



CONNECTING THE PIECES

**Homeless Youth and
Mental Health Services**

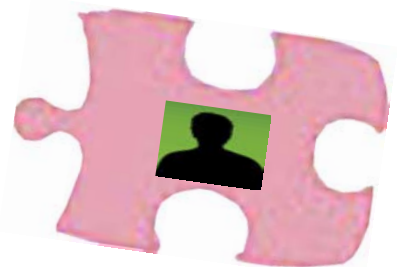
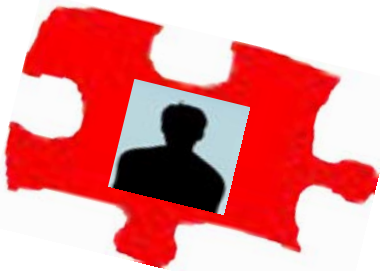
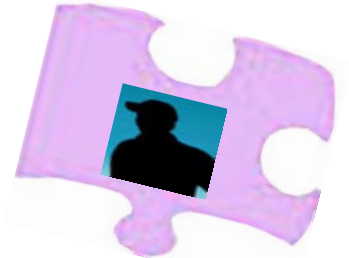
Finding a Fit That Works

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and Family Services**

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Critical to this report however were the perspectives of youth from the many focus groups held around the state. Their input was both brutally honest and brilliantly insightful, and their gift of time, information and viewpoint was priceless.

EMPIRE STATE COALITION

Since its inception in 1974 and its incorporation in 1978, the Empire State Coalition of Youth & Family Services has maintained its vision that all youth have the right to be safe, healthy, and prepared for the future. Committed to the runaway, homeless, and street youth throughout New York State, ESC serves as the leader of a collaborative system which provides capacity building, training, information, coordination and support services for programs serving the homeless youth population throughout New York State.

With an estimated 30,000 homeless and runaway young people in New York each year, the need for a collaborative and coordinated network of services and programs is essential. ESC is a recognized national leader in providing the focus and training and model development which makes it possible for service agencies to expeditiously and compassionately address the traumas faced by homeless youth and effect positive solutions.

Responding to the critical needs of these vulnerable youth is only part of the solution. Without addressing root causes, services and programs are faced with an endless challenge of growing numbers of disenfranchised children and youth. Although these programs are essential, they are reactive in their nature. The Empire State Coalition of Youth & Family Services is therefore in the forefront of youth advocacy and systemic reform with this assessment and analysis of the core programmatic and systemic concerns regarding mental health services and access for runaway and homeless youth.

The Empire State Coalition of Youth & Family Services continues to set the standards which provide homeless, runaway, and street youth the programs and support which dramatically change their circumstances and provides them with real hope.

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EXECUTIVE SUMMARY

All youth deserve to grow up safe, healthy and prepared for the future; this is the philosophical underpinning which guides the work of the Empire State Coalition of Youth and Family Services. Young people who are homeless are at great risk of developing a mental health problem and without appropriate intervention and treatment, that problem will likely become a lifelong disorder hampering their ability to complete their education, find and maintain adequate employment and develop and sustain healthy relationships. In other words, they will face great impediments to growing up safe, healthy and prepared for the future.

Homelessness and mental illness have long been linked. For some, their mental illness has resulted in homelessness. What we now know is that homelessness can, and does, result in mental illness. As alarming as the statistics are, within the homeless youth population there are certain sub-groups who are the most at risk for developing a mental illness. Gay, lesbian, bi-sexual, and transgender appear to have the most pervasive mental health problems. Two other sub-groups within the homeless youth population that suffer disproportionately from mental health problems with numbers that far exceed the general adolescent population or even the general homeless youth population, are youth who had been in state care and youth who have histories of abuse. .

Programs that serve runaway, homeless and street-involved youth from across New York State reporting the number of youth with moderate to severe mental health problems has increased significantly while community resources that once provided counseling and other crisis and long-term intervention have diminished dramatically. As resources dry up, youth who would have been served by community mental health centers, alternative to incarceration programs, aftercare programs for youth existing state care, alternative education and vocational programs, are ending up homeless and without supports. In the face of ever increasing deficits, New York State is one of many states that have cut services for our most vulnerable populations.

Runaway and homeless youth programs report a stunning array of mental

health problems that youth present with at the time of admission or shortly thereafter. Most programs are ill-equipped to handle these problems on their own. It is increasing common for youth who seek services at programs for homeless youth to report: suicide ideation, suicide attempts, cutting/self mutilation, depression, eating disorders (anorexia, bulimia), mood swings/extreme changes in mood, aggression and paranoia, anxiety, and flashbacks. The safety of the individual youth and the other young people in the program has to be considered every time a young person reaches out for help but with no other options, programs are left with the cold choice of taking in a young person who may experience a mental health crisis or allowing that young person with a mental health problem to go back into the street.

Over the past decade, programs that serve the homeless youth population began reporting the increased levels of mental health problems and their inability to connect youth to appropriate services. To gain a more complete understanding of the problem with a goal of developing strategic solutions, Empire State Coalition designed its Mental Health Access Project. The goals of the project were to get a better understanding of the breadth of the problem and the barriers to services. To do this, ESC surveyed programs and spoke directly to homeless youth regarding their experiences with and their perceptions of mental health services.

The project began with a review of the literature about adolescents, homelessness and mental health. The literature confirmed our belief that mental health problems were pervasive in the homeless youth population, and that early intervention and treatment can prevent debilitating mental health disorders from developing. In surveying programs, the project looked for a representative sampling that would provide information and insight from the perspective of upstate, downstate, rural, suburban and urban New York State. Programs surveyed reported high number of youth with mental health problems, long waits for services, and mental health providers who were ill-trained to work with the challenges inherent in the homeless youth population. Young people reported frustration with mental health providers and a general distrust of the mental health service system and the professionals that work in the field. Traditional talk therapy, where the “patient” talks and the therapist listens, was a particularly bad fit for most youth who expressed the desire for a dialogue and practical assistance.

With both programs and youth establishing that even when they were able to find services, the current system was not generally meeting their needs, ESC set out to see what innovative approaches to mental health services were available both here and abroad. The final section of our report is devoted to new approaches which include, using a “first aid” model to train lay people to provide early intervention, de-escalate crisis, and work to link youth who need it to appropriate services, using the virtual world as a platform for counseling, establishing a network of paid, certified peer specialists, expanding satellite technology, and using cell phone technology, including texting to reach young people. Also researched was the possibility of using alternative medicine and healing protocols that can be brought on site at the homeless youth service center.

This report firmly establishes that homeless youth are suffering from mental health disorders in numbers that are grossly disproportionate to that of the general adolescent population yet the current system of care is not meeting those mental health needs. In response, the report offers a wide range of innovative strategies to pilot going forward. It is Empire State Coalition’s charge to policy makers, service providers, and concerned citizens, to recognize the impending crisis and reinvent how mental health services are provided to our most vulnerable young people.

It is time to connect the pieces so that every homeless youth showing signs of a mental health problem can receive the individualized assistance they need and deserve to move on to stability and self-sufficiency.



INTRODUCTION AND OVERVIEW

Over the past five years there has been a drum-beat across the country emanating from programs that serve homeless youth – mental health – mental health – mental health. These programs large and small, rural and urban, crisis and long term all report that youth entering their programs are presenting with mental health challenges that programs are ill-equipped to handle. New York State's service system for homeless, runaway and street-involved youth have joined this drum-beat as the traditional safety net services for homeless youth with mental health needs have dried up, leaving our system as the one place youth can immediately access safety and services. This is particularly true for adolescents with histories of abuse and neglect who are exiting the foster care, juvenile justice system or criminal justice systems and youth who are lesbian, gay, bi-sexual or transgender. Youth from these highly vulnerable groups experience the highest rates of homelessness and mental health needs.

Programs serving homeless youth must expect and prepare to serve young people with un-met mental health needs. This will require programs to think broadly and creatively about how to respond, especially in times when budgets are tight and community resources are least available. The homeless youth program may be the only option for the most vulnerable and neediest youth, and programs must respond by ensuring that each young person will be safe and well cared for at the program or will be integrated into a higher level of care where the level of need is too great for the program to maintain the young person safely.

Early intervention is key, but no one type of intervention is appropriate for all needs. Staff need to be schooled in *Universal Intervention* – those interventions designed for the population at large, in this case, all youth who are served by runaway and homeless youth RHY programs; *Selective Interventions* – those interventions designed for targeted populations at elevated risk: youth who have been in foster care, are gay, lesbian, bi-sexual, transgender, or questioning (LGBTQ) youth who have been

on the streets for long periods of time, youth with histories of abuse and/or neglect, and others. The highest level of intervention, *Indicated Intervention* is designed for those exhibiting early symptoms but who may not have a mental health diagnosis.¹

Early intervention is essential for prevention as well as treatment. Effective intervention and treatment require a developmentally appropriate, interdisciplinary approach that works with young people within the context of their support system (family, friends, and service providers) and community.² Problem behaviors such as drug and alcohol use, aggressive behaviors, and others can be signs of early onset of mental health problems. Early intervention has been shown to actually change the course of the disorder and prevent further problems.³

¹ Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education, "Preventing Mental, Emotional and Behavioral Disorders Among Youth People," (Washington: National Academies, 2009) xiv.

² Board on Children, Youth, and Families, 2009, 18.

³ Board on Children, Youth, and Families, 2009, 29.



MENTAL HEALTH AND THE HOMELESS YOUTH POPULATION

Although some homeless young people may not suffer from any mental health challenges, the vast majority will. In the general adolescent population between 14 and 20 percent of young people exhibit some mental, emotional or behavioral disorder.⁴ Risk factors that result in a young person becoming homeless and/or the risk factors inherent in being a homeless youth, increase exponentially the likelihood of developing a mental health problem. Poverty itself is a risk factor for mental illness.⁵ So, too, is poor physical health, with one study finding elevated levels of both depression and anxiety disorder among asthmatic youth.⁶ Homeless youth more often than not come from poor families and communities and suffer from poor physical health.

Homeless youth exhibit psychiatric disorders at a rate six times greater than the general youth population, with between 66 and 89 percent of homeless youth having symptoms of one or more disorders.⁷ A study of homeless youth in Denver identified only 1.6 percent of homeless youth as not meeting any DSM-IV diagnostic criteria.⁸ Within the homeless youth population, youth who are lesbian, gay, bisexual, transgender or questioning (LGBTQ) are at substantially increased risk for developing a mental health disorder. Two research institutes, The National Research Council and the Institute of Medicine of the National Academies, report in separate studies that youth who are homeless and LGBTQ youth are at the highest risk and in critical need of health and mental health services, yet they are the least likely to be able to access

“Homeless youth exhibit psychiatric disorders at a rate six times greater than the general youth population...”

⁴ Board on Children, Youth, and Families, 2009, 1.

⁵ Board on Children, Youth, and Families, 2009, 100-101.

⁶ Board on Children, Youth, and Families, 2009, 18.

⁷ Carrie Merscham, J.M Van Leeuwen,, Megan McGuire,, Mental Health and Substance Abuse Indicators Among Homeless Youth in Denver Colorado, 2009 (pg. 3).

⁸ Carrie Merscham,et.al 2009, 10.

needed services.⁹ A link has been identified between family rejection and negative mental health outcomes for youth who are LGBTQ with over 40 percent of white and Latino lesbian, gay and bi-sexual youth attempting suicide at least once in their lifetime.¹⁰ While family rejection is one link to mental health problems for LGBTQ youth, victimization, including being assaulted with a weapon, being beaten up, being sexually assaulted and being threatened, put the population of LGBTQ youth at very high risk for conduct disorders.¹¹ Homelessness by itself can trigger significant mental and emotional problems as trauma on the streets can result in major depressive disorders, post traumatic stress disorder, substance abuse, conduct disorder and suicide.¹²

“LGBTQ youth report the highest levels of physical, emotional and sexual abuse with rates upwards of 80%.”

LGBTQ youth have significantly higher levels of depressive disorder than their heterosexual counterparts.¹³ These findings are not surprising as LGBTQ youth report the highest levels of physical, emotional and sexual abuse with rates upwards of 80 percent.¹⁴ LGBTQ youth report the highest rates of street-victimization as well.¹⁵ Manifestation of mental health disorders for homeless LGBTQ youth include untenably high rates of self-mutilation (72 percent); suicide attempts (58 percent); and post-traumatic stress disorder, with most likely to suffer from two or more disorders.¹⁶ Eating disorders disproportionately affect LGBTQ youth, and these disorders can impact the neurochemistry in the brain.¹⁷ LGBTQ youth with eating disorders have high rates of co-occurring disorders such as anxiety and depression (66 percent),

⁹ Board on Children, Youth and Families, National Resource Council and Institute of Medicine, “Adolescent Health Services Missing Opportunities” Washington, The National Academies Press, (2009) 99-100, 104-105.

¹⁰ Caitlin Ryan, David Huebner, Rafael Diaz, Rafael, M. Jorge Sanchez, “Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Youth Adults,” *Pediatrics* 123 (2009): 346-352.

¹¹ Les Whitbeck, *Mental Health and Emerging Adulthood Among Homeless Young People* (New York: Psychology Press, 2009) 54, 75.

¹² Whitbeck, 2009, 39-40.

¹³ Whitbeck, 2009, 69.

¹⁴ Whitbeck, 2009, 126, 127, 129.

¹⁵ Whitbeck, 2009, 130-132.

¹⁶ Whitbeck, 2009, 148-149, 157-159.

¹⁷ National Eating Disorders Association (NEDA) and National Youth Advocacy Coalition (NYAC), “LGBTQ Youth and Eating Disorders” training January, 2010.

obsessive compulsive disorder (40 percent) and post-traumatic stress disorder (between 30 and 60 percent).¹⁸ Factors that contribute to LGBTQ youth's eating disorders include family difficulty, abuse, rejection, harassment and violence.¹⁹

Trauma is substantially linked to mental health disorders with one study finding that a history of trauma was found in 93 percent of homeless youth meeting the criteria for bi-polar disorder, 81 percent of those with symptoms of depression and 100 percent of youth diagnosed with post-traumatic stress disorder.²⁰ These same factors, trauma, family rejection and abuse are predictors of youth homelessness.

