RESEARCH ARTICLE

Youth Homelessness: The Relationships among Mental Health, Hope, and Service Satisfaction

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Abstract

Introduction: This paper reports a mental health assessment of 60 homeless youth. Our study explored the mental health needs of youth accessing an overnight youth shelter (maximum stay 8 weeks). **Methods:** Participants completed an interview (45 to 120 minutes in duration) using one demographic form and one of two standardized questionnaires (Youth Self Report, Adult Self Report). Questions assessed youth mental health symptoms, examined various contacts that youth made with mainstream society (services, family), and identified potential motivating factors (hope, service satisfaction) that may play a role in fostering street survival during adolescence. **Results:** Forty-eight percent of the youth were clinically symptomatic and most youth accessed a range of general health services. **Conclusion:** However, those most in need had significantly less service satisfaction, less hope about the future, and had not accessed mental health services.

Key words: *homeless youth, mental health, hope, service satisfaction*

Résumé

Introduction: Évaluation de la santé mentale de 60 adolescents itinérants; étude des besoins en santé mentale des adolescents qui se présentent à un centre d'hébergement (durée maximale de séjour: huit semaines). **Méthodologie:** Les participants ont participé à une entrevue (d'une durée de 45 minutes à deux heures); ils ont rempli une fiche d'information personnelle et deux questionnaires standards, le Youth Self Report (Rapport de l'adolescent) et le Adult Self Report (Rapport de l'adulte). Les questions portaient sur les symptômes de maladie mentale, les contacts établis par les adolescents avec les services sociaux ou avec leur famille; elles présentaient les raisons qui expliquaient la survie des adolescents dans la rue (espoir, satisfaction face aux services). **Résultats:** Quarante-huit pour cent des adolescents présentaient des symptômes cliniques; la plupart d'entre eux avaient eu recours à des services de santé généraux. **Conclusion:** Les adolescents qui avaient le plus besoin des services étaient les moins satisfaits, n'avaient pas d'espoir et n'avaient pas eu recours à des services de santé mentale.

Mots clés: *adolescents itinérants, santé mentale, espoir, satisfaction face aux services*

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Introduction

Adolescence is a time when youth need a strong support system and a feeling of hopefulness to face the complex and often troubling developmental tasks of creating a stable identity and becoming productive and autonomous adults (Carnegie Council on Adolescent Development, 1995). Yet, an increasing number of adolescents find themselves dealing with an unrealistic test of independence—that of homelessness. Living on the margins of homelessness is challenging at best. Those affected are as diverse as the rest of the Canadian population (Public Health Agency of Canada, 2006) but share in common precarious living conditions and face extreme alienation and disadvantage (Covenant House, 2006), particularly if they also experience poor mental health. Youth comprise the fastest growing age group within the homeless population (Ringwalt, et al., 1998). In fact, estimates suggest that every day in Canada 150,000 youth are living on the streets (Public Health Agency of Canada, 2006).

At least 50% of homeless youth are thought to have serious mental health and/or drug addiction problems (Adlaf & Zdanowicz, 1999; Aichhorn, Santeler, Stelzig-Schöler, Kemmler, Steinmayr-Gensluckner, & Hinterhuber, 2008; Ensign & Bell, 2004; Kamieniecki, 2001). Further, while there is clear evidence that mental illness can undermine the very problem-solving skills needed to survive on the street (Muir-Cochrane, et al., 2006), research has only begun to consider how homeless youth's experience of mental illness might affect, or be affected by, other factors such as, hope, service utilization, and satisfaction with services accessed.

The impact of hope on homeless youth is not well understood. Hope can be defined as a life-sustaining factor involving three elements: goal-oriented thoughts, strategies to achieve the goals, and motivational thought (Snyder, 1994). Hope plays a critical role, particularly for youth, in testing out potential identities (Markus & Nuris, 1986) and in planning for the future (Nulkur, 2009). It also plays a role in help-seeking (Edey & Jevne, 2003), the experience of illness and recovery (Moore, 2005), and in coping with difficult life situations (Kylma & Juvakka, 2006).

