *et al.* 2002, Ensign & Panke 2002, Hagedorn 2002, Kidd 2003). The present study builds upon the work of other researchers (Ensign & Gittelsohn 1998, Ensign & Santelli 1998, Rew 2002, 2003, Rew & Horner 2003, Ensign 2004, Ensign & Bell 2004) who have sought to develop research approaches which actively involve young homeless people in the research process.

Subjects and methods

In the present study, the authors drew on theoretical work in childhood and youth studies grounded in an appreciation of the 1989 United Nations Convention on the Rights of the Child (UNCRC; (United Nations/United Nations Children's Fund 1989) (Morrow 1999, Walker 2001, Alderson & Morrow 2004). Article 12 of the UNCRC states that signatory nations:

Shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters

affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child. (United Nations/United Nations Children's Fund 1989)

Essentially, this establishes children's rights to consultation and participation by expressing their views and having their views given 'due weight'. The present study also builds on a growing body of research that demonstrates the value of consulting young homeless people directly and asking them to describe their perceptions, views and experiences of the health and social issues which affect their lives (Percy 1994, 1995, Ensign & Panke 2002, French *et al.* 2003, Ensign 2004, Kidd 2004).

The study reported here was a research collaboration involving the Streetlink Supported Accommodation Assistance Programme, which provides support and services for young people who are homeless in Adelaide, Australia. Streetlink has provided services to homeless and 'at risk' young people in the inner city since 1986.

Formal ethics approval was obtained from the respective hospital and university ethics committees. Written consent from the young person was obtained prior to each interview. Participants were reassured verbally at the commencement of the interview that they may choose not to discuss a particular issue and that they could stop the interview at any time for any reason. These processes are in accord with recent recommendations for research with adolescents who have mental health problems (Claveirole 2004) and research with homeless youths (Ensign 2003). A reimbursement fee of AU$20 was offered to participants to offset travel and other costs incurred by attending the interview.

The study took a qualitative approach to exploring homeless young people's experiences of their mental health and well-being. Staff at Streetlink assisted with recruitment for this study and helped to produce project information for potential participants that was appropriate, understandable and engaging. Streetlink assisted in distributing the study information packs to young people, who then chose to contact the authors to take part in the present study. In this way, they recruited a convenience sample of young people from within Streetlink's client group who met the study criteria. Data for this stage of the project was gathered from interviews conducted with 10 young people (seven females and three males) aged between 16 and 24 years who met the sampling criteria by being homeless, having experience of mental health problems, speaking English and being willing to participate in the study.

For the young persons' convenience and comfort, interviews were held on-site at the familiar location of Streetlink. An experienced qualitative researcher and/

or an adolescent mental health nurse conducted the interviews. Interviews lasted approximately one hour, and were audio-taped with the specific written consent of the participants and then transcribed verbatim. Participants were offered the opportunity to review the transcripts, but no one took up this offer.

Recruitment information sheets provided an overview of the general areas intended for discussion during the interview. The interviewers prompted discussion with open, focused questions, and enabled the young people to describe and discuss the experiences and issues which mattered most to them in relation to their homelessness and mental health. Beginning the interview by asking the young person to tell their story of becoming and being homeless was sufficient to trigger rich, descriptive responses. If the discussion did not naturally lead to the participant's experience of mental health problems, the authors would raise this issue and also ask if the young person had any experiences which they could share of accessing and using hospital, community or other mental health services. If an experience was described that provided insight into positive or negative aspects of mental health or service provision, the interviewer would prompt for more detail to further explore the scenario. The interview data was discussed and questioned by the researchers following each interview, and potentially salient issues and areas of interest were noted for possible raising in subsequent interviews.

Data were analysed in two stages. First, transcripts were reviewed by the interviewers and a conceptual map of key issues was formulated. Salient themes in the data were coded following a data-driven approach (Boyatzis 1998) and using the NVivo data management computer software. Patterns, similarities, dissimilarities, perceptions and events were highlighted to describe and conceptualise the young people's experiences of homelessness and mental health problems. In the course of the interviews, the young people discussed many aspects of being homeless and living with mental health issues. In this paper, the present authors focus specifically on the young people's perspectives and experiences of accessing and engaging with health and other support services, especially in relation to mental healthcare.