Scientific studies on brain development have shown that the brain continues to develop well into young adulthood and that child maltreatment can have a deleterious effect on brain functioning. Specifically, the development of synapses is linked to childhood experiences as is the growth of myelination (critical for learning) the substance that provides a pathway for synapses.²¹ Childhood maltreatment, including both abuse and neglect, can alter brain development and negatively impact a child's emotional and social growth.²² The brain of an abused child will have an over-stimulated fear response in the region of the brain that monitors fear, and under-stimulation in the region of the brain that involves reasoning and abstract cognition, thereby becoming less competent in those areas.²³ These children may overreact in situations other children find non-threatening and are more likely to be labeled learning disabled because they are not able to maintain the calm needed to achieve learning.²⁴ Adolescents who have been maltreated can have an underdeveloped brain cortex, the area of the brain that regulates impulsivity which

“Adolescents who have been maltreated can have an underdeveloped brain cortex, the area of the brain that regulates impulsivity which may lead to more risky behaviors such as substance use.”

¹⁸ NEDA/NYAC, 2010.

¹⁹ NEDA/NYAC, 2010.

²⁰ Carrie Merscham, et al., 2009, 11.

²¹ US Department of Health and Human Services, Understanding the Effects of Maltreatment on Brain Development, (Washington: Child Welfare Information Gateway, 2009)3.

²² US Department of Human Services, 2009, 6.

²³ US Department of Human Services, 2009, 7.

²⁴ US Department of Health and Human Services, 2009, 9.

may lead to more risky behaviors such as substance use.²⁵

A correlation exists between histories of abuse and experiences of homelessness. For example, 47 percent of homeless youth entering one New York shelter report physical discipline and 37 percent characterize that discipline as abuse.²⁶ Another study, the Adverse Childhood Experience (ACE) study, identified specific long term effects of abuse and neglect on the brain. These included an increased risk for depression, post-traumatic stress disorder, dissociative and memory disorders, and attention deficit/hyperactivity.²⁷ Science now has evidence that adolescence is a time of great brain growth and that such growth continues into young adulthood.²⁸ During the adolescent years, the limbic system, the area of the brain regulating emotions, undergoes a growth spurt.²⁹ Interventions to heal the brain are possible, but those interventions must be designed to target the portion of the brain damaged by the effects of maltreatment or trauma.^{30 31}

47 percent of homeless youth ... report physical discipline and 37 percent characterize that discipline as abuse.

Recognition, intervention and treatment of mental health disorders are critical for youth and for our families, communities, states and nation. Many of the mental health disorders most common in youth up to age 25, including conduct disorder, oppositional defiant disorder, and drug dependence have an effect on the family as well as the individual, and cost society dearly in terms of lost productivity and cost of care.³² Conduct disorder is particularly costly as it is linked to criminal activity and violent

²⁵ US Department of Health and Human Services, 2009, 11.
²⁶ “Study Reveals Harsh Life for Homeless Youth in New York”, *The New York Times*, March 10, 2009, A23.
²⁷ US Department of Health and Human Services, 2009, 11.
²⁸ D. Weinberger, B. Elevevag, and J. Giedd, J., *The Adolescent Brain: A Work in Progress*, The National Campaign to Prevent Teen Pregnancy, June 2005, . 1.
²⁹ US Department of Health and Human Services, 2009, 6.
³⁰ US Department of Health and Human Services, 2009, 13.
³¹ There are a growing number of treatments and interventions that work with abuse victims. For information, visit The Child Trauma Academy’s website: www.childtrauma.org and the National Child Traumatic Network housed at the U.S. Department of Health and Human Services, www.ncetsnet.org/ncets/nav.do?pid=ctr_top_trmnt_prom.
³² Board on Children, Youth, and Families, *Preventing Mental, Emotional and Behavioral Disorders*, op. cit. 2009, 36, 42.

behaviors.³³ Running away is itself one of the DSM criteria for conduct disorder resulting in a tautology that could prove harmful to the way homeless youth are viewed and subsequently treated. Even after eliminating the category of runaway from the criteria used to determine if a young person has a conduct disorder, a Midwest study of street youth determined that 66 percent of street-youth met the DSM standard.³⁴ The findings mirrored those of other studies including one at Covenant House³⁵, the largest provider of services to homeless youth in the nation, (59 percent met the criteria) and a Seattle Study of homeless youth (53 percent met the criteria).³⁶

Far too many youth exhibit symptoms of more than one disorder. Co-morbidity among the Midwest Study youth was very high especially with a co-occurring major depressive disorder (36 percent) and post-traumatic stress disorder (42 percent).³⁷

While mental health disorders in children are not uncommon, neither are they inevitable.³⁸ Studies have shown that there is a window of opportunity for effective intervention that can last up to 4 years from the onset of symptoms to the full blown disorder; early recognition of symptoms and appropriate intervention can reduce the rate of the disorder and are the best means of prevention.³⁹ Mental health disorders are most likely to emerge between the ages of 14 and 24.⁴⁰ Street-life and homelessness exacerbate pre-existing conditions and result in new symptoms even where there was no predilection.⁴¹ In the Midwest study of homeless youth, over the three year period of the study over 75 percent of youth met the criteria for conduct disorder, 35 percent met the criteria for post-traumatic stress disorder, the majority used alcohol and other drugs, 30 percent met the criteria for major depressive disorder at some point, and nearly 70 percent met

Mental health disorders are most likely to emerge between the ages of 14 and 24.

³³ Board on Children, Youth, and Families, 2009, 42.

³⁴ Les Whitbeck, 2009 46-47.

³⁵ Covenant House Institute, "Youth in Crisis: Characteristics of homeless youth Served by Covenant House New York," March 2009.

³⁶ Les Whitbeck, 2009, 46-47.

³⁷ Les Whitbeck, 2009, 49.

³⁸ Board on Children, Youth, and Families, 2009, 48.

³⁹ Board on Children, Youth, and Families, 2009, 50.

⁴⁰ Les Whitbeck, 2009, 14.

⁴¹ Les Whitbeck, 2009, 15.

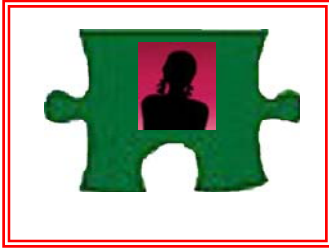
the criteria for two or more disorders.⁴²

Based on the findings of all the studies, and in accordance with what science now knows about brain development, it is essential that staff at programs working with homeless and street-youth not only learn to recognize the signs and symptoms of emerging mental health problems, but be armed with the resources to provide early intervention. Homeless youth can often appear resistant to getting the mental health services that are deemed necessary. That resistance reflects a mismatch between what young people want and what is currently available. This report looks at the fissure that exists between the current system of mental health services and the developmental needs of homeless youth in order to determine what changes need to be made in how we deliver services. It is only through this level of examination that we can begin to design a service system that meets the needs of our youth.

In 2009, with funding from van Ameringen Foundation, Empire State Coalition of Youth and Family Services (ESC) set out to delineate the real and perceived barriers to mental health services that homeless adolescents face and what, if any, promising practices have been designed to provide mental health services to disenfranchised young people. ESC recruited programs from seven counties across the state in order to determine where the barriers lay. These counties represented rural, urban, and suburban areas. Providers completed an extensive survey (see Appendix A) and recruited youth to take part in focus groups organized at locations around the State. Those two sources of information; program staff and youth, form the basis of the findings on barriers to effective mental health services. The last section of this report is an examination of some innovative approaches to mental health services that should be looked at for the homeless youth population. ESC looked worldwide for new models and approaches that are being used with both adults and youth and which can be adopted to meet the unique needs of the homeless youth population.

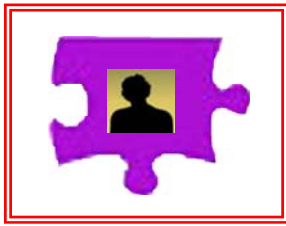
[Homeless youth] resistance [to mental health services] reflects a mismatch between what young people want and what is currently available.

⁴² Les Whitbeck, 2009, 39-40.



HOMELESS YOUTH PROVIDER SURVEYS

ESC's Mental Health Access Project recruited eight homeless youth service programs in seven New York State Counties to complete a comprehensive survey that examined attitudes, service availability and perceived and actual barriers to accessing appropriate mental health care for homeless youth. The counties, Monroe, Onondaga, Nassau, Dutchess, Ulster, Bronx, and Erie, represented upstate and downstate, rural, urban and suburban New York State and are representative of the state in its entirety. The results of the survey across counties were at times remarkably similar and at other times reflective of vast local differences. Programs were asked to identify real and/or perceived barriers to youth receiving mental health care and treatment in the following areas: cost, parental consent, hours of operation, waiting lists, provider perception of homeless youth, youth's perception of providers, travel and location, concerns about confidentiality/disclosure, meeting eligibility criteria for services, onerous paperwork, and the availability of treating professionals with expertise in adolescent development. In addition to barriers, the survey asked about specialized training available in their area, transportation available for youth, transition to the adult mental health service system from children's mental health service system, medication adherence, reluctance for hospitalization, and program mandates for mental health counseling. The survey also included questions about the populations served by the homeless youth program and the services that are available in their communities. Program staff were asked to delineate the behaviors that youth exhibit that indicate the need for mental health services. Programs were then asked about what special services they needed to have in place to compensate for the possible lack of mental health services in their communities. A question was included for comment on New York State's Single Point of Access system, whereby mental health services are screened through a countywide system which triages and prioritizes mental health services for children in their respective counties. Additional comments were solicited from providers in case there were areas of importance that we did not cover. What follows are the actual survey questions followed by a synopsis of responses for each question.



SURVEY QUESTIONS AND RESPONSES / BARRIERS

Are any of the following perceived or actual barriers to youth being served for mental health care and treatment?

Cost

Cost was an issue in five counties with lack of insurance being the major factor. Interestingly, one county reported that even in clinics where the mental health services were free, youth without insurance were denied access. Co-payments were an issue as either youth did not have funds and/or parents were unwilling to pay. In other instances, young people had insurance but the insurance was inadequate to cover their mental health needs. It was also apparent to staff that even were youth had access to insurance, paying an insurance premium was not a priority and therefore they opted out of the plan. Paradoxically, one respondent bemoaned their county switching to Managed Medicaid as creating a cost and access barrier, a provider in a second county stated that only youth with Medicaid were able to access care. This discrepancy in how Medicaid is actualized in localities needs further examination.

For [parental consent] as a major barrier, the reason given was that youth often do not have contact with their parent or guardian.

Parental Consent

Parental consent as a barrier ran the gamut from never being a barrier to being a huge issue. For providers who cited it as a major barrier, the reason given was that youth often do not have contact with their parent or guardian. In another county, there was the knowledge that youth do not always need parental consent to receive mental health services but without a committed parent to navigate the young person through the system, it was almost impossible for the youth to actually receive needed services. Even where programs had a good understanding of the NYS Mental Hygiene Law's exceptions to parental consent, the mental health provider often insisted upon such consent as their internal policy.

Other Legal Issues

Only one provider cited a concern in this section. In their experience they have found that youth with mental health issues are placed in the Juvenile Justice System through Persons in Need of Supervision (PINS) Diversion.⁴³

Are the Hours of Outpatient Treatment Problematic?

With the exception of one provider, every other county's providers reported that community services were offered during hours that could accommodate youth. There were some instances reported when youth had to miss part of a school day, but this was not viewed as overly burdensome on the youth. The only county provider that reported this as a problem stated that clinics did offer some appointments outside of traditional hours but the slots were too few to accommodate all their youth and so youth would often have to miss school, work or both.

Are Waiting List Times Available for Youth who Need Services

Waiting periods of between one and four months were the rule in every county surveyed. Programs report up to a three month wait to see a psychiatrist and up to four months to get assigned an Intensive Case Manager. Some youth decompensate to such an extent during the long wait that they end up having to get an emergency evaluation, which is not very thorough. In some instances the time frames for services are unpredictable. Some mental health providers will call programs when they have a cancellation and a youth can step right into that slot. Programs have to be vigilant to constantly call and check the wait list status in order to get consideration when an opening suddenly materializes.

Programs report up to a three month wait to see a psychiatrist and up to four months to get assigned an Intensive Case Manager.

⁴³ A "PINS", Person in Need of Supervision, is a minor who commits a status offense (being incorrigible, running away, being truant, etc.). It is the person's age at the time that the act was committed that subjects the person to court involvement (if these acts were committed by an adult there would be no judicial involvement). PINS Diversion is a system in place that is designed to work with youth and families and therefore avoid placement into state facilities.

Community Service Providers' (other than RHY Providers) Perceptions of Homeless Youth

In just two of the counties surveyed, programs reported that community service providers understand homeless youth. The other providers all reported problems. The legal rights of homeless youth were almost universally misunderstood, with some mental health providers unable to comprehend that youth did not have access to their parent or guardian and/or assuming that parents should always be involved and would always want to be involved. In one county the provider almost always credited the parent's account of what went wrong in the household. There was a general lack of understanding of the relationship between lack of housing and the increase risk facing

youth, or the lack of housing and the youth's inability to meet rigid deadlines or make appointments either entirely or on time. Lack of stable housing also caused some mental health providers to deny services as they stated the young person would most likely not commit to treatment or remain in the area for very long.

Program staff reported that youth feel labeled by going to mental health services, that they are reluctant to go because chronically mentally ill adults congregate in the lobby or outside the clinics

Youth's Perceptions of Mental Health Service Providers (according to RHY programs)

This question asked programs serving homeless youth what providers perceived were homeless youth's feelings about mental health services. One provider carved out a small exception to the otherwise universally negative response programs reported hearing from youth. The one provider in question stated that some youth have a positive experience with therapists, counselors and case managers, but went on to state that other youth feel their case managers do nothing because of the barriers already stated to getting youth treatment. Program staff reported that youth feel labeled by going to mental health services, that they are reluctant to go because chronically mentally ill adults congregate in the lobby or outside the clinics, feel that mental health providers are nosy, feel stigmatized by having to go to mental health clinics, and in at least one county did not understand where they were going

because the department is named “Department of Mental Hygiene,” and they associate hygiene with good grooming.