There is conflicting evidence about how hope is affected by homelessness. Some evidence suggests that the bleak reality and marginalization of homelessness (Ensign, 2004) undermines hope (Abadia-Barrero, 2002; Lindgren, Wilstrand, et al., 2004) and often results in hopelessness—a known predictor of increased suffering, poor physical outcomes (Clarke, 2003), and suicide (Kirkcaldy, et al., 2006). Yet, there is also evidence that hope persists within some homeless youth (Herth, 1998; Kidd, 2003). Not clear is what factors account for the difference in findings. Some have argued that the stability of hope is relative (Valle, Huebner, & Suldo, 2006). For example, Nalkur (2009) found that youth in unstable housing environments avoided hope so as to circumvent failure, while youth in more stable housing environments relied on hope, seeing themselves as critical agents in enduring hopefulness, and concluded that context (defined as stability of housing) shapes hopefulness. Internal factors seem to play a role in hope. For example, homeless youth who perceive themselves to be more resilient, although disconnected from other people, are less lonely, less hopeless, and engaged in fewer life-threatening behaviours (Rew, Taylor-Seehafer, Thomas, Yockey, 2001). Clearly, the knowledge base on hope is far from complete, particularly within a homeless youth population.

Likewise, the patterns of service use among homeless youth are not well understood. While there is ample evidence that homeless youth rarely use services that have a fee (e.g., Kushel, et al., 2001; Lim, et al., 2002), there is also some evidence that they seldom use services when they are free (Miller, et al., 2004). In particular, data suggest that homeless youth infrequently access primary health care; choosing only to seek services in hospital emergency departments when conditions can no longer be ignored (DeRosa, 1999; Geber, 1997; Greene, 1995). Those who live with mental health problems are even less likely to receive treatment (Bonin, Fournier, Blais, 2007; Klein, et al., 2007; Holmes et al., 2005; Solorio, Milburn, Andersen, Trifskin, & Rodríguez , 2006), particularly if they have poor overall functioning (Buckner, & Bassuk, 1997). Access seems to be determined by factors other than price (Carlson, et al., 2007), including those related to the service (e.g., relevance, location, 'youth-friendliness' and suitability, Ensign & Gittelsohn, 1998; Greenwood, et al., 2005) and those related to the user (e.g., knowledge regarding where to go or what service to use, Solorio,et al., 2006). Few services are specifically directed toward homeless youth (Ensign & Gittelsohn, 1998; Ensign & Panke, 2002; Greenwood, et al., 2005), and those that are, often lack cultural sensitivity and flexible policies (Garrett, Higa, Phares, Peterson, Wells, & Baer, 2008), and/or fail to foster independence, autonomy, and self-worth (Barry, et al., 2002; Christiani, Hudson, Nyamathi, Mutere, & Sweat, 2008; DeRosa, 1999). Clearly, our understanding about the relationships between mental health, service use, and service satisfaction remains limited.

Current Study

The purpose of this study was to develop an enhanced understanding of the relationship among the mental health needs of homeless youth, their hope about the future, and their use and satisfaction with one form of support (health services). Of

particular interest, we wanted to better understand within a homeless youth population (a) how the degree of mental health symptoms relates to hope for the future; (b) how hope for the future influences service use and satisfaction; and (c) how mental health symptoms, hope, and service satisfaction interact together.

Our study explored the mental health needs of youth accessing an overnight youth shelter. We assessed youth mental health symptoms, examined various contacts that youth made with mainstream society (services, family), and identified potential motivating factors (hope, service satisfaction) that may play a role in fostering street survival during adolescence.

Methods

Participants

Participants included a convenience sample of youth between the ages of 16 and 24 years who had spent at least one night in the only youth shelter in Halifax, Nova Scotia (population ˜357,000). Study approval was granted by the IWK Health Centre Ethics Review Board. The final sample included 60 youth (mean age = 19.4 years, SD = 2.43); 43 males (mean age = 20.1 years, SD = 2.42) and 17 females (mean age = 17.7 years, SD = 1.32).

