



Mental Health Service Experiences Among Transition-Age Youth: Interpersonal Continuums that Influence Engagement in Care

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Abstract

Purpose. Transition-age youth (TAY) who have experienced or are experiencing complex trauma, system involvement and homelessness are at increased risk for serious mental health needs and related challenges. However, these vulnerable and historically marginalized TAY typically have low rates of mental health service engagement. This study examines how and why TAY experiencing system involvement, homelessness, and serious mental health and substance use symptoms engage in mental health services, and what facilitates and/or hinders their engagement in services. **Methods.** Twenty-one TAY completed a virtual interview about their previous and current mental health service experiences, and why they did or did not engage with mental health services. A modified grounded theory qualitative analysis approach was used to understand how participants' personal sense of meaning interacted with programmatic factors to construct participant experiences with mental health services. **Results.** Most participants (81%, $n = 17$) received mental health services, namely psychiatry (76%, $n = 16$) and counseling/therapy (48%, $n = 10$), and peer support (10%, $n = 2$). Participants described their mental health service experiences along three interpersonal and relational continuums between themselves and their providers: feeling (mis)understood, being treated with (dis)respect, and experiencing (dis)trust. **Discussion.** Study findings reveal that for these particularly vulnerable and marginalized TAY, relational and interpersonal factors significantly influenced their engagement in mental health services. Study findings call for providers to re-imagine their working alliance with highly vulnerable TAY through culturally-attuned practices that promote understanding, respect, and trust. Findings also call for TAY-serving programs and policies to re-imagine peer support as a mental health service option for this highly vulnerable population.

Keywords Vulnerable transition-age youth · Mental health service engagement · Working alliance · Provider self-disclosure · Developmental relationships

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Introduction

Background

In any given year, approximately 3.5 million transition-age youth (TAY; ages 18–25) experience homelessness in the U.S. (Morton et al. 2018). Of those, about one-third were previously involved with the child welfare system, and half had been involved with the juvenile justice system (Morton et al., 2018). TAY who are experiencing or have experienced homelessness, complex trauma, and/or system involvement are at increased risk for mental health challenges (Narendorf et al., 2020). One longitudinal study of TAY experiencing homelessness in San Francisco ($n=100$) found that 80% met the diagnostic criteria for Post-Traumatic Stress Disorder (PTSD), 74% reported depression symptoms, and 51% reported moderate anxiety symptoms (Dawson-Rose et al., 2020). This trend is neither new nor changing. Edidin and colleagues (2012) found substantial evidence in a literature review that TAY experiencing homelessness invariably presented with high levels of psychiatric disorders such as PTSD, anxiety, depression, conduct disorder, and suicidal ideation or attempts. TAY experiencing homelessness are also at an increased risk for *multiple* mental health challenges and conditions (Hodgson et al., 2013; Rhoades et al., 2018), with research estimating that nearly 70% of vulnerable TAY meet the diagnostic criteria for two or more mental health disorders (Whitbeck et al., 2004).

Despite significant mental health needs, TAY traditionally have low mental health service participation rates. Hodgson and colleagues (2014) found that despite high rates of psychiatric disorders (88%) and psychiatric comorbidity (73%), only 31% of homeless TAY ($n=90$) in a United Kingdom sample participated mental health services. Solorio and colleagues (2006) uncovered a similar low mental health service participation rate (32%) among homeless 12–20 year olds in Los Angeles.