Distance of Mental Health Services

Transportation was cited as a barrier in rural areas but less so in urban or even suburban counties. One county stated that any amount of travel can be a barrier for young people, which is true in rural, urban or suburban areas, especially when travel costs money.

Location of Mental Health Settings (Are services located in youth friendly/ accessible locations?)

While this was not perceived as a problem in the majority of counties surveyed, one county summed up the barrier very succinctly in stating “[f]or the most part the clinical settings are not very youth friendly, Sometimes, they can be *child* friendly, which can be worse than being unfriendly.” The best option mentioned was for a clinician to come to the youth. Those services have been provided at times, but funding is always precarious and so the capacity comes and goes. One provider stated that their mental health services used to be provided at a youth probation office which one would assume would be off-putting to youth, but actually worked well. It seems that youth would rather identify with troubled youth than with mentally ill adults.

“...Sometimes, [mental health services] can be *child* friendly, which can be worse than being unfriendly.”

Are Youth Concerned about Confidentiality of their Mental Health Status?

Interestingly, programs acknowledged that youth are concerned that their confidentiality be protected but did not feel that youth were concerned about their confidentiality being breached in their current circumstances.

Do Youth have Difficulties Meeting Criteria for Mental Health Services Access?

Counties reported mixed experiences when asked about their difficulty with youth meeting mental health service providers’ criteria. In one county only youth with a Global Assessment Functioning (GAF) score below 55 qualify for services. A GAF of

55 indicates moderate symptoms of a mental health disorder (such as a flat affect, circumstantial speech, or occasional panic attacks) and moderate difficulty in social, occupational or school functioning.

Runaway and Homeless Youth programs do not have the staff resources to bring a youth to a clinic three times before any assessment of need can be established.

Another county identified a mental health provider's request for diagnostic information including hospital records in order to access essential services. Behavior problems are also a barrier to services for some youth despite the fact the youth's problem behavior is itself symptomatic of an acute need for consistent and therapeutic intervention.

Finally, one county's program reported that a mental health service provider required that a young person meet with the clinician on three separate occasions before an assessment would even be scheduled. While that might be best practice, RHY programs do not have the staff resources to bring a youth to a clinic three times before any assessment of need can be established.

Do you find the Forms are too Onerous?

The providers did not report that paperwork is a significant barrier to services. At times the extensive documentation may be hard to come by, as when the forms require submission of other records. However, when asked about meeting the criteria for services in a previous question (see above) providers did opine that the need for extensive diagnostic information was a burden.

Are there Accessible Mental Health Professionals in the Community Trained or Specialized in Adolescence or Adolescent Development?

County RHY providers were asked if there were accessible clinicians specializing in adolescent development. The experience of counties was very mixed in this area. Five counties indicated that there were specialists in their communities; one stated that the county offers adolescent treatment training to mental health providers. One county did indicate that there were specially trained professionals but they worked

with families, not with unaccompanied youth. A final provider did not know of any specially trained professionals in the area.

What Trainings are done for Staff Specific to Mental Health Services Access?

Every county was able to cite training that is offered in their area. Some responses included specific training topics such as: Youth Development, Strength Based Services, Common Diagnoses and Medication, Basics of Diagnosis, Trauma, Attachment Disorder, Lethality and Suicide, ADHD and Medication. Other respondents offered more generic information such as a weekly case conference with a mental health PhD, or reference to training on specific disorders and effective case management with youth. Some providers referenced receiving their training from Empire State Coalition which has included such topics as adolescent development, working with homeless substance abusing youth, working effectively with LGBTQ homeless youth and other relevant topics.

Every county was able to cite training that is offered in their area [either from Empire State Coalition or local providers]

Is Transportation a Concern for the Youth or the Agency with Mental Health Service Access?

Over half of the counties responding stated that transportation was not a concern or a barrier. The one county that elaborated stated “Medicaid cabs have proven unreliable modes of transportation and the bus system can be extremely anxiety-provoking for some youth with mental health issues.”

Are You Finding Office of Mental Health Programs Unnecessarily Moving Youth into the Adult System?

Only one county reported this as a problem. The remainder of the RHY providers did not know if this happened, or stated that youth were not being moved to adult services at age 18 because children’s services can extend up to age 21 as long as the youth is living at home and in school. (That provider did not elaborate on how this impacted homeless youth.)

Do Youth Find Adherence to Medication Prescribed a Barrier to Youth Accessing/Maintaining Mental Health Services?

All but one county's providers reported medication adherence as a huge problem.

All but one county's providers reported medication adherence as a huge problem. For example, failure to comply with medication regimens has resulted in a youth being denied continuation of their mental health services. In another county the program reported that youth were deterred from accessing services if they even thought they would be required to take medications. Other programs concur, stating that youth were resistant or at least inconsistent in taking prescribed medications. Another issue mentioned is that youth often suffer from side effects from the medication and it can be months before an appointment with a psychiatrist can be secured to adjust or change the medication prescribed.

Does the Risk of Missing School, due to Hospitalization Potentially Affect the Youth Accessing Services?

This question asked staff if youth were reluctant to seek services due to the risk of missing school if hospitalized. All but two service providing agencies were not aware of this as a potential barrier or stated outright that it was not a barrier. One county reported that it was a barrier but gave no further detail. The county that provided additional insight stated that while they did not believe that missing school was the reason youth might object to services, they did acknowledge that youth generally feel that hospitalization interferes with their academic progress and socialization such as being part of a school sports program.

Are Youth Encouraged or Unnecessarily Pressured to Participate in Mental Health Services whether or not the Young Person Feels they Need to Go?

The project attempts to get an idea of how much mental health counseling is voluntary verses how much is put upon youth despite the young person's willingness to

participate. Three service providers did not feel that this was ever a problem. The others stated that “youth are encouraged/pressured [compelled] to participate in mental health services even when they [the young person] feel they do not need those services”. One county also acknowledged that many mental health providers are neither youth friendly nor youth focused. A second county stated that a referral for mental health services is automatic for all youth entering the transitional living program and that participation is required, at least initially. A third county’s RHY workers stated that it was a requirement and that “[d]espite our community’s attempt to embrace ‘Person-Centered Planning’ approaches, many youth still encounter professionals telling them what is best for them, what they should do, etc. as it relates to mental health services.” One provider stated that the homeless youth they encounter are not able or ready to recognize their symptoms “so staff have to strongly encourage/require participation in mental health services.” A similar sentiment was stated by yet another provider, stating that homeless youth often discontinue treatment and medication, so that the provider always encourages youth to continue treatment once they become involved in services. Youth learn that “getting involved in counseling, vocational training or case management will help them in the long run.”

HOMELESS YOUTH SUB-POPULATIONS

While the project was not designed to do a demographic analysis of the population of homeless youth in New York State, a question was asked about some of the characteristics of youth accessing services. Some of the larger segments of the homeless youth population were youth who were substance users, pregnant and/or parenting; lesbian, gay, bi-sexual and questioning youth, youth who aged out of foster care, youth who had histories in juvenile detention or the criminal justice system, youth whose parents have a mental health disorder, youth whose parents have a substance abuse disorder, and youth with an incarcerated parent. A smaller, but still significant percentage of youth identified being gender variant (transgender) or whose families were homeless.

Youth learn that “getting involved in counseling, vocational training or case management will help them in the long run.”

COMMUNITY/COUNTY RESOURCES

County RHY service providers were asked if there were specialized housing programs for youth with mental health challenges in their communities. Providers stated that such programs do exist in each county, but the programs are not necessarily accessible to homeless youth. Providers responded that the programs have very limited capacity, the application and acceptance process is complicated and time consuming.

Providers also report other barriers for their hard to place teens. One RHY

“...young people do not feel comfortable in what is essentially an adult-centered program with inadequate supports for youth, particularly youth in crisis.

provider reported that a local program was reluctant to take young adults who do not have the requisite independent living skills. Their young people do not feel comfortable in what is essentially an adult-centered program with inadequate supports for youth, particularly youth in crisis. Other reported barriers include long waiting lists, adherence to HUD “homeless” definition, income requirements and the requirement that some youth access income support at the county level before accessing supported housing. Resistance by youth and/or their families to the stigma of entering a residential program for people with mental health needs was also stated as an impediment to entry.

To compensate for the paucity of services for homeless youth with mental health problems, programs attempt to provide multiple services on site. According to one county provider “RHY programs provide crisis intervention services and vigilant monitoring of youth to ensure their safety and the safety of others when they are waiting for or are unable/unwilling to access needed mental health services. Advocacy and counseling are regularly provided.” All counties’ providers reported the importance of providing psychiatrists, psychologists and social workers under one roof. Providers who are not able to provide specialized services on site depend on in-house counseling by staff combined with long term case management. One service provider said “RHY programs must provide intensive case management to assist youth in applying for services. Youth with mental health concerns are housed at RHY programs

for longer periods of time... Extra staff is usually needed in the program to supervise those that many need extra attention...”

When discussing the mental health needs of homeless, runaway and street-involved youth, we asked county providers to delineate the behaviors they see that lead them to believe youth have mental health needs. The list generated of behaviors that were of concern was extremely long and included; suicide ideation, suicide attempts, cutting/self mutilation, encopresis, depression, eating disorders (anorexia, bulimia), mood swings/extreme changes in mood, acting out sexually, youth who are grieving, lying, stealing, blaming others, harming animals, inability to focus on a task, anger, youth who remain detached (do not form any bonds), aggression and paranoia, excessive sleeping, irritability, poor hygiene, anxiety, poor communication skills, nightmares and flashbacks, and inability to care to self. This is an extremely startling list.

[Sample list of behaviors of homeless youth: suicide ideation/ attempts, cutting/self mutilation, encopresis, depression, eating disorders, mood swings, acting out sexually, grieving, lying, stealing, blaming others, harming animals, anger, aggression and paranoia, irritability, poor hygiene, anxiety, nightmares and flashbacks, and inability to care to self.]

NEW YORK STATE’S SYSTEM OF MENTAL HEALTH CARE

One of the final inquiries made of county providers was to assess how New York State’s Single Point of Access system works for homeless youth in their community. According to the New York State Office of Mental Health the system works as follows:

“*Single Point of Access* - Each local government in New York State has been asked to designate a Single Point of Access for Children and Families (SPOA).

The purpose of the SPOA for Children and Families is to:

- Identify children with the highest risk for placement in out-of-home settings;
- Develop strategies to manage these children in their home communities using an individualized, strength-based approach;

- Develop better decisions about individualized care planning for children at risk;
- Support communities to manage access to intensive services.”⁴⁴

In addition to the Single Point of Access for children, there are Single Point of Entry systems for adults. Both serve as gatekeepers for referrals for services.

As with any county driven system, there are huge differences in how localities

Our youth need support and guidance to get through a lengthy application process and to follow the referral through to actual services.

manage their systems of care. In many counties there is a long application process that includes a requirement that the party requesting services already have a referral for services from a professional mental health provider. This in itself is a barrier to services because even obtaining a referral requires a long wait. There are localities around the state where the only resource is a telephone helpline that provides information and appointments but offers no mechanism for follow-up with the caller. For example, there is no outreach to the person seeking assistance to ensure the proper services were received. Adolescents in general and homeless youth in particular are unlikely to be able to follow through with a self-directed system on their own. Our youth need support and guidance to get through a lengthy application process and to

follow the referral through to actual services. Another aspect of SPOA in localities is the formation of a committee that meets periodically (weekly, bi-weekly, monthly) to discuss and prioritize cases. If the committee consists of individuals with an understanding of homeless youth, those youth are somewhat more likely to be prioritized for services. But often homeless youth are just beginning to experience symptoms of mental health disorders and are not yet diagnosed. Furthermore, services, if provided, are generally geared for youth under age 18 but can be maintained for youth up to age 21 for youth already in the system. This means that an 18 year old homeless youth with emerging mental health needs will be referred to the developmentally inappropriate adult system.

⁴⁴ New York State Office of Mental Health, Information for Children, Teens and Their Families, Community Support Services < http://www.omh.state.ny.us/omhweb/childservice/community_support.html>.

In most counties, services are centered around families which puts our youth at a further disadvantage. Of the county RHTY providers surveyed, only one reported that the system worked well. The other providers were frustrated and felt their case managers end up doing the work that should be done by the mental health system. In the words of one homeless youth provider, “the youth is in need of services immediately but the process takes too long.”

OTHER CONCERNS

Although ESC attempted to make our survey as comprehensive as possible, we know that there are issues, concerns and comments that participants had that we could not anticipate. In order to ensure that we received all relevant information regarding mental health needs and services of homeless youth, we offered each county the opportunity to provide any additional information they thought would be useful. The comments were wide ranging. In one county, the closing of public psychiatric emergency care presented a problem because the only emergency psychiatric facilities remaining were over an hour away, privately run and often full. This has resulted in some young people spending the night in the emergency room only to be discharged the next day without receiving the care they need. Another provider discussed the loss of a therapist assigned to their program from a mental health provider. The assigned therapist worked with youth on site at both their crisis shelter and their transitional living program and while the level of adolescent expertise varied depending on who the mental health agency provided, it was a much needed resource for the youth and staff who often needed assistance in learning to manage problem behaviors brought on by mental disorders. The on-site program ended when the state cut funding for the project.

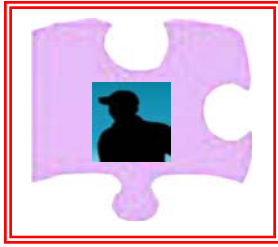
“...some young people [spend] the night in the emergency room only to be discharged the next day without receiving the care they need.”

There was a continuing concern about the mental health system's lack of understanding of adolescent development. With the mental health system overwhelmed with adults and young children, it appears that any excuse can be used to legitimate the closing of a case. If a youth misses an appointment, the case may be closed. In some instances if a youth refuses to accept the label of having a *Serious Pervasive Mental Illness*, the youth will be seen as refusing services and the case will be closed. In either instance, the special developmental needs of adolescents are not being considered. One survey respondent suggested creating a separate system for older adolescents/young adults so they can be with others who share their developmental needs.