All participants completed an interview (45 to 120 minutes in duration) within a week following entry into the shelter (maximum stay permitted—8 weeks). Interviews were conducted with a trained research team member (experienced mental health clinician) in a private room of the shelter, and received an honorarium for their time (bus tickets and/or coffee shop certificates). The interview involved three questionnaires read aloud to ensure that poor literacy was not a barrier to participation. One participant was referred to the on-site health coordinator (as directed by the research protocol) following a reported intention of potential harm to self or others.

Measures

Demographic Questionnaire

A team-developed questionnaire (39-items developed for the study) gathered socio-demographic information about youth including age; education and history of learning problems; family background, reasons for leaving home (most recent departure) and current frequency of family contact; living arrangements; use and suitability of health-related services; and nutrition and health status. Two self-report questions on health status were included. One question was taken from the SF-12 Quality of Life Inventory (Ware, et al., 1996; “In general, would you say your health is excellent (5), very good (4), good (3), fair (2), poor (1).” The other was adapted from the first: “In general, would you say your mental health is excellent (5), very good (4), good (3), fair (2), poor (1).”

Four questions were developed for this study to explore youth perspectives about hope, the future, and service satisfaction. At study onset, the questions were intended more as a way of determining whether these issues were of importance and should be investigated in future research. One question assessed level of hope: “How hopeful are you about the future, on a scale of 1-10 (1 being least hopeful, and 10 being the most hopeful)?” The term hopeful was purposely left undefined so as not to impose meaning. Participants were then asked one follow-up, open-ended question asking youth to envision the future: “What do you think your life will be like in a year?.” To identify the types of services accessed one open-ended question was asked: “In the last 6 months what services have you used?.” Service satisfaction was assessed with one question: “Did the service(s) meet your health needs? (yes or no; yes = 1, no = 0).”

Mental Health

Youth mental health was measured via an assessment of psychological symptoms. The Youth Self-Report (YSR) (Achenbach & Edelbrock, 1991) is a 120-item self-report measure for youth ages 12 to 18 and the Adult Self Report (ASR) (Achenbach & Rescorla, 2003) is a 126-item self-report measure for adults 18 to 65 years. Both measures are empirically-based scales that assess two behaviour problem dimensions: internalizing and externalizing. The Internalizing scale is formed from responses on three subscales: Somatic Complaints, Anxious/Depressed, and Withdrawal. The Externalizing scale is formed from responses on two subscales: Delinquent and Aggressive Behaviours. A total symptom scale is obtained from a sum of all scores. Respondents are asked to think back over the past 6-months and indicate how true each item is for them on a scale from 0-to-2 (O being ‘not at all true’ and 2 being ‘very true’). Scores above 63 are considered to be clinically significant. For the purpose of our study, youth who had significantly elevated scores on the internalizing and/or externalizing scales were considered to have significantly elevated mental health symptoms. Some youth had elevated scores on both scales. Both the YSR and ASR have been shown to have good test-retest reliability (YSR: 0.89 Achenbach, 1999; ASR: 0.88, Achenbach, & Rescorla, 2003); construct and concurrent, discriminate and criterion-related validity; and internal consistency (YSR: range .59-.86, Achenbach, 1999; ASR: range .51-.97, Achenbach, & Rescorla, 2003).

Analysis

The quantitative data obtained from the survey instruments (regarding demographics, mental health symptoms, service use and satisfaction) were analyzed using a range of descriptive and inferential statistics (post-hoc analyses, Pearson correlations, chi-square, t-test, ANOVA). The qualitative findings obtained in response to the question "What do you think your life will be like in a year (in terms of everything—where you live, how you will feel about yourself, etc.)?" were analyzed using thematic analysis. Specifically, the research team carefully read and reread the responses to identify concepts which were then explored for meaning and finally categorized into themes (Glaser and Strauss, 1967). Coding structures were developed through research team discussions where the team explored the direction of the interviews, and emerging themes. These discussions enhanced the connection of the research team to the data as they provided a forum for deliberating potential meanings of interview data and an opportunity to build consensus around what the team was learning.

Results

Demographics

Sixty youth participated in the study (see Table 1). Approximately two thirds of the participants were male and the majority (67%) self-identified as being Caucasian. While most (67%; n = 37), of the youth reported growing up in the province, all had endured a number of moves—at least two during the previous six months.