Factors influencing TAY mental health service engagement are multi-leveled and complex. At the individual level, historically marginalized and system-involved TAY commonly cite taking pride in their independence and ability to fend for themselves (Cohen et al., 2022; Garrett et al., 2008), feeling discomfort or embarrassment for disclosing concerns and asking for help (Booth et al., 2004), fear of providers not maintaining confidentiality (Booth et al., 2004; Solorio et al., 2006), as well as simply having to prioritize basic needs (e.g., food, shelter) over physical and mental health services (Thompson et al., 2006). Historically marginalized and system-involved TAY also cite interpersonal factors, including distrust of adults as a result of their previous/current life experiences (Kurtz et al., 2000; Thompson et al., 2006), provider inflexibility with program

requirements (Thompson et al., 2006), and feeling judged or criticized by providers for their circumstances or choices (Black et al., 2018; Brown et al., 2016). Additionally, TAY cite organizational and systemic factors, such as long waitlists, inflexible operating hours (Cohen et al., 2022; Garrett et al., 2008), and referral processes that lack inter-agency collaboration and follow up (Black et al., 2018). Service cost is another systemic barrier to service use (Booth et al., 2004), especially considering that TAY are in the age group (19–34 year olds) with the highest uninsured rate at 15.6% (Conway, 2020). TAY mental health service providers echo these barriers and highlight additional barriers, including TAY lack of knowledge, stigma about mental health, lack of services, lack of TAY-friendly environments, and organizational processes (e.g., time constraints, limited TAY involvement in service development; Borah et al., 2021; Goodcase et al., 2021; Platell et al., 2017).

The Current Study

Unaddressed mental health challenges among TAY can negatively impact their successful transition to adulthood, and lead to poor educational, employment, and health outcomes later in life (Copeland et al., 2015; Dupéré et al., 2018; Goodman et al., 2011; Lee et al., 2013; Patel et al., 2007). Given the low rates of TAY mental health service engagement in, there is immense need to examine how and why TAY engage in mental health services, and what facilitates and/or hinders their engagement. Additionally, there is a need for in-depth qualitative research to unpack complicated constructs like engagement, particularly for TAY experiencing homelessness, complex trauma and multi-system involvement. As such, this study used a modified grounded theory approach to explore how and why TAY enrolled in community-based social services engaged (or did not engage in) mental health services.

Methods

The University of Texas at Austin Institutional Review Board approved this study. This study took place during the COVID-19 pandemic; all data were collected via online videoconference software for physical safety of the participants and research team.

Study Site

Participants were recruited from a large social service agency in Central Texas that serves approximately 2,200 youth and young adults annually, many of whom have complex, intersecting struggles with homelessness, mental health,

substance abuse, and trauma. The agency offers three central lines of programming: education and workforce, counseling, and housing and homelessness services. Education and workforce services include GED and literacy classes, supported employment programming, life skills training, and teen parent services. Counseling services include contracted psychiatric services; peer support; and office-based, community-based, and group counseling. Housing and homelessness services include street outreach, diversion services, emergency shelter, transitional housing (including a program for young families), permanent supportive housing, rapid rehousing, and aftercare services for youth aging out of foster care. Agency leadership and the university research team have a strong partnership, and together they designed the study in light of their shared interest in understanding the experiences of highly vulnerable TAY who receive mental health services.

Sampling Strategy

In 2020, approximately 1,023 TAY participated in agency counseling services (i.e., contracted psychiatric services; peer support; and office-based, community-based, and group counseling).

Eligibility

To be eligible to participate, TAY needed to be 18–25 years old, current or past participation in mental health services within the community, and either be currently participating in or have recently (within the past one year) received services (i.e., education and workforce, counseling, housing and homelessness services) from the agency.

Recruitment

Agency staff distributed a virtual flyer with study details and eligibility requirements through the agency's mental health and rapid rehousing client listservs (lists of eligible clients who consented to receive email communication and provided an email address). Interested TAY could call or text the research team to learn more about study participation.

Data Collection

The research team conducted interviews virtually using a secure, HIPAA compliant videoconferencing software. Interviews were approximately 60 min in length, audio-recorded, and transcribed verbatim. The agency and university research team collaboratively developed the interview protocol which explored current and previous mental health treatment experiences through the following questions:

“How would you describe your relationship with your mental health providers? What kinds of mental health services did you receive when you were younger? When you compare your experience now with the services you had when you were younger, what is different?” The research team inquired about participant socio-demographics (i.e., gender, race, ethnicity, sexual orientation, education), current mental health status, mental health diagnosis, substance use, and system involvement via participant self-report. Participants received a \$25 electronic gift card via email at the end of the interview.