In some instances if a youth refuses to accept the label of having a *Serious Pervasive Mental Illness*, the youth will be seen as refusing services and the case will be closed.

For one community the waiting list for psychiatrists and therapist was over six months long. Once a young person has been seen a mental health provider, low cost or free medication options are so limited it is extremely difficult for non-Medicaid recipients to maintain mental health if prescribed medications.

Overall, New York State's system of mental health care is ill-equipped to serve homeless youth, a population in need of a great deal of specialized services.



WHAT YOUTH HAVE TO SAY...

The project held focus groups with youth in each of our representative counties. A total of 59 youth took part in the groups. The youth ranged in age from 13 to 25 but the vast majority was under 21 (only two youth were over the age of 21). Youth in focus groups were recruited from crisis and transitional living programs as well as street-outreach services.

Focus group began with a discussion of confidentiality and the voluntary nature of participation. Some youth expressed that their programs had told them to come. We assured them that they were not required to participate in the project. What we found was that the youth were amazingly forthright and that the information they provided was critical to the project's work. What follows are the focus group questions and a summary of responses.

FOCUS GROUP RESPONSES

Have you ever talked to a counselor or seen a therapist?

Of the 59 Participants, seven (7) stated they have never seen a counselor or therapist. The others have been to counseling or therapy at some point in their lives. Many reported seeing more than one professional with some reporting seeing as many as five providers.

Did you have a good experience or a negative experience?

Can you tell us why?

The young people who took part in the focus groups were very forthcoming with their feelings about the therapeutic experience. Young people who reported good experiences say they felt listened to and cared about. In other words, the

“It is good when the therapist is paying attention to you and conversing with you”

detached professional was not a good match for our young people.

“I still keep in contact [with the counselor] because he is a good guy, he is wise, he goes to people’s weddings...”

“She was almost our age and understood us, easy to talk to and made me feel comfortable.”

“It feels good to be listened to, the therapist asked my mother to leave when I said I did not want her there”

“It is a good experience when they listen”

“It is good when the therapist is paying attention to you and conversing with you”

On the other hand, when the young person felt judged or ignored, or when youth felt their confidentiality was breached or did not feel a personal connection, the experience was not good. Unfortunately, the overwhelming responses were negative.

Examples of why young people did *not* feel therapy was a good experience include:

“[the therapy] did not help and the therapist talked about my problems with my sister and made up chores for me to do”

“the therapist asked the same question every time”

“a lot of stuff was supposed to be confidential but it got back to my probation officer, no trust”

“the therapist did not give me any coping strategies, he was like the Nike box, ‘just do it’.”

“the therapist did not give me any coping strategies, he was like the Nike box, just do it”

“I told my therapist that I was a lesbian and the therapist said that I had too many other issues to discuss that now”

“I went since I was 7 and was treated like I was 7 no matter how old I was at the time”

“I feel frustration, anger and depression and they only want to medicate me”

“therapist nitpicks and will challenge you and tell you how to think or not think and will put you off”

Some reported both positive and negative experiences:

“for the most part it has been good – we were able to connect and I felt they would not blurt out anything to my parents, Other times I screened myself and had to filter, self-censor, especially when my parents were in the session”

“some negative, some positive. Negative, those who went to school and are ‘psychologists’; positive, more empathetic, can talk to them, they do not use their degree on you.”

What do you think of when the following words are used...

“Therapist”

Not surprisingly, youth had a range of reactions from “supportive/understanding” to “waste of time” a number associated the word with asking questions including “how do you feel about that” a phrase that came up frequently in our focus groups.

“Psychiatrist”

This term got the most negative reactions with a large number of young people associating the term with being medicated, being “crazy” and being diagnosed too quickly. Only one participant had a positive reaction stating that a psychiatrist was “someone you can talk to and trust you do not have to hide anything.” Sadly, besides that one positive reaction, every other reaction was very negative. Some examples include:

“did not listen to a thing I said about anything. Anytime I did [talk to him] he upped my medication or changed my medication”

“they do not give you a chance, they diagnose you immediately, diagnosis equals money to them.”

“Anytime I did [talk to him] he upped my medication or changed my medication”

“Counselor”

The title “counselor” on the other hand, received positive responses. Youth

associated the term with:

“help, all about help”

”someone to sit down with you and have a talk”

“help with tasks such as finding a job”

“talk to, it feels more easy, unlike a psychiatrist”

“been there for me, flexible.”

All responses were not quite so positive, but the majority contained the themes of helpfulness, listening, flexibility. Those youth who expressed more negative responses usually did so within the context of one particular person as in “I think of a particular person who I really dislike”.

“...when (the youth) heard the term “Mental Health Services,”... The words “crazy” “meds” “diagnose, and “label” were used...”

When youth were asked what they conjured up when they heard the term “Mental Health Services,” the response was similar to that of “psychiatrist.” The words “crazy” “meds” “diagnose, and “label” were used by many of the respondents. Some of the respondents were extremely insightful when they took the time to provide a full answer and explain why they often feel frustrated. For example one focus group participant stated “These people read a book and go to school and we walk into their office and they tell

me about my life but they know nothing about me and if I get mad they say I have an anger management problem.” Other examples include the following responses:

“They make unrealistic demands on you – change right now.”

“They should act more professional, they just sit there and ask some questions.”

“how does that make you feel.”

“You make a statement about yourself and they discount it – completely.”

Although the vast majority of responses were negative, there were a couple of youth who gave some positive feedback including:

“It helps most when it is a conversation, it feels more personal and you can get more out of personal stuff.”

Another opined, “It could be prevention, when I came out of the closet they

helped me.”

Confidentiality/Privacy

There were times in the focus groups when it was apparent that the perceptions of the program staff (as captured in the county provider surveys) and the perceptions of the youth focus group participants were polar opposites. One such area was confidentiality.

Responding to the inquiry *“When you think about seeing a counselor or therapist, do you worry about them keeping your information private?”* just nine focus group participants indicated they did not worry about confidentiality. Of those nine, four cited laws protecting confidentiality such as HIPAA and/or the need to sign a waiver to release information. The much great number of participants stated that their confidentiality was breached when providers:

“They talk about it to others at work and to their families.”

”There is no confidentiality.”

“People gossip all the time.”

“I had my diary taken and the information was disclosed.”

“Sometimes they inform your parents even though it’s not true that they have to and some parents are not involved in your life.”

**“I had my
diary taken
and the
information
was
disclosed.”**

**“I know what
I can and
cannot tell
her and I
censor
myself.”**

Other participants stated their fear of disclosure of personal information by stating that they...

“do not tell them the truth.”

“I tell them what they want to hear.”

“I know what I can and cannot tell her and I censor myself.”

Or, “I do not give them information because [in the past] my information was shared without my signing a release.”

Cost as a Barrier

The focus group questions were geared towards getting a better understanding of all the barriers to mental health services. Youth were asked “Have you ever been told you have to pay the counselor or therapist to speak with you?” Of the six youth who stated that payment was never a barrier; two related that their insurance pays, two that they receive services through a program or a school, one that the therapist does not worry about money, and one offered no further explanation. Problems with payment were evident among both youth who had insurance, including Medicaid, and those who were uninsured. Youth reports regarding cost barriers included:

“I was denied service when my health insurance got switched and the therapist dropped me immediately.”

“I was harassed for the co-pays--I had to pay \$125 that day.”

“I have been to places where they won’t even see you without a co-pay up front and insurance.”

“I had Medicaid but one time I had to see a therapist and I had to wait on line to pay and get the paid bill and the therapist asked first about the bill.”.

Those without money or insurance were denied outright:

“I was denied service for lack of health insurance.”

“My Medicaid was pending and they would not see me.”

When participants were asked, “Have you ever wanted to see a counselor or therapist but the cost was not affordable?” responses were very mixed. A few youth said that they wanted to see someone but were stopped by the cost. Cost was only one barrier youth cited. When asked about what prevented seeing a counselor or therapist, focus group participants reported diverse reasons. Some of the barriers were: lack of family cooperation (for family therapy); fear of being judged; medication compliance requirement; insistence on the need for medication; a parent’s refusal to give consent; and lack of motivation on the part of the youth; lack/loss of insurance.

“My Medicaid was pending and they would not see me.”

The two most consistent answers to the question of cost had to do with medication and insurance. Describing why medication was a barrier, one youth reported “every other session medication is discussed, anti-depressants, I know that

medication has side effects, but they talk about it like it is a pot of gold.” Although cost was discussed separately, many youth chose this section to describe their frustration with insurance. One youth told of how “on my 19th birthday I lost Child Health Plus and for six months could not see my counselor. Then, I got my insurance back – during that six months I could not get my medication.” At least two youth talked about the loss of Child Health Plus with one stating “Child Health Plus ends abruptly at age 19.” Another youth seemingly finishing the thought with “there is no explanation beforehand that Child Health Plus gets cut off at 19.”

Parental Consent as a Barrier

New York State’s Mental Hygiene Law §33.21, Consent for mental health treatment of minors, recognizes the importance of parental/guardian involvement in the treatment of mental health concerns of minors.⁴⁵ However, the law recognizes certain instances when parental involvement is neither practicable nor appropriate. In those

“...an outpatient practitioner can see a minor where the practitioner determines that (1) the minor is “knowingly and voluntarily’ requesting services; (2) services are indicated and necessary; and (3)(i) the parent/guardian is not reasonably available; or (ii) requiring parental consent would have a detrimental effect; or (iii) the parent or guardian has refused to give consent and a physician determines that treatment is needed...”

cases, an outpatient practitioner can see a minor where the practitioner determines that (1) the minor is “knowingly and voluntarily’ requesting services; (2) services are indicated and necessary; and (3)(i) the parent/guardian is not reasonable=y available; or (ii) requiring parental

consent would have a detrimental effect; or (iii) the parent or guardian has refused to give consent and a physician determines that treatment is needed.⁴⁶ Minors over the age of 16 may consent to treatment using psychotropic medications if they meet a

⁴⁵ New York State Mental Health Law §33.21(b).

⁴⁶ NYS MHL §33.21(c).

slightly higher criteria than the one described above.⁴⁷ Despite this right, many practitioners still insist on parent consent as their internal policy. In our small sample, approximately 45 percent of youth indicated some problem with parental consent. One young person related that his mother was in prison and that the therapist would not accept the consent of his grandmother with whom he lived. In most other cases, the parent simply refused consent because, according to the youth, “my parent is in denial” or “my parents said therapists are a waste of money” or simply “my parent refused consent.” The majority of youth however did not identify consent as a barrier.

“Everyone is making all the decisions for you, a person should be more active in treatment, the most active person in treatment should be the youth.” This sentiment was expressed by a youth when we asked about parental consent. At least one young person was aware that they did not need to get consent under certain circumstances and was able to access services without consent.

Hours of Operation of Mental Health Services

The focus group facilitators asked about hours of operation for some mental health services and if those hours conflict with work, school or other scheduled activities. While the great majority of focus group participants who responded to this inquiry reported scheduling was a problem, there were a smattering of youth who worked with programs/therapists who provided enough flexibility to accommodate the youth’s school or work hours. One youth stated “I have a Saturday morning appointment which is perfect because there is no conflict with work.” That was not the experience for most however, as we heard “there is no flexibility with the times or days and so you cannot do some things you want to do like go out with your friends.” Another said “the one-on-one sessions are supposed to be around my schedule but they are not.” A third reported: “Once I had to go to an evaluation and I had to go during work hours, my boss did not want me to go but he let me. I had to bring a note back to work.” One

“the one-on-one sessions are supposed to be around my schedule but they are not.”

⁴⁷ For the purpose of consenting to medication, the treating physician and a psychiatrist need to determine that the youth will benefit and that the youth has capacity to consent. §33.21(e)(2).

participant summed it up nicely “I always had to get pulled out of school which I dreaded. I feel the counselor had a responsibility to advocate for a better time.” Finally, youth who are themselves parents were faced with additional barriers: child care responsibilities and the sometimes impossible problem of traveling with young children who may need a car seat, stroller, etc.

Transportation

Travel and transportation for homeless youth is almost always a consideration. In urban areas there is often public transportation, but without funds, youth cannot

access it. In rural areas, these resources do not exist and young people have to rely on others to get them to and from appointments. In suburban areas there is often some public transportation available, including rail and bus routes, but it is costly and/or unreliable. Youth in only one suburban program indicated that transportation was never a problem, and that sentiment was shared by all the youth who participated in that particular focus group. In the balance of the focus groups however youth did indicate that it was sometimes a problem, often a problem or always a problem. Responses included:

“School ended at 2:15 and counseling started at 6 p.m., but I had to work from 6 p.m. until closing and counseling was very far away. So I could not get there for both reasons.”

“Counseling was ½ hour away so I always had to rely on someone for a ride.”

“It depends on the weather. It’s a long walk.”

“School ended at 2:15 and counseling started at 6 p.m., but I had to work from 6 p.m. until closing and counseling was very

far away. So I could not get there for both reasons.”

“My mother would not let me go and I had no means of transportation.”

“The buses are not there on time.”

A very few respondents had no transportation difficulty because the counseling was “around the corner” and in one case “it was a straight walk and I enjoyed the location.”

Mental Health Service Settings

The ambiance at the counseling location was of paramount importance to many of the young people interviewed. Young people reported that therapists were “rude, snooty and had an attitude” or youth expressed frustration that they “do not pay attention they just write things down and never make eye contact.” In one case youth reported that staff at a counseling center “made comments about you when you go to the area where mental health services take place.” A number of youth reported that mental health staff treated them like they were children or just stupid. All youth who responded appeared sensitive to how they were treated and took the perceived or actual handling very seriously. Youth reported that “staff answered their cell phone when you were talking to them”.

“Support staff and reception staff treated me like I was just crazy.”

One youth reported a harrowing experience where he tried to tell the front desk person that he was “having suicidal thoughts but she was too busy to tell my therapist and told me to accomplish it and I did try to suicide.” Fortunately most youth, while frustrated by the inattentiveness and rudeness of clinic staff, don’t have as abusive experience as that.