Most youth were under-educated (60% = grade 10; n = 36), nearly half (47%; n = 28) reported learning difficulties and/or special needs in school. At the same time, four (7%) of the participants had some education beyond high school and nearly a fifth of the youth (18%; n = 10) were employed. Not surprisingly, many of the youth had a long history of family upheaval, nearly a third (29%; n = 17) were raised outside the family home (10% by extended family), and family conflict was the triggering factor for most (61%; n = 36) to leave home—both currently and historically. Yet, family contact persisted for 88 percent (n = 53) of the participants and remained regular (= weekly) for the majority of the youth (79%; n = 43). Post-hoc comparisons showed that the quality of youth relationships with parents was related to developmental stage as 75% (n = 15) of the 16-18 year old youth indicated that their relationship with their parents was "worse than average" (YSR question—"relationship with parents") while 74% of the older participants (n = 27; ages 18—24 years) rated their relationship with their parents as being "about average" or "better than average" (ASR question

Table 1. Sociodemographic characteristics of youth participants

Characteristic	Mean ± SD	Range
Age (in years)	19 (± 2.43)	16-24
	n	%
Gender		
Female	17	28
Male	43	72
In which province did you grow up?		
Within Nova Scotia		
Outside province		
In what kind of location did you grow up?		
Urban	33	60
Rural	22	40
Upbringing included		
Both parents	26	43
Mom and dad only	39	65
Out of family home	17	29
Extended family caregivers	6	10
Primary reason for not living at home		
Family conflict/Kicked out	36	61
Own choice	8	14
Other reasons	15	25
Do you have contact with your family?		
Yes	53	88
Frequency of family contact		
Daily	17	33
Weekly	24	46
Monthly	7	13
Less than monthly	4	8
In how many different situations have you lived over the past 6 months?		
Shelter	60	100
Apartment	39	65
Family Home	34	57
Street	15	25
Churches	8	13
Other	26	43

[1] Multiple answers permitted (n will be > 60)

continued

Table 1. Sociodemographic characteristics of youth participants (continued)

Characteristic	n	%
Do you have income?		
Yes	25	42
If yes, from where?		
Employed (regular or irregular)	11	44
Social assistance	12	48
Panhandling	2	8
What was the last grade that you completed in school?		
Grades 6-8	7	12
Grade 9-10	29	48
Grade 11-12	19	32
Post high school	4	7
Did you have any special needs in school, such as learning or behavioural difficulties?		
Yes	28	47
If yes, please describe:		
Learning difficulties	21	78
Behaviour difficulties	3	11
Emotional difficulties or other	3	11
In general, would you say your mental health is:		
Good or better	41	68
Fair	12	20
Poor	7	12
In general, would you say your health is:		
Good or better	45	75
Fair	12	20
Poor	3	5

[2] Multiple answers permitted (n will be > 60)

"Compared with others, how well do you get along with your mother/father)." Perceptions about the quality of family relationships improved with age.

Mental Health Symptoms

Scores on the YSR and ASR revealed that 22% of the youth (n = 13) fell in the clinical range on the Internalizing Symptom scale and 40% of the youth (n = 24) fell in the clinical range on the Externalizing Symptom scale. Forty-eight percent of the youth (n = 29) had scores that currently fell in the clinical range on both the internalizing and externalizing scales. For the purpose of further analyses, youth with clinically significant internalizing or externalizing mental health symptoms, are referred to as "youth with clinically elevated symptoms."

Interestingly, on the demographic questionnaire three quarters of the youth (75%; n = 45) self-reported good physical health and over two thirds reported good, very good or excellent mental health (68%; n = 41). Yet, Pearson correlations calculated to compare the one-word responses of the youth evaluating the quality of their mental health and general health with the externalizing and internalizing symptom scales were as expected. Self-reported quality of mental health was significantly negatively correlated with both externalizing symptoms ($r(60) = -.45$, $p < .001$) and internalizing symptoms ($r(60) = -.50$, $p < .001$). Ratings of general health were also significantly negatively correlated with externalizing symptoms ($r(60) = -.27$, $p = .041$) and internalizing symptoms ($r(60) = -.50$, $p < .001$). The correlations support the internal consistency of the youths' responses to the measures. Youth reporting more mental health symptoms also rated their mental health and general health more poorly.