Data Analysis

This study used a modified grounded theory qualitative analysis approach (Charmaz, 2004). This study sought to deeply understand service experiences among highly vulnerable TAY to construct a theory around how and why vulnerable TAY engage in mental health services, and what facilitates and/or hinders their engagement. A modified grounded theory methodology was applied – all interviews were co-facilitated by two members of the research team and led by the first author. All interviews were completed before any analysis took place. To ensure trustworthiness of study findings, the research team used investigator triangulation methods in which multiple researchers independently analyzed study data (Lincoln & Guba, 1986). First, the coding team (first and second authors) independently listened to interview recordings, iteratively read interview transcripts, and produced written memos. Upon completion, the coding team then collaboratively created a matrix of participant characteristics and mental health treatment experiences, using the following codes: service type participated in (or not), conditions that led to participation (e.g., system-involvement, referral source, age, relationship with provider) and consequences (e.g., changes in mental health, avoidance or pursuit of future services). Initially, the coding team focused on analyzing differences in how participants described their child and adult mental health service experiences. However, through frequent discussions among the research team, the relational aspects of mental health service experiences remained consistently salient across child and adult services as barriers and facilitators to engagement. New analytic questions emerged, and codes were reorganized to examine how and why participants felt (mis)understood and (dis)respected, and experienced (dis)trust in their interactions with child and adult service providers, which are detailed in the model described below.

Table 1 Participant Description, n=21

	N (%)
Gender	
Female	16 (76)
Male	4 (19)
Transgender/Gender Non-Conforming	1 (5)
Race/Ethnicity	
Black/African American	5 (24)
Hispanic*	3 (14)
Hispanic White	6 (29)
Multi-racial	3 (14)
Non-Hispanic White	4 (19)
Sexual Orientation	
Heterosexual	17 (81)
LGBTQ	4 (19)
Parenting	11 (52)
History of Homelessness	18 (86)
Justice System Involvement	15 (71)
Child Welfare System Involvement	11 (52)

*“Hispanic” represents participants who indicated Hispanic ethnicity and “other” for race.

Participants

Thirty-six participants contacted the research team to learn more about participation in the study, 28 were eligible to participate and signed the study consent form, and 21 completed an interview. Seven individuals consented but did not complete an interview, possibly due to competing priorities, changes in availability, forgetfulness, and/or disinterest. Of the 21 who completed an interview, 76% ($n=16$) identified as female, 43% ($n=9$) identified as Latinx, 24% ($n=5$) identified as Black/African American, and 19% ($n=4$) identified as LGBTQ. Half of participants (52%, $n=11$) were parenting. Most participants (86%, $n=18$) had a history of homelessness, 71% ($n=15$) had previous justice system involvement (e.g., probation or arrest for trespassing, truancy, family violence), and 52% ($n=11$) had current or previous child welfare involvement (i.e., engagement with Child Protective Services (CPS), foster care placement). Additional details about participant demographics are in Table 1. Relative to the overall population of the agency, those who participated in the current study were more likely to identify as female, and a greater proportion reported parenting, having a history of homelessness, and experiencing systems involvement. The research team assigned pseudonyms to protect participant confidentiality.

Table 2 Participant Mental Health Service Histories, n=21

	N (%)
Mental Health Struggles*	19 (90)
Anxiety	9 (43)
Depression	15 (71)
Attention Deficit Hyperactivity Disorder (ADHD)	8 (38)
Other (i.e., PTSD, insomnia, psychosis)	11 (52)
Child Mental Health Services*	17 (81)
Counseling/Therapy	12 (57)
In-patient Treatment	4 (19)
Out-patient Treatment	1 (5)
Psychiatry	11 (52)
Adult Mental Health Services*	17 (81)
Counseling/Therapy	10 (48)
Peer Support	2 (10)
Psychiatry	16 (76)

*Some participants indicated multiple categories; counts per category are not mutually exclusive.