The ambiance of the counseling location extended beyond just the experience with individual staff, it also was reflected in the policy, procedures and general look of the place. On the one hand youth did not feel comfortable in a place that was too corporate or too fancy, nor did they feel comfortable in a room that was too institutional with “old magazines and a water cooler in the waiting room” or where “the chairs were bolted down.” In one location a youth reported that they were required to “sign in and get a hall pass.”

**“Support
staff and
reception
staff treated
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just crazy.”**

Therapists Understanding of How to Work with Adolescents

Youth expressed almost unanimous frustration about how the professional therapy staff work with them. One young person summed it up nicely by saying “there are not too many people in the field who know how to work with youth. There are some who know how to work with small children.”

This sentiment was echoed by others including one youth who complained “as a

kid I was treated as a child and treated like I did not understand the world. As I got older they still treated me like I was six.”

Staff who are trained to work with different stages of adolescence was important to many of the youth who took part in the focus groups. For example, youth reported “you cannot treat all adolescent teenagers the same.”

Another youth stated “they talk down to you and treat a 13 year old and an 18 year old the same”

“...there are not too many people in the field who know how to work with youth. There are some who know how to work with small children.”

One youth surmised “they are not trained to work with different age groups/brackets.” Experience and attitude were most important to the young people who participated in our project research. While some youth reported they wanted a therapist who was older, some expressed a need to work with someone closer to their own age. Some wanted a therapist of their own gender, sexual orientation, or of the opposite gender. Some expressed the desire to have someone reflective of their experiences or personality. Despite these variations in whom a particular youth felt they could best relate, the overwhelming sentiment was that personal experience and experience with adolescents counts for a lot. Youth stated “they understand you when they have personal experience or experience working with the population”; or as one youth put it “it’s all about experience.”

Attitude included the ability to listen and be flexible. Youth want counselors/therapists who listen, talk and respond and are empathic. Some youth did not mind being given advice as long as it was grounded in the reality of a homeless young person’s life.

Flexibility was another theme that emerged: “you have to have a personal touch. There are some that just want to go by the book, and any deviation from the book rattles them.”

“They treat everyone the same. They have one way of working with people whether it works for you or not.”

One youth received agreement when he expressed that some therapists “understand how to work for youth but not with youth.” In other words, youth want to

be part of the discussion about their own lives. Empathy was an important attribute for many of the youth interviewed. Sentiments expressed by some adults that they understand what a youth is going through are not believable to many young people.

“They say they understand but they really do not. Individuals who have struggled their whole lives need to be understood.”

“Older adults say they have ‘been there’ but it is a different time today.”

“My counselor thought she knew what she was talking about but she cannot tell you how to think.”

Every focus group had participants who reported feeling ignored or discounted.

“They ask questions and say ‘um’ or just keeping writing and give you the nod.”

Mental Health Service Providers Perceptions of Homeless Youth

Although the vast majority of youth had been in counseling and had even worked hard to access counseling, their experiences with the counseling professional was often frustrating and non-productive. This frustration surfaces when youth were asked “If or when you have seen a counselor before, what do you think the counselor thinks of you or your situation when they find out you are or have been homeless?”

Only two youth reported an empathetic and helpful response. One youth reported that after he explained the situation, the counselor understood. A second youth reported that the counselor was helpful in finding resources. All others reported a negative reaction. While this is, albeit, the young person’s perception and not necessarily really how professionals viewed them, their perceptions colored the experience and should serve as a valuable lesson in how words, body language and attitude can enhance or destroy a therapeutic relationship. Some of the most telling responses from youth expressing their resentment about being judged:

“They judge you before they know you.”

“They judge you before they know you.”

“They hear bad things and think you are bad.”

“He thinks I am crazy and seems to move away from me.”

“He treats me like I am going to do something terrible any second. His eyes do not leave me.”

“They look at you as troubled, but everyone here is here in part because of our parents.”

Other youth were bothered by what they deemed to be assumptions about how they felt:

“Some assume you are traumatized by the experience.”

“They automatically think you are depressed.”

Youth also expressed displeasure when they felt blamed for their homelessness:

“They think you disobey you parents and that is why you are on the streets.”

“They assume the teenager is the problem, not the family. Why am I being diagnosed?”

“My counselor thought my story was exaggerated.”

“My counselor encouraged me to stay in my bad situation.”

Some therapists gave youth the impression that the young person was powerless over their situation:

“They want to pity you.”

“The counselor expects me to become one of the bums on the street.”

Youth over and over again expressed frustration with what they perceive as judgment, blame, doubt and hasty diagnosis communicated by mental health providers.

“Sometimes I am confused, some questions were personal, it’s just too much, it’s better to talk about then put it on paper.”

Paperwork

We next asked about paperwork as a barrier. While a large number of youth had been required to complete much of the paperwork themselves, for the most part this was not a barrier. Some youth liked the freedom of being able to complete the forms on their own. Others discussed how they are asked the same questions every time they go

somewhere new, so the information is easy for them to recall, and in at least one case, the youth stated that verbal intake is more off-putting. There were a minority of youth who were uncomfortable with the process and wanted to talk to someone immediately

about what their needs were, but for the most part, youth took it in stride and as yet another set of papers that had to be completed before anyone would talk to them. Those who found it difficult to complete the paperwork themselves cited reasons such as:

“I was young and did not know what the words meant, I was 14 at the time.”

“Sometimes I am confused, some questions were personal, it’s just too much, it’s better to talk about then put it on paper.”

“There were some questions I was not prepared to answer either because I did not have the information or the question made me uncomfortable. These questions included family history, family questions, questions about the past, verbal questions. I did not know who would see it.”

One young person expressed hurt because she stated she “had a capable parent who should have done it.”

What are some indications that RHY staff understands your needs?

The focus group asked a number of questions about what youth felt was wrong with the mental health services they had experience with. We also wanted to know what worked and why. So we asked “How do staff from the runaway/homeless youth program demonstrate that they understand the emotional needs you might be having?” And we learned a great deal about what youth want from a professional relationship.

**“They don’t
take notes
they listen.”**

Some of the keys to engaging youth are: listening to what a young person wants; showing staff care about a youth; respecting young people’s space and personal business; knowing when to ‘book off’ (leave youth alone); staff treating youth as individuals; staff being there for you (one young person related how when she was in the hospital the staff were there for her, not her family. Another related how the staff came to her graduation).

Youth stated they know staff cares about them as individuals when:

“They don’t grill you, they just say ‘talk to me.’”

“They don’t take notes they listen.”

“They joke with you.”

“They put you in a good mood.”

“There is a give and take.”

“They get to know you.”

“The door is always open.”

“They call me to find out how I am doing.”

“They know how to tell your story (they advocate for you). “

Of course not all experiences were good. Confidentiality breaches were a big factor in making an experience a negative one. Staff at RHY programs gossiping, making inappropriate comments about what a young person had revealed in the past to a different staff member or staff just throwing something back at a young person that was discussed during a prior counseling session were some of the reasons stated to show that the RHY counselor did not understand their emotional needs. In other cases, youth reported that the counselor put their own needs ahead of the young person’s as when a counselor puts their feeling first or when a counselor seems to be there only for the paycheck and does not want to really help.

Waiting Lists

Waiting lists and wait times for mental health services were discussed at each of the focus groups. In some regions, youth reported that they never had to wait for a counseling slot. In other geographic locations the wait was months long, over nine

“if I call it takes forever but if my [RHY] case manager calls I get in right away.”

months for one youth. When an adult was advocating for the youth the wait was much shorter. In one case a youth reported that “the [RHY] program coordinator called and got me ahead on the list.” Another youth reported that “the wait was only 2 days because my mother pushed the issue.” One youth related “if I call it takes forever but if my [RHY] case manager calls I get in right away.” Two, three and four months waits were not uncommon, and then the experience may not be productive. One young person told of waiting weeks for an

evaluation only to have the evaluator “cut and paste” the report. Despite the negative experiences, youth know they must go through the process since many program

require that a youth be in mental health services before a young person can access housing, skills training or many other needed services.

Mental Health Services as a Prerequisite to Obtaining Other Services

To quantify this we asked “Have you ever been told that in order to get served at a program you have to see a Counselor, Psychiatrist or Therapist?” Only three youth had never had the experience of being told they must see a mental health provider before they could begin services. Some youth were told they needed to see someone before they could begin a housing program, others were held up from entering employment training, still others were required to enter counseling in order to join school extra-curricular activities. It was no surprise that youth generally felt resentful about this pre-requisite to getting whatever it was they were seeking. In two cases, youth reported that they did not want the mental health counseling to show up on their record and refused to cooperate, thereby losing whatever opportunity they were seeking. According to one youth “when you apply for a job they do a background check and mental health comes up and then I get disqualified from the job.” A second young person stated a similar sentiment “I did not want to go through with it because I did not want it on my record that I saw a therapist.” A number of other youth reported that they simply refused to go into counseling against their will.

“when you apply for a job they do a background check and mental health comes up and then I get disqualified from the job.”

Experience with Medication

The number of youth who were either on medication or who had been prescribed medication was startling. In every focus group a large segment of young people talked about the medications they had been prescribed, often after seeing a psychiatrist one time for a forty-five minute session. These youth openly discussed the challenges involved in taking medication while homeless, and some youth credited medication for making it possible to get through tough times. For youth who are or

were street homeless, medication compliance is especially problematic. One youth summed it up nicely “when you are homeless it is difficult to do anything routinely, you lose stuff, there is a chaotic atmosphere, routines are impossible”.

This sentiment was echoed by another who stated “I forget to take it especially when everything is chaotic”.

Another stated “I sell my meds and buy what I know works for me.”

A third worried “if you need medication and you are homeless then it is very hard, what if you run out?”

Of course the reality of getting medication was a concern. As one youth stated “Medication really works well but it costs \$400 a month. I need the pills.”

Although the question specifically asked about the challenges of taking medication while homeless, many youth used the opportunity to talk generally about their experiences with medication, which ran the gamut from very successful to

extremely problematic. Youth who have or had a positive experience with taking medications reported such things as “medication makes me chill more. I am not as hyper. It is easier to work. I am not as sidetracked. The program gives me my meds every day.”

“they keep changing my medication, every six months they change it like I am a rat. Maybe I am.”

Another youth stated “I used to be against medicine when I was younger, 14 or 15, and I was off medication for about a year and now I am on a new medication and I have major improvement.”

Experimentation with going on and off medication was not uncommon. In the words of a young person “I took myself off meds once, and they found out how detrimental that was, but I was lucky.”

Those with a negative experience with being prescribed and taking medication far outnumbered those youth who felt positive about it. From the simple declarative “medication does not help” to the frustration of feeling like a guinea pig “they keep changing my medication, every six months they change it like I am a rat. Maybe I am.”

Others complained of side effects. For example, one youth felt “aggravated with medication because it stays with you and causes other problems.”

The question elicited a strong reaction. A couple of the youth noted that at one

time they may have needed medication but, now felt they no longer do. This sentiment was expressed as “at first the meds helped me, but after a while they started causing problems. But you are reluctant to take yourself off.”

“I am getting older and do not need meds. Meds make me stutter or talk slow.”

One youth openly asserted “the psychiatrist, he will give you medication for anything. I know what symptoms to describe to get which medication, but if you really need it, it’s bad because you have to go through so many people to get meds.”

Finally, a number of youth expressed that when staff know they are on medication, every little problem becomes a symptom of a mental health disorder. One young person put it this way, “When you are in a program and you are acting a certain way, --crying, angry, etc.-- the first thing is to ask ‘did you take your medication today?’”

Self Medication

After discussing prescribed medications, each of the groups was asked to talk about self-medicating. Stress was the number one reason that youth stated they needed to self-medicate. While marijuana was the drug most often cited as a way to cut down on stress, followed by alcohol and cigarettes, youth also discussed a variety of ways that they manage stress including listening to music, reading, crying, rapping, physical activity including all kinds of sports, running and walking. One youth described self-medication as “band-aid therapy’, you do it when you’ve had it.” In discussing the topic of self-medication, even those who admitted to drugs and alcohol as a way of coping, also discussed the fact that it was not the best means of coping.

One youth described self-medication as “band-aid therapy’, you do it when you’ve had it.”

One young person summed it up “I had to go through a lot because of drugs.”

SUMMARY

The young people who participated in the focus groups provided a unique and critical perspective that was essential to obtaining a full picture of what works, and what does not, in our current approach to providing mental health services for homeless

youth. The results from our focus groups were in line with other studies of adolescent attitudes and experiences with mental health services. For example, a study by Lee and Munson, published in 2006, of 389 foster care youth in Missouri who had experience with mental health services revealed that 37 percent had a positive experience, and of those who had a positive experience, practical assistance was cited as one protective factor as was a positive emotional outcome such as feeling better about oneself.⁴⁸

There were some remarkably similar sentiments expressed by foster youth interviewed in the Lee and Munson Missouri study and the homeless youth who took

[National Youth Summit] priorities included self-directed and individualized services, options for medication including alternatives to medication, peer support in understanding and navigating the mental health system, sharing of information about diagnosis, ending mental health labeling and the need for a mental health bill of rights for youth

part in our focus groups. Therapist's willingness to listen and to see the individual, as opposed to the diagnosis, were most valued by Missouri foster care youth who responded to that study. They also valued the capacity for empathy in those whose held did not stop at the office door. Their therapists gave the impression that they were available to the youth anytime⁴⁹.

Missouri youth responding with negative reactions (26 percent) also cited reasons very similar to those our homeless youth expressed. The push to medicate was stated over and over as an example of what these foster youth thought was wrong with the mental health system. Another recurring theme was the youths' frustration with therapists who did not

engage in helpful, practical conversations with youth expressing anger at being ignored or misunderstood.⁵⁰ Breaches of confidentiality, being treated like a child and feeling

⁴⁸ B. Lee, R. Munson, et al., "Experiences of and Attitude Toward Mental Health Services Among Older Youth in Foster Care," *Psychiatric Services*, 57/4, April 2006, 488.

⁴⁹ B. Lee, 2006, 489.