Service Use and Satisfaction

During the previous 6-months, aside from the on-site shelter nurse whom most youth had accessed (68%; n = 40), half the youth (51%; n = 30) had used emergency services. However, non-emergent services had also been accessed. More specifically, nearly half the youth (44%; n = 26) had visited a family doctor, twenty percent (n = 12) had accessed a Community Health Clinic, and about the same number reported using mental health services (22%; n =13). See Table 2 for a listing of health services accessed by the youth in this study.

When health service use was compared by means of an independent samples t-test, the youth with clinically elevated symptoms reported accessing significantly more health services (of any kind) ($M = 2.86$, $SD = 1.41$) than those without elevated symptoms ($M = 2.00$, $SD = 1.15$; $t(57) = 2.57$, $p < .05$). Likewise, a chi-square test comparing youth access to their family physician (yes/no) over the past 6 months showed that youth with clinically elevated symptoms (61.5%, n = 16) had accessed their family physician significantly more often than those without elevated symptoms (38.5% , n = 10); $\div 2$ (1, 59) = 3.70, $p < .05$). However, a second chi-square analysis comparing access to specialty mental health services (yes/no) showed that most youth with clinically elevated symptoms (clinical symptoms yes/no) had not accessed any specialty mental health services (n = 18, 65% of those with clinical symptoms; $\div 2$ (1, 59) = 5.81, $p < .05$).

In terms of service satisfaction, the majority of the youth (84%; n = 47) indicated that they were satisfied with the services they had accessed over the past 6-months. However, those youth with clinically elevated symptoms were significantly less satisfied with accessed services.

Table 2. Health service use by youth participants

Characteristic	n	%
In the past 6 months have you used any of the following services?		
Nurse at the youth shelter	40	68
Emergency at hospital	30	51
Family Doctor	26	44
Mental health services	13	22
Community health clinic	12	20
Drug dependency service	7	12
Help Line	7	12
Gay/Lesbian support	5	9
Did the service(s) meet your health needs?		
Yes	47	84
No	9	16

Note: N = 60

Hope for the Future

A full range of hopefulness about the future was reported by the sample (range from 1 = least hopeful to 10 = most hopeful); however, most were at least somewhat hopeful (mean score of 7.48, SD = 2.26). From the thematic analysis of the responses to the question "What do you think your life will be like in a year (in terms of everything—where you live, how you will feel about yourself, etc.)?," two themes emerged: basic needs are met, living a product life. Ninety-seven percent (n = 58) of the participants hoped first that basic needs would be met (e.g., a place to live) and that the basic needs would then enable them to live productively (e.g., go to school, have a job, feel good). Interestingly, none of the participants mentioned immediate survival items (e.g., food). Further, only two youth were extremely pessimistic about the future, their comments were full of despair—(viewed the future as "HELL") and hoped just to "be alive."

We calculated an independent samples t-test to compare youth with and without clinically significant mental health symptoms (either internalizing or externalizing levels of clinical symptoms; independent variable) and their level of hopefulness for the future (dependent variable). Not surprisingly, youth without clinically elevated mental health symptoms were significantly more hopeful about the future (M = 8.26, SD = 1.95) than youth with clinically significant mental health symptoms (M = 6.66, SD = 2.30; t (58) = 2.92, p = .005).

Next, we correlated youth's self-report measures of well-being (Demographic Questionnaire—single questions regarding physical and mental health ratings; ASR/YSR reported mental health internalizing and externalizing symptom scores) with hopefulness and service satisfaction (see Table 3). Results showed that hopefulness was significantly related to the single question ratings of both mental health (r (60) = .41, p = .001), and general health (r (60) = .27, p = .039). Poorer ratings of health (physical or mental) were related to less hopefulness. Hopefulness was also significantly negatively related to internalizing symptom scores (r (60) = -.44, p = .001). Youth with higher levels of symptoms were less hopeful. In contrast, hopefulness was positively correlated with level of satisfaction with services accessed (r (56) = .51, p < .001). Youth with higher ratings of service satisfaction were more hopeful.