Results

Mental Health Status & Service Engagement

Most participants (90%, $n=19$) reported experiencing struggles with their mental health and engaging in mental health services. Although some reported PTSD, insomnia, and psychosis, the most common mental health challenges were depression (71%, $n=15$), anxiety (43%, $n=9$), and ADHD (38%, $n=8$). Most (81%, $n=17$) participated in mental health services before age 18, with 57% ($n=12$) participating in counseling or therapy and 52% ($n=11$) in psychiatry and medication management. More than half (57%, $n=12$) began services in early adolescence (ages 12–16), via perceived parent/caregiver or child welfare system mandate. Most (81%) also participated in mental health services as a young adult (18 or older), namely psychiatry (76%, $n=16$), counseling/therapy (48%, $n=10$), and peer support (10%, $n=2$). Additional details about participant mental health service histories are in Table 2.

Given participants' co-enrollment in multiple programs at the agency (e.g., education and workforce, counseling, and housing and homelessness services), they sometimes reflected broadly on their service experiences, not strictly on their mental health service providers.

Interpersonal Continuums and Mental Health Service Experiences

Participants described their mental health service experiences along three interpersonal continuums between themselves and their mental health providers: *feeling (mis) understood, being treated with (dis)respect, and experiencing (dis)trust*. Figure 1 depicts these continuums. These