Results

The young people's perspectives of healthcare services

During the interviews, participants described their experiences of accessing and using a range of healthcare services, both hospital and community, and both public and private. From the young people's accounts, it was

clear that they had experienced some of the best and worst of service provision. Here the present authors use a similar approach to Buston (2002), highlighting their positive and negative perspectives of services, and discussing the salient aspects of how they judged both the value and quality of the healthcare professionals whom they encountered.

Perceptions of current healthcare services

The young people described both positive and negative aspects of their encounters with services and service providers. The present authors begin by highlighting particular problems and issues which were seen as detrimental to their using or returning to use particular services.

Labelling

As young people deemed to be homeless, the participants were already part of a marginalised group; and having mental health problems superimposed a further stratum of stigma. The young people described various ways in which they felt 'labelled' within the system, either behaviourally, perhaps as a 'troublemaker', or more medically, as a 'psychotic' or 'schizo':

My diagnosis was drug-induced psychosis, and I thought that was really pathetic because I was not, I was traumatic, I had done that [psychotic behaviour] because of what had happened, I had these people bashing me up and locking me in the house and threatening to kill me and all sorts. (Interview 3)

Labelling is, of course, a hugely complex issue, involving questions of perception, identity, selfhood, semantics and diagnostics, while also having significant practical influence on treatment, service provision and eligibility. Labelling can be positive and valuable if, for example, the label is an accurate diagnosis or assessment that leads to effective treatment or the provision of a necessary service. However, the young people's perceptions of labelling were much less positive, and they railed against what they believed were often attempts to categorise them as little more than a constellation of symptoms and behaviours:

Like each time they get a list of all my problems, it's like catatonic schizophrenia, paranoid schizophrenia, schizophrenia, fits, seizures, depression and just violent outbursts and psychotic behaviour and all the rest of it. (Interview 9)

It is well recognised that such labelling can colour and influence the perceptions and reactions of others, including service providers.

The young people also described labelling as a kind of 'shortcut' or 'shorthand' approach to understanding their problems and issues, whereby the name or label

becomes an end in itself rather than a starting point. This participant described such a perception:

I think they're just trying to label you – you know, the quicker we label them, the quicker we can get them on medication, the quicker we can get them out of here. (Interview 4)

The experiences of mental health assessment described by the young people may have contributed to this sense of being summarily labelled rather than carefully assessed.

'Drive-by' assessment

The young people's accounts of medical/psychological/psychiatric assessment suggested procedures which were hasty, and which offered them little opportunity for discussion or involvement in the process. One young person recalled that, on admission to hospital following a suicide attempt:

I was interviewed by a lady for about 20 s, which I thought was pretty poor. (Interview 1)

Others described similar cursory approaches:

I didn't really like the doctors because they would come in and see you once a week and say, 'No, you're not ready to leave,' and then walk out. (Interview 6)

They just asked me what kind of medication I was on and they gave me a prescription, and that was about it, yeah, they didn't really counsel me or anything or ask me what was wrong. (Interview 10)

Lack of explanations

The participants' sense of being processed in a cursory way extended to their accounts of communication with some hospitals and health professionals, and the explanations and information which they received. Participants reported feeling vulnerable and afraid in hospital; the lack of explanations they received only exacerbated their fears and sometimes resulted in erratic behaviour. One participant described being told with no further explanation that she was being sent to an acute psychiatric hospital and subsequently becoming so afraid that, as she describes:

I ran away, escaped, ran through town with my see-through top and see-through shorts and no knickers, no bra, I didn't care, I wasn't going there mainly because of stories that I'd heard. (Interview 1)

Another ascribed her increasing anger or 'stroppiness' in hospital as a response to her conditions and treatment, which she felt were almost purposefully antagonistic:

It's [hospital] somewhere that you're supposed to be helped, and not just stuck in there and just poked with a stick to see

whether you'd fight or something. I didn't feel right when I woke up, that's why I think I was a bit stroppy with the nurses. (Interview 2)

Lack of personal control
Feeling as though they had little control over their treatment and future plans was a common problem for these young people. It is difficult to be influential in your world when the most commonplace action poses a significant challenge. How do you get from service A to clinic B on the other side of town in time for your appointment if you have no money for a bus? Who do you contact for help when you are alienated from your family, and when your friends are often transient and living on the streets? How do you arrive looking your best for an appointment or consultation if you have had to sleep in your clothes and have no access to a shower and toiletries? Many of the young people described health service staff as 'playing head games' during their encounters, which seemed to be their shorthand for a complex system of interactions and manipulations by people in authority. This was perceived to be:

… [M]ainly saying things to make someone else feel either bad or guilty or stupid or like a loser or crazy, something like that. (Interview 1)

For another young person, their sense of whatever autonomy and personal agency they maintained was shaken by members of a mental health support team, who took it upon themselves to move her furniture without any discussion:

They walk in and they move the furniture around to how they feel, I'm serious, and they were just coming across not the right way. […] Yep, they moved the furniture, they weren't happy about how my grandma's furniture was in her lounge so they moved the furniture, they were complaining about it. And they were very arrogant, the man was very arrogant. (Interview 5)

Public versus private facilities
Two young people in the present study were still covered by their parents' private health insurance, and therefore, had the experience of receiving treatment in both public and private mental health facilities. These young people's experiences highlighted significant differences in attitudes and approaches between these facilities. Private healthcare facilities were noted for their welcoming attitude, more respectful approach and increased level of facilities offered:

[In] Hospital Y [private hospital], the nurses are really nice, you know, outside you've got like a nice gazebo to sit in, it's calming, you've got a craft room and the food is really nice, you go in there and you come out like 10 kilos extra. It's really, it's really nice there, I don't know, they'll compromise with you because, with my meds, they made me really tired and I

wanted to watch TV a couple of nights, and I said, 'Can I watch this,' and they're like, 'Oh yeah, all right then, as long as you take them, ra, ra, ra,' and that's fine, you know. (Interview 5)

The only reason why I was allowed to stay there [Hospital X, a private hospital] was because I was under my parent's private cover, they were really good there, really nice, but there's nowhere else, not that I know of. […] I actually, in the end, ended up finding it only because of my doctor and my parent's private cover, but in [Hospital X], it was, you know, admittance was at any time, the people there were very nice and just the treatment of being there is very, very different to being in hospital. (Interview 1)

Sadly, the participants' experiences of the public hospital and community health systems were generally less positive and were often characterised by descriptions of poor food, busy staff who seemed officious, dismissive, and who had 'no time' or 'no idea of what it was like' for the young people; nor was there any access to outdoor recreational or other activity areas. While some community 'crisis' or outreach services for young homeless people were valued, it was rare for them to mention any valued aspects of mainstream mental health services specifically intended for their use at such crisis or emergency points. Participants who commented on this mainstream health service were highly critical:

Yes, and she referred me to [this service] people and they were stupid. I'm sorry, they were, don't like them, they went and said I had nothing and I'm fine … (Interview 8)

I actually see [the mental health services] through [this service], they're morons, everything is textbook and I hate that. […] Yeah, [this service] team, I totally do not like them at all, they are so judging. […] I actually had to go through them to be able to see [another service]. […] They are just terrible, they are disgusting. (Interview 5)

Probably the [service] team, some of the [service] workers, and just a lot of mental health nurses think they're God's gift as well, think they know it all, like I've worked here for the last 10 years, good on you. (Interview 4)

Given this perceived contrast in service perception, one of the above participant's questions does seem to demand an answer:

Why is everything like, the government stuff is crap and the private stuff is good, like it shouldn't be like that for mental illness, why do they? (Interview 5)

Coordination between services
Many of the services described by participants seemed dispersed and fragmented, and one visit often resulted in a referral to several other services (e.g. medical services were separate from emergency housing services). As this participant noted:

Because a lot of the [health] services, well, all of them actually, don't help out with accommodation. They refer you on to another place that will refer you on to yet another place. (Interview 10)

The frustrations associated with this situation were not only in having to deal with logistics of time and transport, but also in having to repeat one's story again and again at every place visited:

It was like you had to re-explain your whole, entire friggin' story to them so, like, they didn't just send a crappy little referral. (Interview 4)

Even within a particular place, such as a local hospital, personnel and services were frequently changing, so they would have to repeat their history yet again:

I hate new doctors because I have to go through everything all over again. (Interview 5)

Many of the participants described how they had learnt about available services from other people on the streets or from an organisation. They believed that advertising and awareness could be improved by having more pamphlets available in all community services (e.g. social security/benefits offices and doctor's rooms). The idea of a 'one-stop shop' was also suggested as a way of improving services in South Australia. One participant gave the example of a facility in Brisbane that offered multiple services for youth, including food, a doctor's surgery, counselling, entertainment (i.e. a pool table, computer games and movies) and shower facilities.