Service Satisfaction

We then wanted to know if there were differences between the youth who were and were not satisfied with services. An ANOVA was calculated to examine differences in the mental health symptoms (internalizing t score, externalizing t score) and hopefulness (the dependent variables) among youth who were satisfied (n = 47) and not satisfied (n = 9; independent variable) with services (yes or no; yes = 1, no = 0; M = .84, SD = .37). Results showed that youth who were less satisfied with services accessed reported significantly less hope for the future (M = 5.22, SD = 2.73) than youth who were satisfied with services received (M = 8.09, SD = 1.63; F (1, 54) = 18.45, p < .001). In addition, youth who were less satisfied with services reported significantly higher levels of internalizing symptoms (M = 68.00, SD = 11.46) than youth who were satisfied with services (M = 58.81, SD = 9.99; F (1, 54) = 6.11, p = .017). No significant differences between the groups were found on the externalizing symptom scale.

Discussion and Recommendations

This study examined mental health, hope, service use, and service satisfaction among homeless youth. Consistent with other research reports (Morrell-Bellai, Goering, Boydell, 2000; Reid, Berman, Forchuck, 2005; Rew, 2002; Rew, L., Taylor-Seehafer, M., & Fitzgerald, M.L., 2001), most youth in our study left home because of trauma (family conflict and/or violence) and intolerable conditions—the street was viewed as their only/best alternative. Yet, the majority maintained regular contact with family. Interestingly, relationships were viewed more positively by older youth. This suggests that developmental stage may play a role in the family upheaval and reinforces the need for a better understanding of the positive function that supportive family contacts

Table 3. Correlation Matrix of Potential Markers of Homelessness Life Cycle Position by Measures of Well-Being

	Age	Family relationship	Family contact	Transience	Service use	Satisfaction with services	Hopefulness about future
Demographic variables							
Age							
Family Relationships	.32*						
Family Contact	–.04	.04					
Transience	.12	.11	–.08				
Service Use	–.13	–.20	.09	–.27*			
Satisfaction with Services	.16	.14	–.07	–.03	–.27*		
Hopefulness	.20	.23	.08	–.04	–.17	.51***	
Self–Report							
Quality of Mental Health	.32*	.24	–.01	–.15	–.39**	.38***	.41***
Quality of General Health	.15	.32**	–.02	–.14	–.27*	.31*	.27*
YSR and ASR Symptom Checklists							
Internalizing Symptoms	.04	–.07	.01	.01	.36**	–.32*	–.44***
Externalizing Symptoms	–.19	–.06	.09	.11	.24	–.15	–.23

Note: N = 60. * p < .05, ** p < .01, *** p < .001.

Quality of Mental Health and General Health questions more positive answers indicate more positive ratings of health (1-5).

Family Relationship = quality of family relationship (0-2) with higher scores as most positive).

Family Contact = frequency of family contact, lower scores indicate less frequent contact;

Transience = Number of different living locations (i.e., cities, towns etc.) over past 6 months;

Service Use = count of different community resources accessed in past 6 months; Service Satisfaction (0 or 1, with 0 being not satisfied and 1 as satisfied).

(not necessarily a parent) can/do play in assisting youth who are homeless (Kidd, 2003).

Consistent with other studies (Busen & Engebretson, 2009; Ferguson, 2009; Kidd, 2003; Rachlis, Wood, Zhang, et a1.2009), most youth in our research were not well educated (e.g., did not finish high school). Yet, some had progressed quite well academically (achieved post-secondary education), reinforcing the fact that homeless populations are a diverse group, and the need for diverse supports and resources. Further, contrary to societal opinion (e.g., 'homeless youth are lazy'—Reid, Berman, & Forchuck, 2005), most study participants held very conventional aspirations to be full participants in society (e.g., to return to school, get a job). So what holds homeless youth back and what would assist them in pursuing their goals? Obviously, hope plays a critical role—by creating an internal sense of personal agency (Snyder, 1994) and fostering motivation—and many of the study participants were very hopeful. But evidence also suggests that hope can be undermined by many factors—both external, such as living context (e.g., unstable housing, Nalkur, 2009), and internal, such as lack of resilience (Rew, et al., 2001). Clearly, in order to achieve their aspirations, homeless youth need a range of relevant and integrated external supports (e.g., secure housing) and internal resources (e.g., resilience skills) to mobilize their hope and motivation (Slesnick, et al., 2008).