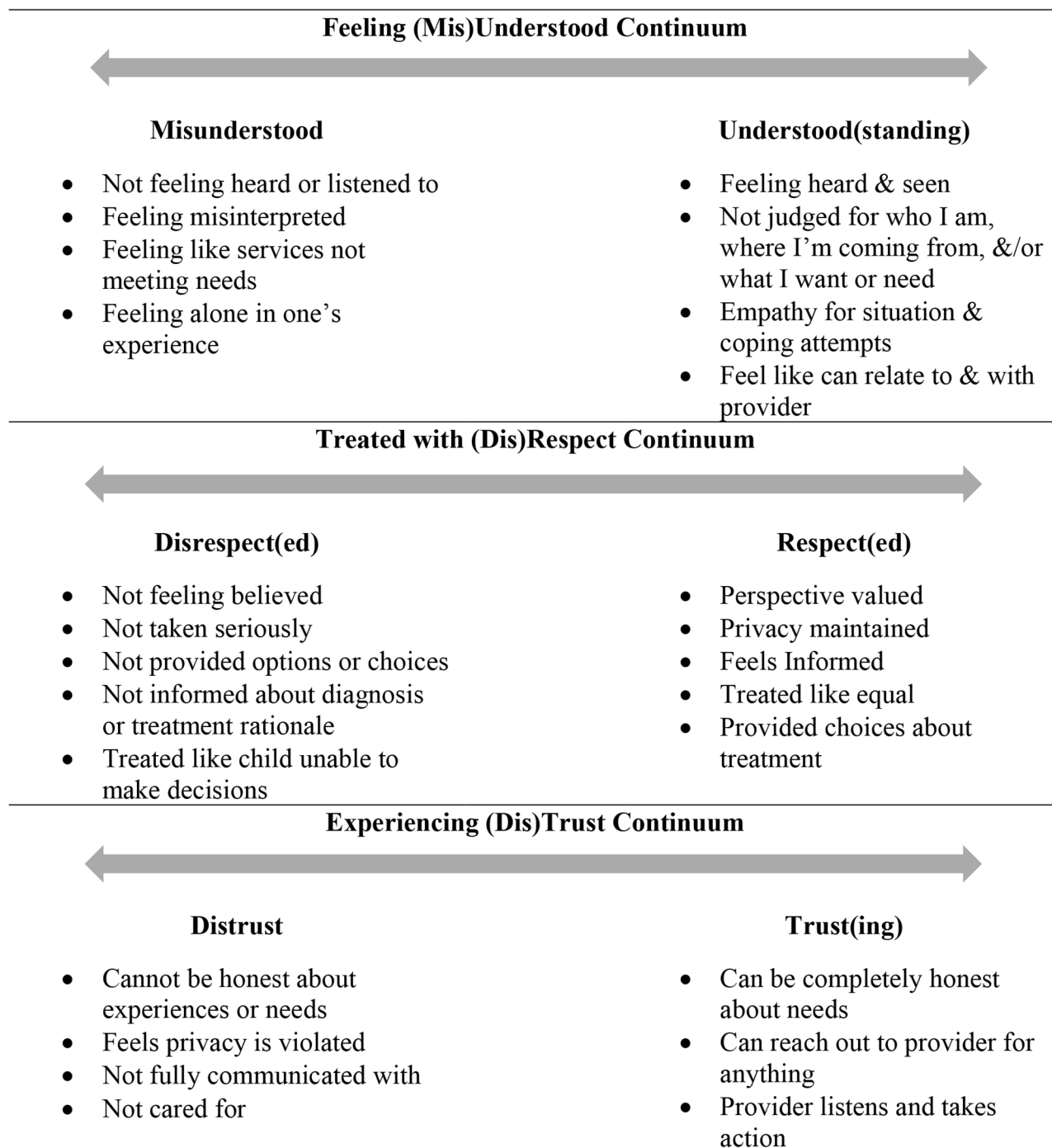


Fig. 1 Interpersonal and Relational Continuums Between Participants and Mental Health Providers: Themes and Key Experiences

client-provider interpersonal experiences are particularly relevant for this marginalized, under-studied population, as they appear to shape mental health service engagement and outcomes. These three interpersonal concepts are inter-related and thus challenging to disentangle. However, they are grounded in the perspectives of multi-system-involved TAY who provided salient examples of how these core

interpersonal experiences are critical for their engagement in and perceived benefit from mental health services.

Feeling (Mis)Understood

When reflecting on their mental health service experiences, participants frequently described whether or not they felt

providers understood them—who they were, where they were coming from, and/or what they wanted from services—and were “understanding” of their behavior (e.g., ambivalence about treatment, use of harmful coping strategies, difficulty self-regulating emotion). Unsurprisingly, feeling understood was consistently described as critical for establishing a trusting relationship, one in which participants felt safe enough to be open and honest about past traumas, risk-taking, relationships, and mental health.

Additionally, participants emphasized the importance of provider authenticity and self-disclosure in cultivating the sense of feeling understood. Having bounced between four different therapists and a psychiatrist in the previous two years in foster care, 20-year-old Alicia, now receiving peer support, expressed appreciation for provider interactions that felt more mutual:

“I’m not the one talking the whole time, like I have people who [are] like, ‘So let me tell you a little bit about myself, you know, the things that I went through,’ and it kind of makes me feel more comfortable.”

Alicia explained that hearing her peer provider’s experiences let her know that she is “*not alone going through struggles; that other people, even if they’re successful, that they been through things, too.*” This was especially important, given her earlier experiences with therapists: “*They just want you to talk the whole time and I can’t do that.*” Alicia also recalled being “*too shy*” to speak to the psychiatrist about the significant negative side effects she experienced from ADHD, depression, and anxiety medications, which eventually led her caregiver to halt her pharmacological treatment—a decision Alicia has sustained despite daily experiences of distressful mental health symptoms.

Similarly, 19-year-old Valencia was no stranger to mental health services, having rotated through several foster care placements, group homes, and correctional facilities until she aged out of care at age 18. When asked about the services most helpful to her, Valencia named the “community peer support,” she participated in while at a domestic violence shelter. She expressed feeling inspired by “*people that have gone through what you’ve gone through, and you live with them, and you talk to them, and you get to know their story, and get to know them and know their journey.*” Learning about peers’ and providers’ past struggles conveyed to participants that they were not alone, nor “the problem.”