⁵⁰ B. Lee, 2006, 490.

punished for disagreeing with the therapist also resulted in negative experiences.⁵¹

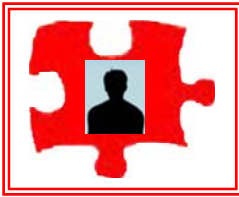
These expressions of what youth see as essential in a meaningful therapeutic experience were further corroborated by a report from a National Youth Summit which took place in 2009 in Portland Oregon. The group represented youth from states across the country, and of their 17 identified priorities, eight were related to mental health services. Of the four priorities included in their National Action Plan, all included a mental health component.⁵² The priorities included self-directed and individualized services, options for medication including alternatives to medication, peer support in understanding and navigating the mental health system, sharing of information about diagnosis, ending mental health labeling and the need for a mental health bill of rights for youth.⁵³

The experiences and perceptions of youth who participated in our project ranged the full spectrum from very good to very poor. The exploration of what worked and why, of when something was frustrating or annoying, and most importantly, what young people expressed as their ideal in a therapeutic relationship have each been essential in formulating the next section of the report.

⁵¹ B. Lee, 2006, 490.

⁵² Rebecca Strachan, L. Kris Gowen, Janet S. Walker, "The National Youth Summit Report," Portland Research & Training Center, 2009.

⁵³ Rebecca Strachan, et al., 2009, 10-13.



COMPARISON OF YOUTH AND PROGRAM PERCEPTIONS

POTENTIAL BARRIER	COUNTY RESPONSES	FOCUS GROUP RESPONSES
Cost/insurance	Significant Barrier: Youth have no insurance or inadequate Insurance. Youth cannot afford the co-payments.	Insurance abruptly cut-off. Co-payments limit ability to get services. Inability to get insurance.
Parental Consent	Some counties cite as major barrier. Some cite no barrier. Some mental health providers insist on parental consent/involvement.	42 percent of youth indicated that consent had been a barrier at some point.
Hours of Operation	Generally not a barrier as hours of operations can accommodate youth.	Majority of youth did not see this as a barrier, but a minority of young people did cite this as a problem as appointments conflicted with school, work, other activities or all three.
Wait lists	Significant barrier: Waiting time for services was between one and four months.	Experiences varied greatly from never having to wait to a wait of nine months.
Community providers perception of homeless youth	Approximately 66 percent cited this as a significant barrier including a lack of understanding of the population and their rights.	98 percent of the youth sample indicated that the provider had a negative response to the youth because of their homelessness.
How youth perceive the mental health service provider community	Strong negative feelings due to feeling labeled, being associated with older mentally ill persons, or not relating to the provider.	Youth generally expressed anger and frustration over the lack of appropriate services for their age range.
Transportation	Urban – somewhat of a barrier. Rest of state – significant barrier.	Youth reported a range of responses from “never a problem” in one suburban community to “always a problem” in both urban and rural settings.
Mental Health Settings	The majority of county RHY providers believed that while settings were not youth friendly this was not a significant barrier.	The settings were a significant barrier for the youth who cited rude or inappropriate staff or settings that made them uncomfortable.

Confidentiality	County RHTY providers did not feel this was a problem.	85 percent of youth believed that their confidentiality had been breached or worried that their information was not going to be kept private.
Medication Adherence	Significant problem with resistance to taking medication and inconsistency on taking medication cited as the two major concerns.	Adhering to medication regimens when homeless was described as practically impossible due to chaos in their lives and the need for money both to purchase prescribed medications and selling medication as a way to earn money.
Mental health service as a prerequisite to services	Half did not see this as a significant problem.	99.5 percent of youth stated that they have had the experience of being told they cannot access services (housing or other) unless they are enrolled and participating in some form of mental health counseling.



RECOMMENDATIONS AND PROMISING PRACTICES

Formulating recommendations and exploring promising practices began with a worldwide search of interesting and innovative approaches to working with youth to address their mental health needs. Our search looked at communication methods that youth feel comfortable with and looked at ways of providing service without the need for immediate labels and diagnosis. Regardless of the treatment modality, youth were clear about what is essential in the therapeutic relationship: being valued as an individual; being treated with respect; being listened to; engaging in a conversation; offering practical advice; being there when needed; being there outside the therapeutic setting (at birthdays, graduations, etc.). Regardless of what method of care or treatment is used, advocating with all providers to establish a mutually respectful and engaging relationship will be factored in to all best practice recommendations and into all training activities as ESC moves to deconstruct the real and perceived barriers highlighted in this report.

RECOMMENDATIONS

The following are based on the county surveys and focus groups responses and, if adopted, would assist mental health providers in their work with homeless adolescents.

Cost as a Barrier

Insurance

Provide youth with hands-on assistance making the transition from Child Health Plus to other forms of insurance. While youth may have been given information that their Child Health Plus insurance would cease at age 19, they did not have an understanding of what that actually meant. Many thought the transition to new

insurance would be automatic. Therapists and case managers need to take responsibility for explaining to young people the limits of their insurance and how to best prepare for any action they need to take. This discussion may need to happen more than once and over time as adolescents generally will not fully understand or appreciate the information the first time it is explained. For youth without insurance, mental health providers should have on-site services to assist youth to apply and ideally have a discretionary fund to cover the cost of the service for the youth while an application is pending. Finally, there may be more opportunities for youth now that the federal health care legislation is beginning to be put in effect, both mental health providers and RHY programs need to be proactive in using the newly enacted law to benefit homeless youth.

Co-payments

Mental Health providers should have a special fund for unaccompanied youth to assist them with their co-pays. This fund would not only insure that youth receive the services they require, but it would be a way of demonstrating their value as individuals to the providers.

Parental Consent as a Barrier

Parental consent should never be a barrier to youth in need of care. New York State law is on the side of providing services, yet clinics and other providers often have their own policies that prevent them from serving minors without parental consent. All RHY programs should have on hand a copy of New York State's Mental Hygiene Law §33.21, and staff should be trained to fiercely advocate on behalf of each youth who needs services and is entitled to those services if parental consent is not obtainable, is refused, or would be harmful to the minor is required.

Mental Health Services Limitations as a Barrier

Hours of Operation

While this was not generally cited as a major barrier, *more flexible hours,*

including weekend hours, would be helpful so youth did not have to choose between school, work or therapy.

Waiting Lists

The wait for professional services is likely to continue well into the foreseeable future. *It is incumbent on the mental health system to devise other modalities to provide basic services in the interim.* Support for Mental Health First Aid, the use of satellite technology and the training of primary care providers (each discussed in the promising practice section) are some of the models that can be initiated while the wait for a therapist continues.

Training of Providers in Basic Adolescent Development and about Homelessness

Mental Health professionals need to understand homelessness, its causes, and the impact it has on a young person's development and mental health. Professionals also need basic adolescent development training to begin to understand why traditional methods of therapy are misunderstood and resented by many young people. Part of the training needs to be devoted to engaging adolescents and designing approaches that are different from the ones used to work with children.

Youth Lack of Information as a Barrier

Youth appear to lack basic information about mental health and the professionals in the system. They seem particularly resentful of psychiatrists whom they view as detached medication automatons. Spending a few minutes at the beginning of a session explaining the practitioners role and their area of expertise may help youth to accept the services. The most helpful approach however may be the development of a cadre of peer specialists (discussed in the best practices section) who would assist mental health providers to serve the population effectively.

Lack of Access to Transportation as a Barrier

New York State should look into expanding county public transportation so that it is reliable, affordable and accessible.

Mental Health Settings as a Barrier

A welcoming atmosphere matters, especially to adolescents who have heightened sensitivity to feeling unwelcome. Training for reception staff and administrative staff is essential in helping to set the tone of the provider. Space that is too institutional looking is off-putting, and space must be designed to be adolescent friendly not just child friendly.

Breaches of Confidentiality as a Barrier

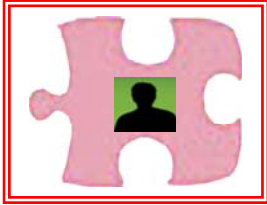
Youth and providers both need information and training on confidentiality and its limits. Some providers are too cavalier with young people's private information, especially in sharing information with others including family and other service providers. Youth, on the other hand, need a basic understanding of what confidentiality is and with whom information may be shared. An overview of confidentiality at the initial interview is not enough. Young people may be unable to take in everything they need to absorb at intake, so confidentiality should be brought up regularly until the provider is sure the youth is clear about it. An understanding of informed consent is also critical as is a compliance mechanism for those times when a youth feels their confidentiality has been breached.

Medication and Medication Adherence as a Barrier

Most youth felt medication was too freely administered. They may have a point, and the state should address the overmedication of our youth. Those who found medication useful found that sticking to a medication regimen while homeless was almost impossible. Therefore practitioners should take into consideration the youth's living circumstance before writing a prescription. Information on how to get free medication is also essential for youth who are homeless.

Mental Health Services as a Prerequisite to Services

Homelessness must be seen as so critical a circumstance that any prerequisite to services is an untenable barrier. Once a young person is involved in an RHY program, that program can set a timetable for obtaining mental health services if needed. If the youth disagrees, there should be some dispute resolution mechanism.



PROMISING PRACTICES

In addition to focus groups with youth and surveys of participating local providers, ESC did an extensive review of the literature for promising practices in meeting the mental health needs of adolescents. Not only were innovations across the United States looked into, but we reached broadly and found interesting work in Australia, Italy and Holland. In some cases, there may be modifications that need to be made to the practice in order to serve a homeless youth population. Promising practices are being looked at in terms of early intervention and therapeutic intervention services and many of the practices rely on cutting edge technology.

ACCESS TO INFORMATION:

For Youth

Many of the youth who took part in our focus groups lacked basic information about their rights, responsibilities and benefits that may be available to them. There was a great deal of confusion about confidentiality including what its limits are. So too was there confusion about parental/guardian consent. While RHY programs do provide much of this information at intake, youth are often bombarded with information at intake. These topics should be broached on a regular basis with the case manager, at house meetings, or whenever a particular program feels it best fits into their schedule, as long as the information is not provided once. This project will develop a short tip sheet for youth that programs can distribute and leave in public areas as a reminder. Information about public and private health insurance benefits is also essential for youth to have. Many of the young people were taken by complete surprise when their Child Health Plus benefits abruptly stopped at age 19. Once the benefits were lost, so

Youth who took part in our focus groups lacked basic information about their rights, responsibilities and benefits that may be available to them.

too were needed services. Youth became angry and frustrated and many expressed feelings of betrayal. A few information sessions on public and private benefits and a tickler system at the program level to alert case managers when a youth is approaching a critical birthday for the purposes of insurance coverage, will alleviate many problems including gaps in needed services or complete loss of services.

Information about youth rights should also be included on program websites and other websites that youth may access.

For Mental Health Providers

Providing information to therapists about what we now know youth value in a therapeutic relationship can assist the therapists to adjust the therapeutic environment to best meet the youth's needs.

In many counties, RHY programs rely on a few mental health providers for their young people. It appears that too often these professionals do not have a basic understanding of adolescent development or of youth's rights. Providing information to therapists about what we now know youth value in a therapeutic relationship can assist the therapists to adjust the therapeutic environment to best meet the youth's needs. Each young person may not feel empowered to discuss their likes/dislikes with a therapists, but if staff begin the conversation with general information about what they have learned about what youth feel is an efficacious therapeutic relationship, the therapist can open the dialogue with each young person.

TRAINING

The mental health needs of homeless youth range from the need for some support and counseling to the need for long term care and medication. Recommendations therefore, are not designed to meet the needs of all youth but should be viewed as the beginning of a menu of options that should be available for any youth in need.

One of the models to be explored was first developed in Australia by Betty Kitchener and Professor Tony Jorm, who applied the concept of medical first aid to

mental health. Mental Health First Aid (MHFA) is a recovery-based curriculum that embraces the theory that lay people can be trained to recognize early symptoms of mental health disorders and to perform immediate interventions. The MHFA provider will be able to immediately intervene until a crisis dissipates or professional help arrives.

The analogy is drawn to certified first aid providers first aid coming upon someone in the street who appears to be unconscious. After calling in for emergency assistance the provider would check whether the person was breathing and had a pulse or heart beat. CPR might be administered, or the person might need to be covered with a blanket, kept calm, or some other non-medical intervention until professional emergency medical response team gets there. In some cases the person recovers quickly and denies the need for additional medical services; in other cases the person may be taken to a hospital.

As with medical first aid, the MHFA response is to quickly assess the situation and respond accordingly. Except for the most severe mental health problems, an intervention with a trained layperson can de-escalate or even alleviate an immediate crisis.

Although the origins of MHFA are in Australia, to date it has been replicated in 13 countries in addition to the United States. Those countries are: Scotland, Hong Kong, Canada, Finland, Singapore, England, Wales, Cambodia, Japan, Maaori of New Zealand, Northern Ireland, South Africa and Thailand. In Australia the model is used in programs that serve homeless youth through the Youth Accommodation Association (YAA) of New South Wales. When discussing their approach, the YAA states

Mental Health First Aid (MHFA) is a recovery-based curriculum that embraces the theory that lay people can be trained to recognize early symptoms of mental health disorders and to perform immediate interventions.

“Contrary to popular belief you do not need to be an expert or a clinician to be able to effectively support young people with mental illness. Youth workers can also play a critical role in assisting a young person to access clinical and

*diagnostic services and to develop self help strategies. The use of some simple strategies that build on existing skills, along with the development of specific knowledge of mental disorders will go a long way to providing a better service to this client group.*⁵⁴

Empire State Coalition first learned of MHFA and its benefits for the homeless youth population from Michael Coffey, CEO of the Australian Youth Accommodations Association.

In the United States MHFA was adapted by the National Council of Behavioral Health, Maryland Department of Health and Mental Hygiene and the Missouri Department of Mental Health. These three entities have since begun a collaborative training and dissemination project. All training and certification of trainers is done by the collaboration with the National Council for Community Behavioral Healthcare (National Council) serving as the primary contact.

MHFA certification program consists of 12 hours of training in the following areas: depression, anxiety disorder, psychosis, substance abuse disorders, and eating disorders. Crisis situations covered include: suicidal behaviors, non-suicidal self injury, panic attacks, trauma, and more. Each section provides information on symptoms and offers action steps to assist in alleviating the immediate crisis, where possible.