Not surprising, nearly half of the youth in our study reported clinical-level symptoms of psychological maladjustment, similar to the findings of other Canadian studies (Adlaf & Zdanowicz , 1999; Ayerst, 1999; Taylor, 2004). Yet, most youth also self-reported that their general health status (75%) and mental health status (68%) were good. Reid and colleagues (Reid, et al., 2005) found similar contradictions among homeless girls/young women who, in spite of numerous physical and mental health problems, reported their health to be good—"if I'm not dying, then I'm okay" (p. 247). The severe circumstances which homeless youth endure seem to redefine the nature of 'good health.' Such findings emphasize the importance of gathering multiple forms of information when assessing the health of homeless youth—using quantitative survey assessments to gain standardized information, and qualitative narratives of the lived experience to gain definition/meaning. Together they may provide a better understanding, not only of the health needs of homeless youth, but also of the relevant ways to assist.

While half the youth in this study accessed emergency services, contrary to other reports (DeRosa, 1999; Geber, 1997; Greene, 1995), many youth also accessed primary health care services. However, youth with clinically elevated symptoms were significantly less likely to access specialty mental health services. Clearly, even in the absence of economic barriers to health care, there are other significant obstacles that prevent the use of mental health services for homeless most in need (Bonin, Fournier, Blais, 2007). Both youth and service provider factors may account for this finding. Evidence shows that some youth lack the knowledge/skills for navigating the health system (Solorio, Milburn, Andersen, Trifskin, Rodríguez, 2006); a point not to be overlooked considering that 78% of the youth in our study reported learning difficulties.

Evidence also shows that some homeless youth have developed a mistrust of services following negative experiences (Garrett, Higa, Phares, Peterson, Wells, & Baer, 2008), and/or fear social service agency notification or legal intervention (Klein, Woods, Wilson, Prospero, Greene, & Ringwalt, 2000). Further, as noted above (Reid, et al., 2005), evidence shows that other survival needs (e.g., finding food, shelter) may take priority over even significant mental health needs. As well, for some homeless youth, the decision not to use services is embedded within a culture of self-reliance-it is a matter of pride (Garrett, et al., 2008). And for others, the decision not to access services is made in an effort not to be stigmatized and viewed as one of the 'permanently homeless group'-the grown-ups (Flick & Roohnsch, 2006 cited in Flick, 2007). In sum, for youth who view themselves as self-reliant, or who fear stigmatization, or who have other more pressing survival needs, either no services or emergency services may the only acceptable choices-no matter what alternatives are available. Clearly, the reasons for not using mental health services are not a simple fix. More research is needed to better understand which factors are most critical, for which youth, and under what circumstances. Once identified, the challenge will be in finding alternative ways to offer relevant assistance that are viewed as acceptable.In addition to the numerous youth factors, lack of service use may also be determined by a number of provider factors (Renedo, & Jovchelovitch, 2007). For example, access to mental health services in Canada typically requires referral from a family physician, and waiting lists for mental health services are lengthy (many months). Therefore, family physicians, rather than mental health professionals, tend to deliver the majority of mental health interventions (Nova Scotia Government, 2002). Yet, primary care physicians do not always provide effective diagnosis, documentation, or treatment of mental illness (Hartley, et al., 2004). Indeed, diagnosis and treatment of common mental health disorders in primary care is highly variable and detection rates are often poor (less than fifty percent) (Thompson, et al., 2004). Given the special needs of a homeless youth population, research needs to better understand what types of mental health services homeless youth actually receive, from whom, and to what end (what outcome effects).