Stable, safe accommodation for young people also appeared limited. Two participants, both of whom had been previously hospitalised with mental health problems, pointed to the need for an accommodation facility that could also provide assistance for those with mental health issues:

A place that provides medical help and accommodation at the same time. (Interview 10)

A youth shelter, but [sic] as a hospital, where they have people come in that need a bit of help with their thinking. (Interview 7)

Positive aspects of care which enhanced engagement

The young people's accounts of their encounters with health facilities and professionals conveyed a clear sense of the qualities and attributes which made health professionals 'helpful' and valuable. Trust and respect were cornerstone issues in building a therapeutic relationship between services and homeless people. Trust was often cited as something that was 'extremely hard' to foster, as a consequence of the abuse that many of the participants had suffered. The examples given below illustrate the criteria identified by participants as being helpful when engaging with a health service.

'I felt like I mattered'

The young people described the profound impact of what were often 'small acts' of kindness and human caring when someone connected with them and told them that they mattered as human beings:

You think this bad time's going to go on forever and it's never going to end, and when someone, an adult, you know, starts showing interest and care in you and like you feel safe around that person, it's, that was the start for me. (Interview 3)

Some acts by health professionals vindicated the individual's presentation with a problem, and affirmed their need for help and support:

I actually always carried a letter from my doctor on me which said roughly, '[P1]'s had problems with this and this, she hasn't been feeling too well,' because the hospitals had my records and whatever, 'can you please see her if she needs help.' (Interview 1)

People who actually listened

It is difficult to maintain a coherent sense of self and self-worth when others in your world may appear dismissive or uninterested in you as a person. Participants cited many examples of when they felt that someone was actually listening to their problems and not merely 'going through the motions':

The psychiatrist, it was the fact that she actually listened, I don't think anybody had actually listened to what I had to say before. (Interview 4)

He's the one to sit there and calmly talk with you and listen to you, it's just the calmness not the bluntness, the understanding and all that stuff. (Interview 2)

I felt safe around her and it was just the way she talked to me, and like, you know, didn't push to ask questions or anything, she just let me say or whatever, or if I didn't want to say anything, it was fine, you know, and she, I think, she could see through all my pain. (Interview 3)

Perhaps it was bitter experience, but the participants believed that they had a highly attuned sense of when they were being dealt with fairly and honestly:

I think that you really need to get along with your doctor or counsellors or whatever, and I think they need to be honest as well. (Interview 1)

She was very straightforward, you know, a lot of, she was not just a book person, if you understand what I mean. (Interview 3)

Having a non-judgmental approach

Being homeless or using illicit drugs or having a mental health problem are not value-neutral states. These are

stigmatising experiences, and it matters little whether the stares of passers by or the more studied looks of professionals are curious, contemptuous or pitying; the gaze is relentless and always insinuates the judgements: 'junkies', 'wasters', 'psychos', 'bludgers' … 'Why don't they just … ?' 'If that was my kid I'd …' 'What they need is …'

The experience of feeling scrutinised and judged by others was common, and often deterred the participants from contacting further services. Judgemental attitudes on the part of service providers were frequently described; for example, a doctor 'looking down his nose' and giving preferential treatment to non-street people in an emergency department (despite the severity of injuries). Similarly, if participants were asked if they had taken drugs, this then became the major clinical and diagnostic focus rather than any possible mental health problem that may have been the primary reason for seeking help.

One participant described sensing almost immediately that the mental health workers visiting her were dismissive and judgemental:

I didn't feel that they even knew what they were doing. […] They didn't even have to say anything, I knew straight away. It was more the way they behaved and the way they were talking as well, and the way they spoke to my worker at the time. […] They looked at me strangely. […] And yet they're meant to be mental health people, they're not meant to look at you like you're some strange person […] just because I couldn't explain to them how I was feeling and what I was feeling, to me they looked like as if, 'My God, what are we doing here?' (Interview 8)

In contrast, their experiences when they did not feel judged were remembered positively:

She never judged me or anything, she was always there to give me a hug if I felt down and that, and like, she, I just, you know, when you're young and for someone to just show to you that they care about you, even though they don't know you from a bar of soap, that makes you, it helps a lot. (Interview 3)

Many such positive experiences related to the personal attitudes of healthcare providers, as demonstrated in all of their dealings with the young person. One participant described the positive and enabling qualities of her key worker in language that would be anathema to a healthcare system driven by throughput, outcomes, standardisation and measurement:

Interviewer: I was just wondering if I could ask you to have a think about what it was about [key worker] that made you or helped you bond with her?