The National Council offers a five day train-the-trainer course which allows individuals to become certified trainers in their communities.

The young people who took part in the focus groups fairly consistently expressed their preference for counselors at their programs as opposed to more traditional mental health providers. Most program counselors, however, are not mental health practitioners and are ill-equipped to deal with the emerging mental health symptoms experienced by some young people. The result is that problems escalate and youth usually leave the program or the program feels the need to refer the youth out to a higher level of care. By certifying front-line staff in MHFA, many situations that result in a disruption of a young person's stay may be resolved safely, which will benefit the young person and the entire program.

⁵⁴ "Mental Health and Homelessness in New South Wales, Australia – an unfortunate scenario", Undercurrent, Youth Accommodation Association, I: October 2008.

INNOVATIVE USE OF TECHNOLOGY

Virtual Counseling

One of the most innovative approaches we found to meeting the mental health needs of adolescents is a project to provide substance abuse treatment using the internet based virtual world of *Second Life*⁵⁵ and avatars created by participants to represent themselves in the virtual world.

**[In Second Life]
Trained therapists
provide group and
individual counseling
to adolescents with
substance abuse
problems interacting
with avatars created
by the youth.**

This innovative use of technology is being piloted by Preferred Family Healthcare Inc. (PFH), St. Louis, Missouri. The director of the pilot project is Dick Dillon, Senior Vice President for Planning and Development. PFH has rented private space in *Second Life* and set up their own virtual community, some of which is not accessible to the general public. PFH has set security options to filter out intruders and established settings that allow only pre-authorized individuals into certain islands on their site.⁵⁶ Trained therapists provide group

and individual counseling to adolescents with substance abuse problems interacting with avatars created by the youth. The counselor is the only one in the group that knows the actual identity of the participants so that the therapist can track progress and monitor problems.

The project has shown remarkable results to date and all of the adolescents who started the counseling program remained with the pilot program. In addition to counseling, the site hosts an art space for youth, recreational activities, and trainings. PFH is one of a number of not-for-profits that have established “islands” in *Second Life*. Linden Labs boasts of at least 40 different not-for-profits that rent virtual real estate

⁵⁵ Second Life is a site established by Linden Labs of San Francisco, California, which allows users to create animated representations of themselves (avatars) that engage in daily activities. In May of 2008 a group of leading researchers and practitioners in the addiction field convened a conference, funded by Robert Wood Johnson, to explore the use of virtual technology in the treatment of substance abuse. For more information see “Exploring the Potential of the Web-based Virtual World of Second Like to Improve Substance Abuse Treatment Outcomes”, Network for the Improvement of Addiction Treatment (NIATx), The University of Wisconsin, Madison, 2008, <www.niatx.net>

⁵⁶ Linden Lab’s *Second Life* has the ability to rent private “islands” to not-for-profits.

there. Some universities, including Princeton, Harvard and Ohio State have established virtual classrooms.⁵⁷

There are a number of benefits to this mode of counseling that could be beneficial to servicing homeless youth. These benefits include:

Low cost and Shared Cost

Membership in *Second Life*⁵⁸ is free, so youth do not have to face the barrier of cost to access services. Even youth with insurance have stated that they are often precluded from accessing mental health services due to co-pays or changes to their insurance. For youth who do not have any insurance, this is one option for getting needed support. Linden Labs has special non-profit options that make the cost for the not-for profit low as well. Youth serving agencies can collaborate on a site and share the cost of a therapeutic professional to provide needed mental health services. Private space can be equipped with security features installed so that only pre-approved visitors can access the area.

Access

Youth can access service from any computer. Whether a young person is still in a program, at home, currently homeless, or in a transient situation, counseling and support is immediately available. In addition, since the professional therapist knows the youth's real identity, youth who do not show up for a session can be reached out to.

Specialization of Services

If statewide programs work collaboratively on a virtual counseling space, specialty services such as counseling youth who engage in non-suicidal self injury, have eating disorders, are dealing with trauma, or are diagnosed with other specific disorders can be provided regardless of geography. Programs in rural areas where specialized services are frequently not available will benefit greatly by being able to offer those services for youth in the privacy of their programs.

⁵⁷ "Exploring the Potential of the Web-based Virtual World of Second Life to Improve Substance Abuse Treatment," 2008, 4

⁵⁸ Second Life is being used as an example only. There are other sites that host virtual worlds.

Confidentiality

Youth who go to counseling groups in their communities report that their confidentiality is often breached by others in the group. This problem was exemplified at one of the youth focus groups the ESC project held when a young person began talking about something that happened during a group counseling session and the facilitators had to intervene and ask him to immediately stop. By substituting an avatar for the young person there is a sense of freedom in being able to be honest yet safe in the knowledge that what you say cannot be linked back to you by any of the other participants, yet the professional counselor will be able to follow-up individually where the need arises.

SATELLITES AND OTHER TECHNOLOGICAL ADVANCES

Videoconferencing

New York State's Office of Mental Health (OMH) has begun piloting *Project TEACH (Training and Education for the Advancement of Children's Health)*. The goal of the project is to bring mental health services right into the office of a primary care physician through satellite technology.⁵⁹ With only 7,400 child and adolescent psychiatrists in the entire United States, only about 10 to 15 percent of youth with a mental health problem are able to see a psychiatrist with a specialization in child or adolescent mental health.⁶⁰ Project TEACH was established to bring needed psychiatric care through telepsychiatry via the use of videoconferencing where a psychiatrist can offer direct consultation to a youth while the young person is with his/her primary physician or for the primary physician to consult with the psychiatrist following the youth's office visit. Consultations must be requested by the primary care physician through a regional OMH coordinator. OMH will be using two providers to provide the telepsychiatry: Child and Adolescent Psychiatry for Primary Care (CAP PC) a consortium of five university medical center departments of psychiatry, and Child and Adolescent Psychiatry Education and Support (CAPES), a program of Four Winds Hospital.⁶¹

⁵⁹ New York State Office of Mental Health, OMH News, May 2010, 1

⁶⁰ OMH News, May 2010, 1

⁶¹ OMH News, May 2010, 2

Online Chats and Telephone Counseling

Holland has been experimenting with using online one-on-one chats though the Dutch Kindertelefoon.⁶² The young people who contacted Kindertelefoon were suffering from severe mental health disorders, but following a study of the use of telephone and one-on-one chat technology, the researchers found that “children experienced a higher sense of well being and a reduced severity of their problems after consulting the Kindertelefoon”.⁶³ Chat services fared slightly better than telephone services in the study.

PEER NAVIGATORS / CERTIFIED PEER SPECIALISTS

Another innovative approach to be explored is the use of certified peer specialists who can assist in navigating a young person through the mental health system and also serve as an advocate for that young person.

The use of peer based services has long been established method for engaging and working with adolescents. Many programs working with runaway and homeless youth train peers to provide outreach and counseling: schools use trained peers to mediate disputes; benefits programs employ peers to help applicants navigate systems; physical health care providers train peers to work with adolescents to get them into care and maintain them in care. Huckleberry House in San Francisco used the concept of peer workers to develop the *Huckleberry Wellness Academy* which trains young people to work at their health clinic, the *Huckleberry Cole Street Clinic*, for 10 hours each week. The internships have the dual benefit of assisting disenfranchised youth to understand and get the health care they need and introducing youth to the field of health services.

The use of peer based services has long been established method for engaging and working with adolescents.

Peers trained to lend their expertise in the field of mental health is another

⁶² Fukkink, R.G. and Hermanns, J.M.A., Children’s Experiences with Chat Support and Telephone Support, *Journal of Child Psychology and Psychiatry and Allied Disciplines*, <http://www.scopus.com/scoppesprx.elsevier.com>.

⁶³ Fukkink, .,

example of how peer models can be effective in working with persons who are seeking mental health services and working with care providers to teach them engagement and maintenance skills. Georgia is among the only States to recognize certified peer specialists as a critical component of comprehensive mental health services.⁶⁴ The Georgia program was inspired by the 1999 Surgeon General's Report on Mental Health in which peer support was recognized as one key to recovery.⁶⁵ Georgia's Rehab Option Plan supports certified peer specialists and as such, these services are Medicaid reimbursable. As paid employees of both public and private mental health care providers, the peer specialists' role is to serve as a role model and to provide help and support. Each peer must go through an extensive training and certification process. Georgia's process is funded through a grant from Substance Abuse Mental Health Services Administration (SAMHSA) of the federal government.

Certified peer specialists focus much of their work on recovery. To that end their training includes working with individuals around skill building, goal setting, problem solving, setting up and sustaining self-help groups, and building individualized self-directed recovery tools. A critical component of their work is *Wellness Recovery Action Plan (WRAP)*⁶⁶ WRAP is intended to be used in conjunction with other treatment options and is designed by the person suffering with a mental health disorder. WRAP is comprised of five recovery concepts: hope, personal responsibility, education, self advocacy, and support. The Vermont Recovery Education Project (VREP), designed by Mary Ellen Copeland with funding from the Henry van Ameringen Foundation and the state mental health department is one example of WRAP in action. VREP was evaluated with results showing a positive impact on the ability of persons suffering from a mental health disorder to recognize their own warning signs, cope with onset of symptoms, use wellness routines in their daily lives and advocate for themselves. Interestingly, one area where there was not a significant change was in the person's comfort with discussing medication with their doctors.

The certified peer specialist program, WRAP and VREP are all adult service

⁶⁴ Information about the Georgia Program including the program's Mission, qualifications for Peer Specialists, Medicaid reimbursement and their Code of Ethics, is available at: <http://www.gacps.org/Home.html>.

⁶⁵ U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. <http://www.surgeongeneral.gov/library/mentalhealth/home.html>

⁶⁶ Mary Ellen Copeland, "About WRAP," <<http://www.mentalhealthrecovery.com/aboutwrap.php>>.

programs. The positive results both anecdotally and, in the case of VREP, from a vigorous evaluation justifies including these types of services in a comprehensive approach to working with homeless adolescents who are exhibiting symptoms of mental health problems. Adolescence in particular is an excellent match for peer directed services as developmentally teens look to their peers for support and guidance.

ALTERNATIVE MEDICINE

The appeal of [acupuncture] use with adolescents is that it reduces the need for extensive talk therapy in which many youth are reluctant or unable to engage.

The use of acupuncture for the treatment of opiate dependency has been accepted in western medicine for decades. The treatment of withdrawal from opiates using auricular acupuncture began in Hong Kong in 1972.⁶⁷ Not long thereafter, two substance use programs, one in San Francisco and another at Lincoln Memorial Hospital in the South Bronx section of New York began using auricular acupuncture to treat addiction and for relapse prevention.⁶⁸ The Lincoln Hospital clinic developed a five-point protocol that was found to be effective in the treatment of crack cocaine as well.⁶⁹ According to the National Acupuncture Detoxification Association (NADA), there are more than 1500 clinics using the five-point protocol treatment in the United States, Europe, Australia, and the Caribbean.⁷⁰ In 2001, the National Institute on Drug Abuse cited a Yale University School of Medicine Study that found auricular acupuncture effective in the treatment of Cocaine addiction when used in conjunction with psychological treatments.^{71 72} The appeal of use with adolescents is

⁶⁷ Sharon Skok, Ming-Dong Li, Doug Eisenstark, "Treatment of Withdrawal Symptoms Associated with Substance Abuse Detox with Acupuncture: A Case Study," *Acupuncture Newsletter* 2/5, July 2004, <http://www.acupuncture.com/newsletters/m_july04/main1.htm>.

⁶⁸ Rosemary Guiliano, "Auricular Acupuncture in a Community Based Setting – An Alternative Treatment for Drug Dependence (available from author).

⁶⁹ Rosemary Guiliano,

⁷⁰ <http://www.acudetox.com>

⁷¹ National Institute on drug Abuse, NIDA Notes, Volume 15, Number 6, January 2001

⁷² Guiliano op.cit.

that it reduces the need for extensive talk therapy in which many youth are reluctant or unable to engage. NADA, in its training manual, states that because the five-point treatment is non-verbal, it works well with resistant and hard to reach persons.⁷³ Additional studies need to be done to look more closely at the benefits of auricular acupuncture for use with substance abuse disorders, but there are some proven benefits such as its ability to calm a individual.⁷⁴ For homeless adolescents suffering from a substance abuse disorder offering a method to feel calm may be critically important to maintaining that youth at a program.

Although acupuncture protocols for use with drug dependent individuals has been around for over three decades, there have been few examples of its use with other mental health disorders. A small pilot study has just been completed on its efficacy with treating Post Traumatic Stress Disorder (PTSD), a disorder with high prevalence amongst homeless youth. In a small study undertaken by Michael Hollifield, M.D., the researchers found that acupuncture was similar in its effectiveness to Cognitive Behavioral Therapy and both were superior to those in the control group who were offered no immediate intervention.⁷⁵ This was a very small study, and, while promising, no definitive benefits can be read into the results just yet.

Other mental health disorders being studied for the benefits of alternative therapies include anxiety disorder, severe depressive disorder and eating disorders. In a number of randomized clinical trials (RCT) the efficacy of acupuncture was compared to drugs and behavioral therapies for generalized anxiety as well as other forms of anxiety. The authors of the literature review of the studies determined that although there is insufficient evidence of the effectiveness of acupuncture treatment for anxiety disorder “there are promising results in the management of situational anxiety and the positive findings reported for generalized anxiety indicate that further research is warranted.”⁷⁶

One study on the use of acupuncture to treat depression during and after pregnancy found significantly lower rates of depression and post partum depression

⁷³ Guiliano op.cit.

⁷⁴ Guiliano op.cit.

⁷⁵ National Center for Complementary and Alternative Medicine, “Acupuncture May Help Symptoms of Posttraumatic Stress Disorder”, <<http://nccam.nih.gov/research/results/spotlight/092107.htm>>.