While access to services is important, many studies (e.g., Carlson, Sugano, Millstein, & Auerswald, 2006; Milburn, Rotheram-Borus, Rice, Mallet, & Rosenthal, 2006) fail to recognize a key role in health outcomes played by service satisfaction (Kisely & Chisholm, 2009). Further, among those studies that have gathered information about service satisfaction (e.g., Kidd, 2003; Reid, et al., 2005), they fail to identify which youth are most, and least, satisfied. We learned that the youth with higher levels of internalizing symptoms and those who were less hopeful about their future were least satisfied with services (any type) accessed. Knowing which youth are more/less likely to use services and the factors that promote satisfaction may serve as important indicators of motivation and hope—a willingness to take action and an expectation that improvement is possible. Equally important, a better understanding of the factors that influence choosing/refusing services, and how different types of youth fair with/without services, both in the short- and long-term, may assist in building multiple ways for engaging and assisting the diverse needs of homeless youth.

Clearly, if youth are motivated to access mental health services and hopeful, it is critical that services are viewed as relevant. Unfortunately, evidence suggests that psychiatry is often presented as either a ‘simple fix’ or as an ‘agent of social control’ (Barry, et al., 2002; DeRosa, 1999). In turn, psychiatry is often considered by homeless youth as essentially ineffectual—it lacks cultural relevance for the harsh realities of street life (Kidd, 2003). Those who use mental health services, note the importance of having a case manager (Solorio, et al., 2006), caring staff, a nonjudgmental atmosphere, and flexible policies (Garrett, et al., 2008). They also identify a critical need for health “mentors” to assist in navigating the medical system, and for service providers to be culturally competent about homelessness (Christiani, Hudson, Nyamathi, Mutere, & Sweat, 2008). While these are noteworthy suggestions, they come from homeless youth who use services. There is a great need to understand better from non-service users how to provide services in ways in which they would find appealing.

Sadly, evidence shows that even when treatment (case management and individual therapy) is offered in relevant ways

(e.g., through drop-in centres for homeless youth) and results in a positive impact on health, infrastructure problems (a lack of collaboration among services, and funding) can create barriers that prevent medical service use from being sustained over time (Slesnick, Kane, Bonomi, & Prestopnik, 2008). Clearly, service use among homeless youth is dependent on a complex array of factors related both to the youth (e.g., internal motivation, trust, knowledge to navigate the system, cultural relevance), and the service provider/policy-maker/funder (infrastructure) (Garrett, et al., 2008).

In sum, like other recent studies (Carlson, et al., 2006; Milburn, et al., 2005), our investigation found that homeless youth are not a homogenous group. Hence, it cannot be assumed that all homeless youth have the same needs. Our study found that mental health may well be one critical distinguishing factor. Health was positively correlated with several factors known to assist in overcoming challenges in life—hope (Edey & Jevne, 2003; Moore, 2005) and service satisfaction (Kisely & Chisholm, 2009). While the working mechanism is unclear, it may be that youths' perception of being 'healthy' acts as an enabler for hope and as a buffer (protective factor) against hopelessness, thus giving homeless youth the courage, or motivation, to keep going/deal with challenge (internal or external risks or threats) and build resilience (the interaction between risk and protective factors) (Rew & Horner, 2003). Clearly, a better understanding of how homeless youth are able to 'rise above' and overcome their adversity of homelessness, and how services can be of meaningful assistance, is needed.

Limitations

The current study has some limitations. The data lacked specific questions about the length of time spent on the street and the level of service satisfaction for each service accessed. Data on related issues, such as specific history of abuse, were also not collected. Our data on hope were taken from a single question. Nevertheless, the findings do suggest important areas for future research, in particular, the need to consider the role that mental health, hope and service satisfaction play in survival on the street and adolescent development.

Finally, these data are from a cross-sectional study so change over time was not possible to measure. The data were also taken from a sub-sample of homeless youth—those who had sought out a shelter for homeless youth. The data, therefore, are applicable to this subset of homeless youth. However, as our findings indicated, homeless youth are not a homogeneous group, even within this population, and therefore, caution must be used to avoid overgeneralization. In addition, while some of the analyses show significant correlations, they cannot be confused with causal relationships.

Clinical Significance

The results from this study highlight the need to build knowledge regarding the mental health struggles of homeless youth and their relationship with two factors thought to play a role in adolescent development and street survival—hope and service satisfaction. This information also suggests that merely making services available is not sufficient. Service providers need to find more relevant and suitable ways to engage those youth with the greatest mental health needs to assist with a healthy transition through adolescence.

Acknowledgements / Conflicts of Interest

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