P1: Probably just the love that she gives to people and the fact that she ran the [programme], and that gives people time to get away and think about stuff. (Interview 8)

The following discussion highlights the type of care from health services that encouraged engagement and ongoing consultation for this group of young people.

Discussion

People who are homeless have multiple needs, including housing, financial assistance, healthcare and social support. Access to health services was not seen by the young people as the major issue that might have been anticipated at the outset of the present study. Certainly, it does not seem to be as crucial an issue in Australia as for homeless young people in the USA, for example, where basic health insurance and healthcare cover may not be available (Geber 1997, Hatton *et al.* 2001, Ensign & Bell 2004). The young people in the present study seemed to be able to access health services without too much difficulty, but whether these 'accessible' services were sensitive, caring and appropriate to meet their needs is another question. The young people mentioned making frequent visits to accident and emergency departments at times of crisis. Their accounts of such visits were generally negative, and they described feeling stigmatised, patronised and generally made to feel unwelcome and unworthy, to the extent that one participant described being 'chased' from the hospital's emergency department by security guards.

As other studies have demonstrated (Clark & George 1993, Kushel *et al.* 2001), many people who are homeless are more likely to attend accident and emergency centres for health problems. This type of service is unlikely to be able to provide adequate attention to the interdependent and possibly long-standing problems which need to be addressed if care is to be effective for young people who are homeless and experiencing mental health problems. In an American study, Klein *et al.* (2000) found that young people living in shelters who had access to a reliable source of primary healthcare were more likely to use non-emergency services: this is one of the primary care and preventative services provided by Streetlink in South Australia.

Central themes in the participants' experiences relate to trust and respect between client and service provider. Ulager *et al.* (2005) encapsulated much of this issue in the title of their study, 'Why should I tell you?', which shows the importance of honesty, respect, non-judgemental behaviour and respect for privacy as essential prerequisites in helping young homeless people. Similarly, for the young people in the present study, many of whom were required to visit a variety of healthcare services, it was often difficult to 'open up' to a stranger they had never met before. In many instances, the foundations of trust and respect were established during the first interaction with a healthcare

service, and when a relationship of mutual trust and respect was established, the strength of this relationship was significant. Young people would not only pursue ongoing treatment for an illness, but could also interact with the healthcare personnel in ways which helped build feelings of self-worth and develop trust in others. As Levy & O'Connell (2004) have noted, once trust is established with a health professional, multiple problems of a physical, psychological and social nature are often revealed. However, the time required to provide appropriate holistic care is often difficult to find in a healthcare climate that demands quicker and ever more supposedly efficient 'throughput'.

The present study also suggests that, once trust was established with a healthcare worker, it was possible to assist the young person to begin taking responsibility for their ongoing health needs, thus potentially reducing the demand on tertiary healthcare services in the long term. A pressing challenge for health and social care professionals is to establish a level of meaningful engagement with homeless young people that allows them to foster self-help initiatives and a sense of self-worth within the young person (Thompson *et al.* 2006). Here, the attitudes conveyed by the health professionals seem crucial. Kidd's (2003) study with Canadian street youth highlighted similar frustrations to those expressed by participants in this study. Participants described mental health professionals of their experience as 'uncaring pill-pusher[s]' or 'ineffectual' (Kidd 2003, p. 251). They spoke of the need to educate health providers to understand the needs of those living on the streets, with the hope that increased awareness would result in less judgemental and condescending attitudes by health professionals (Kidd 2003).

