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Homeless youth: Barriers and facilitators for service referrals

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ABSTRACT

Young people who are homeless and experiencing mental health issues are reluctant to use relevant services for numerous reasons. Youth are also at risk of disengaging from services at times of referral to additional or alternative services. This study aimed to identify barriers and facilitators for inter-service referrals for homeless youth with mental health issues who have already engaged with a service. Qualitative, semi-structured interviews were conducted with homeless youth (n = 10), homelessness support workers (n = 10), and mental health clinicians (n = 10). Barriers included: resource shortages; programs or services having inflexible entry criteria; complexity of service systems; homeless youth feeling devalued; and a lack of communication between services, for example, abrupt referrals with no follow up. Referral facilitators included: services providers offering friendly and client-centred support; supported referrals; awareness of other services; and collaboration between services. Relationships with service providers and inter-service collaboration appeared essential for successful referrals for homeless youth. These facilitating factors may be undermined by sector separation and siloing, as well as resource shortages in both the homelessness and mental health sectors. Service transitions may be conceptualised as a genuine service outcome for homeless youth, and as a basis for successful future service provision.

1. Homeless youth: barriers and facilitators for service referrals

In Australia's most recent census, 105, 237 people were identified as homeless and 25% of this group were youth aged 12–24 years (Australian Bureau of Statistics, 2012). In those who are homeless, mental health issues are common (Hodgson, Shelton, van den Bree, & Los, 2013; Medlow, Klineberg, & Steinbeck, 2014). In Australia, the lifetime prevalence of psychiatric disorders in homeless youth was found to be 82–85%, with current prevalence varying between 27.6 and 53% (Kamieniecki, 2001). Moreover, homelessness itself has been linked to deteriorating mental health in young people (Cleverley & Kidd, 2011; Martijn & Sharpe, 2006).

Research has consistently indicated that despite acute needs, young people experiencing homelessness and/or psychiatric disorders can be reluctant to engage with helping services. Barriers to service engagement include: a lack of awareness about services (Booth et al., 2004; Skott-Myhre, Raby, & Nikolaou, 2008; Solorio, Milburn, Andersen, Trifskin, & Rodríguez, 2006); service inaccessibility such as waiting lists and service location (Booth et al., 2004; Garrett et al., 2008); concerns about confidentiality (Booth et al., 2004); not wanting to engage with strangers or tell one's story repeatedly (Keys, Mallet, Edward, & Rosenthal, 2004); mistrust of service providers (Skott-Myhre et al., 2008; Solorio et al., 2006); feeling judged or that staff have 'agendas' (Garrett et al., 2008); lack of perceived need for mental health services (Munson et al., 2012; O'Reilly, Taylor, & Vostanis, 2009); a belief that services are not helpful (Skott-Myhre et al., 2008; Solorio et al., 2006); or disliking needing help (Keys et al., 2004).

Accessing one service is generally not sufficient to meet the multiple and complex issues affecting homeless youth who experience mental health issues. For example, emergency accommodation services do not treat depression or trauma symptoms, and receiving mental health treatment will not resolve homelessness. This paper aimed to identify inter-service referral barriers and facilitators experienced by homeless youth when they attempt to navigate both the health and homelessness sectors.

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2. Methods

2.1. Design

This was a qualitative research study with a phenomenological approach aiming to explore the lived experience of service referrals through in-depth interviews. A sample size of $n = 10$ homeless youth was specified *a priori*, in keeping with Morse's (2000) suggestion that 6–10 cases are sufficient when large amounts of data are expected per participant, in phenomenological studies employing in-depth interviews. To triangulate this data, samples of mental health clinicians ($n = 10$) and homelessness support workers ($n = 10$) were also conducted.

2.2. Materials

Two semi-structured interview schedules were developed: one for service providers and one for young people. The semi-structured format ensured that all relevant areas were explored in a systematic manner, at the same time allowing flexibility in phrasing, question sequencing, and probes. Interviews were conducted by three interviewers: RP interviewed homeless youth, EB interviewed homelessness support workers, and IF interviewed mental health clinicians. All interviews were recorded using a digital voice recorder.

2.2.1. Homeless youth

This interview schedule collected information about demographic factors, past and present experiences of homelessness, and use of mental health and homelessness services. The contextual factors surrounding entry and exit from the different services were of particular interest: participants were asked to describe their referral experiences.