⁷⁶ Karen Pilkington, Graham Kirkwood, et. al “Acupuncture for Anxiety and Anxiety Disorders – a systematic literature review”, *Acupuncture in Medicine* 25/1-2 (2007)-1-10 <www.acupunctureinmedicine.org/uk/volindex.php>.

finding that “[d]espite limitations, this randomized controlled pilot study indicates that acupuncture holds promise as a safe, effective, and acceptable treatment of depression during pregnancy, and that a larger clinical trial is warranted. This study also indicates that any successful treatment of depression during pregnancy incurs protection from postpartum depression.”⁷⁷

There do not appear to be rigorous clinical studies of the use of acupuncture in the treatment of eating disorders, but there is some discussion of its effectiveness at websites such as acufinder.com and developments in this area should be followed carefully.

For homeless youth who face myriad barriers to accessing mental health services, acupuncture may be a safe, low cost and easily accessible intervention either as a stand alone or in conjunction with a more traditional form of therapy.

COGNITIVE BEHAVIORAL THERAPY

Many of the youth we interviewed stated that what they wanted was practical help and the ability to have an exchange of ideas with a therapist. These two key concepts form the basis of cognitive behavioral therapy (CBT) and therefore it appears to be a good fit for our homeless youth population. CBT is a solution focused, short term, practical therapeutic intervention, and, while it will not work for all youth, as it requires full participation and buy- in of the youth, those young people willing to put in the work can see significant changes in their lives in a relatively short period of time. Of course there are many mental health disorders that are not amenable to this type of therapy, but for anxiety, depression, eating disorders, and possibly other mental health problems and disorders, it is one avenue that can be explored with a young person if a cognitive behavioral therapist is available. There are also a number of self-help books that use CBT theory which can be explored if no other viable option is available.

**CBT is a
solution
focused, short
term, practical
therapeutic
intervention...**

⁷⁷ Rachel Manber, Rose Schnyer, et. al., Acupuncture: a promising treatment for depression during pregnancy, *Journal of Affective Disorders*, 83 (2004) 89-95.



CONCLUSION

Runaway, homeless and street-involved youth are statistically more likely to face mental health challenges than the general adolescent population. Early intervention and developmentally appropriate services and treatment can mitigate or even eliminate these challenges. The cost of doing nothing on the other hand is exorbitant. Left untreated and/or poorly treated, mental health disorders can result in a lifetime of debilitating problems, homelessness and intermittent incarceration. The community of youth service providers who open their doors to the runaway and homeless youth population need innovative and accessible therapeutic supports to enable them to do what they do best, help youth transition from the streets to a healthier and more productive life.

Current research shows that early intervention can interrupt the progression of a mental health disorder for some people. Youth who receive early intervention at a time when they are experiencing prodromal symptoms can completely recover or can be assisted to manage their mental health problems by learning to recognize triggers and manage their symptoms. Since homeless youth are less likely to receive appropriate professional services when symptoms first emerge, it is up to programs that work with them to bridge the divide between their immediate needs and the services that may best be able to help them. Without assistance homeless youth face a life debilitated by mental illness.

The current configuration of the mental health system in New York State is failing our homeless youth. Many youth are symptomatic but do not have a diagnosis which impedes their ability to access needed services. At the same time, these same youth may be wary of being labeled just to get some assistance with a mental health

problem. Our study showed that waiting lists for mental health services are untenably long. Then, even if a homeless youth can finally get mental health services, those services do not match the developmental needs of the population.

Although woefully under-serviced, additional capacity and mental health services alone will not solve the problem. We need to work with mental health providers to assist them in having a better understanding of the unique needs of homeless youth. We also need to train staff at programs serving homeless youth to de-escalate impending crisis and make better use of the advances in technology and the promising practices being piloted both in this country and abroad. Pilot projects that use alternative approaches such as virtual worlds, satellite technology, the internet, the internet and telephone technology are being accepted by youth as a viable and perhaps preferable means of receiving assistance.

Listening to young people and to the staff at the programs that provide critical services to homeless youth, it is clear that everyone is frustrated by the current state of mental health services available (or not available) to youth. This study offered a voice to those frustrations and searched for innovative solutions. Some may work, others may not, but it is only through admitting that the status quo is failing our youth and boldly trying new approaches that we can ensure a better fit between the needs of homeless adolescents and the programs available for them.

APPENDIX

A. YOUTH FOCUS GROUP QUESTIONS

Have you ever talked to a counselor or seen a therapist?

Did you have a good experience or a negative experience?

Can you tell us why?

What do you think of when I use the word “therapist”?

What about when I use the word “psychiatrist”?

How about the word “counselor”?

What do you think of the idea of Mental Health Services?

When you think about seeing a counselor or therapist, do you worry about them keeping your information private?

Have you ever been told you have to pay the counselor or therapist to speak with you?

Have you ever wanted to see a counselor or therapist but the cost wasn't affordable?

What were other reasons for not being able to see a counselor or therapist when you wanted to?

- Did the counseling program's hours or days of operation conflict with your work, school or other schedules?
- Was the counseling program located too far for you to get to?
- Were the people at counseling program unfriendly?
- Did you think that the counselor or therapy program understand how to work with youth?
 - Why? Why not?
- Was the office too corporate or business-like?
- Required your parent's consent, but you couldn't get it or your parent wouldn't give it?

If or when you have seen a counselor before, what do you think the counselor thinks of you or your situation when they find out you are or have been homeless?

In order to see a counselor or a therapist, have you ever had to fill out the forms yourself?

- What was easy about it?
- What was difficult?

How do the staff from this youth program demonstrate that they understand the emotional needs you might be having?

Have you ever been on a waiting list to see a counselor or therapist?

If so, how long were you on it before you saw someone?

Have you ever been told that in order to get served at a program you have to see a:

- Counselor?
- Psychiatrist?
- Therapist?

What would you think is difficult about taking psychiatric medication and being homeless?

What do you think of youth who find they are having to “self-medicate”?

Can you identify different sub-populations of homeless youth in your community?

B. COUNTY PROVIDER SURVEY FORM

ARE ANY OF THE FOLLOWING PERCEIVED OR ACTUAL **BARRIERS** TO YOUTH BEING SERVED FOR MENTAL HEALTH CARE AND TREATMENT?

Issue	Yes	No	Comments
Cost?	<input type="checkbox"/>	<input type="checkbox"/>	
Parental Consent?	<input type="checkbox"/>	<input type="checkbox"/>	
Other Legal Issues? <i>Please Define:</i> _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	
Are the hours of outpatient treatment problematic? (i.e. Are nights and weekends offered or are youth missing part of school or work to go to mental health outpatient appointments?)	<input type="checkbox"/>	<input type="checkbox"/>	
Are waiting list times available for youth who need services?	<input type="checkbox"/>	<input type="checkbox"/>	
Non-RHY Mental Health Provider's Perception of RHY Population	<input type="checkbox"/>	<input type="checkbox"/>	
Youth's Perception of Mental Health Service Providers (This will also be addressed in the focus groups)	<input type="checkbox"/>	<input type="checkbox"/>	
Distance of Mental Health Services: Are services too far for youth to travel?	<input type="checkbox"/>	<input type="checkbox"/>	
Location of Services: Are the services housed in a youth- accessible/ friendly location, (i.e. easy to find, not overly corporate or clinical setting, etc.?)	<input type="checkbox"/>	<input type="checkbox"/>	
Are you or the youth concerned about Confidentiality of their mental health status?	<input type="checkbox"/>	<input type="checkbox"/>	
Do staff or youth have difficulties meeting Criteria for Mental Health services access? (What specifically? i.e. diagnosis, behavioral indicators of mental illness, age, location, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Do you find that the forms are too onerous? (Do the requirements outweigh the benefits?)	<input type="checkbox"/>	<input type="checkbox"/>	
Are there accessible mental health professionals in the community trained or specialized in adolescence or adolescent development?	<input type="checkbox"/>	<input type="checkbox"/>	

What trainings are done for staff specific to mental health issues and are they regularly offered?	<input type="checkbox"/>	<input type="checkbox"/>	
Is Transportation a concern for the youth or the agency with Mental Health Service access?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you finding OMH programs unnecessarily moving youth into the adult system	<input type="checkbox"/>	<input type="checkbox"/>	
Do you find Adherence to medication prescribed a barrier to youth accessing/ maintaining mental health services?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the risk of missing school, due to hospitalization, potentially affect the youth accessing services?	<input type="checkbox"/>	<input type="checkbox"/>	
Are youth encouraged or unnecessarily pressured to participate in Mental Health Services whether or not the young person feels they need to go?	<input type="checkbox"/>	<input type="checkbox"/>	

EXISTING RESOURCES		IDENTIFY SPECIFIC PROGRAMS IN YOUR COMMUNITY / COUNTY	
THERAPEUTIC		<input type="checkbox"/> In-Patient	<input type="checkbox"/> Out-Patient
		<input type="checkbox"/> In-Patient	<input type="checkbox"/> Out-Patient
		<input type="checkbox"/> In-Patient	<input type="checkbox"/> Out-Patient
		<input type="checkbox"/> In-Patient	<input type="checkbox"/> Out-Patient
PSYCHIATRIC		<input type="checkbox"/> In-Patient	<input type="checkbox"/> Out-Patient
		<input type="checkbox"/> In-Patient	<input type="checkbox"/> Out-Patient
		<input type="checkbox"/> In-Patient	<input type="checkbox"/> Out-Patient
		<input type="checkbox"/> In-Patient	<input type="checkbox"/> Out-Patient

ALTERNATIVE		<input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient
		<input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient
		<input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient
		<input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient
SUPPORT GROUPS		
SUBSTANCE USE	SPECIFIC PROGRAMS	
RESIDENTIAL TREATMENT CENTERS		
OUT-PATIENT		
ALTERNATIVE		
Mandated Services: Specific Programs <i>(In each box below, name the specific Mandated Services agencies and summarize the services each provide, one agency, per box)</i>		

PLEASE IDENTIFY THE SUB-POPULATIONS OF HOMELESS YOUTH IN YOUR COMMUNITY

Homeless Youth Sub-Populations	Estimated number of these youth in your community	Percentage of these youth that your agency serves	Exact or Estimated Number?	Services Geared to this sub-population in your community	Services your program provides to this sub-population
Sexual Orientation: GLBTQ			<input type="checkbox"/> Exact (date: _____) <input type="checkbox"/> Estimated		
Gender Variant / Transgender			<input type="checkbox"/> Exact (date: _____) <input type="checkbox"/> Estimated		
Aging Out of Foster Care			<input type="checkbox"/> Exact (date: _____) <input type="checkbox"/> Estimated		
Youth from Juvenile Justice / Criminal Justice System			<input type="checkbox"/> Exact (date: _____) <input type="checkbox"/> Estimated		
Goth or Other Alternative Youth: (Please Identify: _____)			<input type="checkbox"/> Exact (date: _____) <input type="checkbox"/> Estimated		
Substance Using Youth			<input type="checkbox"/> Exact (date: _____) <input type="checkbox"/> Estimated		
Pregnant/ Parenting			<input type="checkbox"/> Exact (date: _____) <input type="checkbox"/> Estimated		

**PLEASE IDENTIFY THE HOMELESS OR RUNAWAY YOUTH IN YOUR COMMUNITY EXPERIENCE
PARENTAL ISSUES**

Youth with Parental Issues	Estimated number of these youth in your community	Percentage of these youth that your agency serves	Exact or Estimated Number?	Services Geared to this sub-population in your community	Services your program provides to this sub-population
• Parents with Mental Illness			<input type="checkbox"/> Exact (date: _____) <input type="checkbox"/> Estimated		
• Substance Abusing Parents			<input type="checkbox"/> Exact (date: _____) <input type="checkbox"/> Estimated		
• Homeless Families			<input type="checkbox"/> Exact (date: _____) <input type="checkbox"/> Estimated		
• Incarcerated Families			<input type="checkbox"/> Exact (date: _____) <input type="checkbox"/> Estimated		
• Other _____ _____ _____			<input type="checkbox"/> Exact (date: _____) <input type="checkbox"/> Estimated		
• Other _____ _____ _____			<input type="checkbox"/> Exact (date: _____) <input type="checkbox"/> Estimated		

ARE THERE SPECIALIZED HOUSING PROGRAMS FOR YOUTH WITH MENTAL HEALTH CHALLENGES IN YOUR COMMUNITY?

Name of Specialized Housing Programs	Barriers to Accessing the Program

WHAT MENTAL HEALTH SERVICES DO YOUR RHY PROGRAMS HAVE TO PROVIDE TO COMPENSATE FOR LACK OF ACCESS?

<hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/>
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WHAT BEHAVIORS ARE YOUTH EXHIBITING THAT WOULD LEAD YOU TO BELIEVE THEY NEED MENTAL HEALTH SERVICES?

<hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/>
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WHAT IS THE SINGLE POINT OF ACCESS (SPOA) PLAN IN YOUR COMMUNITY?

HOW DO YOUTH FIT INTO THE SPOA PLAN?

• **DOES THIS WORK FOR RHY?**

- YES NO NOT SURE, YET

HOW DOES IT WORK/NOT WORK?

BELOW PLEASE PROVIDE US WITH COMMENTS OR CONCERNS WE HAVE NOT COVERED IN THIS SURVEY!!

THANK YOU FOR COMPLETING THIS SURVEY!



The Empire State Coalition is a membership organization using its collective voice to promote the safety, health and future of runaway, homeless and street-involved youth.

The Empire State Coalition is committed to working on behalf of runaway, homeless and street youth to ensure their rights. Youth have the right to be safe, healthy and prepared for the future.

The Empire State Coalition brings together agencies and individuals from throughout New York State who share our ideals and who, by serving youth in the full context of their families, their cultures and their communities, provide a continuum of services that works towards making that ideal a reality.

As an advocacy organization, the Empire State Coalition is a collective voice to:

- Promote voluntary strength-based services for youth and their families.
- Advocate for resources in every community.
- Share ideas and expertise; disseminate information.
- Network for a full range of quality services.
- Develop program models to meet new and changing needs.

If you, or your agency, is interested in becoming a member of Empire State Coalition of Youth and Family Services, we welcome you to apply to join us in our collaborative efforts to ensure the rights of Runaway and Homeless Youth locally, nationally or globally. For more information about this or other projects Empire State Coalition is working on, please visit our website at www.empirestatecoalition.org or contact us at:

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