McCabe *et al.*'s (2001) research in the USA described criteria for positive engagement with healthcare professionals similar to those described by participants in the present study. Committed care involves healthcare providers not 'giving up on' their client, i.e. rather than being punitive if appointments are missed or medication is omitted, they would assist the young people to overcome whatever obstacles prevent them from implementing their treatment. The engagement phase of a therapeutic alliance for young people with mental health problems, described by French *et al.* (2003), resonates with many of the present study findings. Young people want to be treated in a manner that does not reflect negative prejudices, but rather, with respect, acceptance and genuine caring. Inclusionary rather than exclusionary care practices are required where healthcare professionals explain treatments and ensure they are understood (prior to implementation), and young people are involved in decision-making regarding their own health and future. The climate for this type of care is often enhanced when healthcare services specifically address the needs of young homeless people by the provision of services which are flexible, community-based and multidisciplinary. A recent Scottish study (Neale & Kennedy 2002) has highlighted many elements of best practice in providing services and care for homeless drug users with which the younger Australian participants in the present study concurred. These include the provision of a generally and emotionally supportive service with non-judgemental staff where: there is a safe 'good atmosphere', helping them to build self-esteem and self-confidence; they have access to immediate, appropriate health and social supports; and they are treated with a respect that acknowledges not simply their 'voices' as 'consumers', but also their involvement as active citizens.

Limitations of the present study

This was a small, exploratory, qualitative study conducted among the clients of one service for homeless young people in one city. Therefore, it would be unwise to over-generalise from the study to the entire population of young homeless people who have experienced mental health problems. The individual interview, like any other data collection approach, has inherent limitations. It cannot discern changes in viewpoints over time, nor does it offer the possibility of continuing dialogue with the respondent. Despite these limitations, we can learn much by listening carefully to the accounts of those most directly affected by youth homelessness and mental health problems. This study has explored and presented important aspects of young people's perceptions and understandings which should not be discounted because 'only' 10 young people have described them. Therefore, the study builds on the developing body of research exploring young people's experiences of homelessness, mental health and service use. As Darbyshire (2003, p. 305) has commented, 'What can we learn from only a small scale study?' is a criticism frequently levelled at qualitative research. The answer, as Harry Walcott (personal communication) explained recently, is simply, 'As much as we can.'

Conclusion

The young people who took part in the present study were homeless and had experienced mental health problems, but they were fundamentally and most importantly young people. Unsurprisingly then, their accounts of positive and negative healthcare experiences seem similar to the experiences of other adolescents with mental health problems who are not homeless. In Buston's (2002) study, she found that: 'The

major theme to emerge from these interviews is the value placed on an understanding and supportive clinical relationship' (p. 240). The young people who took part in the present study were also well aware of differences in service provision and in the quality of care, attention and help that they received when they were most in need. These were often the 'crisis times' when they went to an emergency service or hospital or clinic for help. Their accounts suggested that they encountered some of the most positive and negative aspects of service provision and professional attitudes. In some places, they were received with respect and listened to with care and attention, while in others, they seem to have been treated with near-contempt.

The young people also had a good sense of the features of a service that they found to be helpful, supportive and enabling. They needed specific, clear information and advice across a wide range of health and social issues. They appreciated not having to travel to three or four different places for services, appreciating services which were more of a 'one-stop shop' where they could, for example, sleep, socialise, access health services, and get help with housing and/or benefits and employment from people who knew and understood both them and 'the system'.

Above all, these young people appreciated being respected and treated by professionals as fellow human beings who matter. In this respect, the study findings support very recent US work stressing the need for services to be 'supportive, accommodating and *caring* (Thompson *et al.* 2006, p. 42; present authors' italics). This seems such an obvious and essential grounding for any healthcare encounter between a person seeking help and a service or individual professional that it should be simply 'a given'. That, in some areas, this seems to be a goal to be attained should be a cause for concern.

Acknowledgements

References

Alden D., Hoa D. & Bhawuk D. (2004) Client satisfaction with reproductive health-care quality: integrating business approaches to modeling and measurement. *Science and Social Medicine* **59**, 2219–2232.

Alderson P. & Morrow V. (2004) *Ethics, Social Research and Consulting with Children and Young People*. Barnardo's, Ilford.

Barry P., Ensign J. & Lippek S. (2002) Embracing street culture: fitting health care into the lives of street youth. *Journal of Transcultural Nursing* **13** (2), 145–152.

Boyatzis R. (1998) *Transforming Qualitative Information: Thematic Analysis and Code Development*. Sage Publications, Thousand Oaks, CA.

Buck D., Rochon D., Davidson H. & McCurdy S. (2004) Involving homeless persons in the leadership of a health care organisation. *Qualitative Health Research* **14** (4), 513–525.

Buston K. (2002) Adolescents with mental health problems: what do they say about health services? *Journal of Adolescence* **25** (2), 231–242.