2.2.2. Service providers

This schedule assessed workers' experiences of working with homeless youth with mental health issues, how this group was identified, service referral outcomes, and perceived barriers and facilitators for successful referrals. Service collaborations were also explored.

2.3. Procedure

2.3.1. Homeless youth

Homeless youth learnt about the study through posters placed in homelessness and mental health services, and through flyers distributed by the mental health clinicians and the homelessness support workers to youth who met the inclusion criteria. Inclusion criteria were: being aged 16–25 years; having experienced homelessness (past or present); being located in Melbourne's Eastern Metropolitan Region; and having experienced mental health issues. Mental health issues were determined by participants self-reporting these, and evidenced by contact with mental health services. One person directly contacted the interviewer to participate. The remaining young people, upon hearing about the study, chose for their contact details to be supplied to the interviewer by their service provider. The interviewer then contacted them directly with an invitation to participate. All young people contacted agreed to participate.

Interviews were conducted at a community location nominated by the participant ($n = 3$), or at EACH Social and Community Health's office ($n = 7$). EACH Social and Community Health is a community based organisation offering an integrated range of health, disability, counselling, and mental health service at numerous locations along the eastern seaboard of Australia.

The aims of the project, the voluntary nature of participation and confidentiality, and the informed consent process were explained verbally and with written information. If participants agreed to proceed, their written consent was obtained on Participant Information and Consent Forms. Participants received a $20 shopping voucher on completion.

2.3.2. Service providers

Staff from mental health and homelessness services were notified about the study via recruitment posters located in their workplace and via email or phone calls from the researchers. Purposeful sampling was used to ensure an information-rich sample. The research team (RL, HM, CR, PB, and RP) have had many years of experience in the homelessness and mental health sectors in the region, as well as participating in inter-service networking forums. Key contacts in both the youth homelessness and the mental health sector were identified by this group and subsequently approached by two researchers from the team (EB, IF). All nominated participants from both sectors agreed to participate. No one from the research team was interviewed in this study.

Mental health clinicians were recruited from both child and youth, and adult mental health services. These included: triage, inpatient units, outpatient clinics, crisis assessment and treatment teams, and intensive mobile treatment teams. Homelessness support workers who participated in the study were recruited from: youth refuges, youth housing services, short-term supported accommodation, a non-government community health organisation with a specific project on homeless youth, residential services for adolescents in the foster care system or post-foster care, a service addressing both mental health and homelessness, and a local government youth service.

Consent to participate followed the same process as for the young people. Interviews with service providers took place at their workplace. The duration of the interviews with mental health clinicians ranged from 32 to 72 min ($M = 54.07$), and the interviews with homelessness support workers were between 33 and 70 min ($M = 48.93$). On completion, a $10 donation was made to a charity of the participants' choice in recognition of their time.

This research was approved by Eastern Health's Human Research Ethics Committee [HREC # E34/2011] and by EACH Social and Community Health's Board of Directors.

2.4. Data preparation and analysis

Recorded interviews were transcribed and managed using NVivo 9 software for qualitative data. Thematic analysis was employed for data analysis due to its theoretical freedom and flexibility as a research tool (Braun & Clarke, 2006). Briefly, this method of analysis of qualitative data involves systematic coding of the features of the interview, then collating the codes into broad headings which, in turn, are organised into higher-order headings or themes (Braun & Clarke, 2006).

The codes, categories, and themes were generated iteratively. Firstly, two researchers (IF, HM) independently coded $n = 3$ (10%) of the interviews. Disparate ratings were subsequently discussed until agreement was reached, allowing for the refinement of the codes and the coding process. Consensus discussions between the researchers were then used to group the initial codes into broader categories and themes. The remaining interviews were subsequently coded by a single researcher (IF).

3. Results

The participating homeless youth included two males and eight females, ranging in age from 17 to 23 years ($M = 20.9$ years). Three individuals were homeless at the time of the study, and seven had experienced a past episode of homelessness. Interview duration ranged from 44 to 72 min ($M = 53.28$).

Participating service providers comprised eight males and 12 females (10 from the homelessness sector and 10 from the mental health sector). Years of experience in their given sector ranged from 2.5 to 35 years ($M = 13.2$ years). Interview duration ranged from 32 to 72 min ($M = 51.5$).