Centre for Economic and Social Inclusion (2005) *Access to Mainstream Public Services for Homeless People: A Literature Review. A Report for 'Crisis' Prepared by the Centre for Economic and Social Inclusion, November 2005*. [WWW document.] URL http://www.crisis.org.uk/downloads.php/239/Service%20Access%20Lit%20Review.pdf

Chamberlain C. & MacKenzie D. (2003) *Australian Census Analytic Program: Counting the Homeless 2001*. ABS cat. no. 2050.0. Australian Bureau of Statistics, Canberra.

Chan S. & Twinn S. (2003) Satisfaction with child health services in the non-government sector of Hong Kong: consumer evaluation. *Nursing and Health Sciences* **5**, 165–173.

Chung D. & Tesoriero F. (1997) *Innovative Health Services for Homeless Youth Program*. School of Social Work and Social Policy, University of South Australia, Adelaide.

Clark C. & George C. (1993) *Accessible, Acceptable, Appropriate. Health Service Journal* **103** (March), 28–29.

Claveirole A. (2004) Listening to young voices: challenges of research with adolescent mental health service users. *Journal of Psychiatric and Mental Health Nursing* **11** (3), 253–260.

Commander M., Davis A., McCabe A. & Stanyer A. (2002) A comparison of homeless and domiciled young people. *Journal of Mental Health* **11** (5), 557–564.

Commander M. & Odell S. (2001) A comparison of the needs of the homeless and never homeless patients with psychotic disorders. *Journal of Mental Health* **10** (4), 449–456.

Darbyshire P. (2003) Mothers' experiences of their child's recovery in hospital and at home: a qualitative investigation. *Journal of Child Health Care* **7** (4), 291–312.

Ensign J. (2003) Ethical issues in qualitative health research with homeless youths. *Journal of Advanced Nursing* **43** (1), 43–50.

Ensign J. (2004) Quality of health care: the views of homeless youth. *Health Services Research* **39** (4, Part 1), 695–708.

Ensign J. & Bell M. (2004) Illness experiences of homeless youth. *Qualitative Health Research* **14** (9), 1239–1254.

Ensign J. & Gittelsohn J. (1998) Health and access to care: perspectives of homeless youth in Baltimore City, USA. *Social Science and Medicine* **47** (12), 2087–2099.

Ensign J. & Panke A. (2002) Barriers and bridges to care: voices of homeless female adolescent youth in Seattle, Washington, USA. *Journal of Advanced Nursing* **37** (2), 166.

Ensign J. & Santelli J. (1998) Health status and service use: comparison of adolescents at a school-based health clinic with homeless adolescents. *Archives of Pediatrics and Adolescent Medicine* **152** (1), 20–24.

French R., Reardon M. & Smith P. (2003) Engaging with a mental health service: perspectives of at-risk youth. *Child and Adolescent Social Work Journal* **20** (6), 529–548.

Geber G.M. (1997) Barriers to health care for street youth. *Journal of Adolescent Health* **21** (5), 287–290.

Goldman H., Morrissey J., Rosenheck R., Cocozza J., Blasinsky M., Randolph F. & Team A.N.E. (2002) Lessons from the evaluation of the ACCESS Program. *Psychiatric Services* **53** (8), 967–969.

Guo S., Biegel D., Johnson J. & Dyches H. (2001) Assessing the impact of community-based mobile crisis services on preventing hospitalisation. *Psychiatric Services* **52** (2), 223–228.

Hagedorn S. (2002) Caring for street youth: a nursing challenge. *Journal of Specialists in Pediatric Nursing* **7** (1), 34–37.

Hatton D., Kleffel D., Bennett S. & Gaffrey E. (2001) Homeless women and children's access to health care: a paradox. *Journal of Community Health Nursing* **18** (1), 25–34.

Hodder T., Teesson M. & Buhrich N. (1998) *Down and Out in Sydney: Prevalence of Mental Disorders, Disability and Health Service Use among Homeless People in Inner Sydney*. Research Group in Mental Health and Homelessness, Sydney.

Jimmieson N. & Griffin M. (1998) Linking client and employee perceptions of the organization: a study of client satisfaction with health care services. *Journal of Occupational and Organizational Psychology* **71** (1), 81–97.

Kamieniecki G. (2001) Prevalence of psychological distress and psychiatric disorders among homeless youth in Australia: a comparative review. *Australian and New Zealand Journal of Psychiatry* **35**, 352–358.

Kidd S. (2003) Street youth: coping and interventions. *Child and Adolescent Social Work Journal* **20** (4), 235–261.

Kidd S.A. (2004) 'The walls were closing in, and we were trapped': a qualitative analysis of street youth suicide. *Youth Society* **36** (1), 30–55.

Klein J.D., Woods A.H., Wilson K.M., Prospero M., Greene J. & Ringwalt C. (2000) Homeless and runaway youths' access to health care. *Journal of Adolescent Health* **27** (5), 331–339.

Kushel M., Vittinghoff E. & Haas J. (2001) Factors associated with the health care utilization of homeless persons. *Journal of American Medical Association* **285** (2), 200–206.

Levy B. & O'Connell J. (2004) Health care for homeless persons. *New England Journal of Medicine* **350** (23), 2329–2332.

McCabe S., Macnee C. & Anderson M. (2001) Homeless patients' experience of satisfaction with care. *Archives of Psychiatric Nursing* **15** (2), 78–85.

Morrow V. (1999) 'We are people too': Children's and young people's perspectives on children's rights and decision-making in England. *International Journal of Children's Rights* **7** (2), 149–170.

Neale J. & Kennedy C. (2002) Good practice towards homeless drug users: research evidence from Scotland. *Health and Social Care in the Community* **10** (3), 196–205.

O'Toole T., Gibbon J., Hanusa B. & Fine M. (1999) Preferences for sites of care among urban homeless and housed poor adults. *Journal of General International Medicine* **14**, 599–605.

Percy M.S. (1994) *Children Who Are Homeless Describe What Is Special: A Photographic Heuristic Study*. PhD Thesis, University of South Carolina, Columbia, SC.

Percy M.S. (1995) Children from homeless families describe what is special in their lives. *Holistic Nursing Practice* **9** (4), 24–33.

Powell R., Holloway F., Lee J. & Sitza J. (2004) Satisfaction research and the uncrowned king: challenges and future directions. *Journal of Mental Health* **13** (1), 11–20.

Power R., French R., Connelly J., George S. & Hawes D. (1999) Health, health promotion, and homelessness. *British Medical Journal* **318**, 590–592.

Randolph F., Blasinsky M., Morrissey J., Rosenheck R., Cocozza J., Goldman H. & Team A.N.E. (2002) Overview of the ACCESS program. *Psychiatric Services* **53** (8), 945–948.

Rew L. (2002) Characteristics and health care needs of homeless adolescents. *Nursing Clinics of North America* **37** (3), 423–431.

Rew L. (2003) A theory of taking care of oneself grounded in experiences of homeless youth. *Nursing Research* **52** (4), 234–241.

Rew L. & Horner S. (2003) Personal strengths of homeless adolescents living in a high-risk environment. *Advances in Nursing Science* **26** (2), 90–101.

Robinson C. (2002) 'I think home is more than a building': young home(less) people on the cusp of home, self and something else. *Urban Policy and Research* **20** (1), 27–38.

Rosenfeld S.L., Keenan P.M., Fox D.J., Chase L.H., Melchiono M.W. & Woods E.R. (2000) Youth perceptions of comprehensive adolescent health services through the Boston HAPPENS program. *Journal of Pediatric Health Care* **14** (2), 60–67.

Rosenheck R. & Lam J. (1997) Homeless mentally ill clients' and providers' perceptions of service needs and clients' use of services. *Psychiatric Services* **48** (3), 381–386.

Thompson S.J., McManus H., Lantry J., Windsor L. & Flynn P. (2006) Insights from the street: perceptions of services and providers by homeless young adults. *Evaluation and Program Planning* **29** (1), 34–43.

Ulager J., Pearson A., Tomescu O., Hill C., Auerswald C. & Ginsburg K. (2005) 'Why should I tell you?' Homeless youth share what it takes for professionals to earn their trust. *Journal of Adolescent Health* **36** (2), 133–134.

United Nations/United Nations Children's Fund (1989) *Convention on the Rights of the Child*. [WWW document.] URL http://www.unicef.org/crc/

Walker S. (2001) Consulting with children and young people. *International Journal of Children's Rights* **9** (1), 45–56.

Wood A., Sclare P. & Love J. (2001) Service innovations: a service for the homeless with mental illness in Aberdeen. *Psychiatric Bulletin* **25**, 137–140.