Providers’ self-disclosure needed not be deep or overly personal in order to be meaningful to participants, however. Alyssa, a 24-year-old mother of three, identified her case manager as the “*one person who I can open myself up and tell her anything,*” and indicated her provider shared a bit

about herself through casual conversations that were not clinical in nature or explicitly structured:

We [my housing case manager and I] talk every other week. She asks, you know, if I need anything, if I have anything new that’s going on that I need to update her about. She’ll ask about my kids. I’ll ask about her dog, but we have a good relationship.

Shanelle, a 21-year-old mother who participated in variety of mental health services in early adolescence, described how her current experience stands in contrast. A recent life-threatening car accident led her to reconsider and consult with a psychiatrist regarding her ADHD. Though a positive experience overall—“*We spoke, I told her my issues, what I felt like and all that, and she prescribed something and then I asked questions about it, she gave good answers*”—Shanelle highlighted her provider’s unwillingness to connect on a more personal level: “*I asked her questions afterwards, and she was like, ‘Oh, I’m not comfortable sharing with you.’ But I just got through sharing so much stuff about me with her.*” Shanelle’s frustration highlights how mental health providers’ lack of self-disclosure can reinforce the professional nature of the working alliance and the intrinsic power imbalance between service providers and recipients, ultimately alienating and stigmatizing some TAY seeking treatment for their mental health distress.

Participants also described how *provider age* impacted one’s sense of feeling (mis)understood. Raul, now 21 years old, recalled that in his two years of care in child welfare and adoption processes, he saw multiple providers (i.e., case managers, therapists, at least five psychiatrists), but felt none of them were helpful: “*Just wasn’t the right kind of fit ‘cause, like, just the age difference. It was a different level of understanding.*” Raul shared that he now meets with a psychiatric nurse practitioner who, while not near-aged, listens to him and supports his decisions about medication for his anxiety, depression, and PTSD. Yet, his feedback remains the same: providers should be closer in age to clients because: “*It’s just easier to communicate. (...) People tend to gravitate more towards people in their age range.*” For 20-year-old Julio, who previously participated in mental health care through substance use treatment facilities and juvenile justice system referrals, it was not simply the actual age difference, but more so how middle-aged and older adult providers perceived and treated him. Being responsible for his siblings at a young age, Julio saw himself as a mature adult yet felt providers did not see nor treat him as such, thus leading him to feel that his providers misunderstood him. Julio described:

I tend to be a little more honest [now] than I was when I was younger because... some of them [child psychiatrists] would always try to downgrade me as a child... [but] when I talk to the psychiatrists at [agency], they're more understanding [about his behavioral issues and coping mechanisms].

Because Julio's child providers did not understand his early maturation, he felt he could not trust them with the details needed to inform his mental health care. In contrast, his adult providers valued understanding his experiences and used that information to inform his care.

Treated with (Dis)Respect

Being heard and believed emerged as central to feeling respected in the working alliance between participants and providers. Participants felt respected when their providers equipped them with information to make choices about their treatment, and perhaps more importantly, when providers supported their decisions. For example, 18-year-old Bryce described working with a string of different mental health providers through CPS and foster care, but what differentiated his current adult providers from the providers of his youth was that they ensured he was informed and gave him choices. *"They [agency providers] always try to make it obvious that you are the client, so it's going to be up to you... There's very little thing that you can't really choose for yourself."* Being informed about his multiple mental health diagnoses and being able to make choices about his medications facilitated Bryce's increasing treatment engagement, contributing to his health and recovery.

Participants also experienced respect in their mental health services when they felt like an equal partner in decision-making processes. Participants recognized that given their professional role, providers were more knowledgeable about mental health diagnoses and service options, but participants felt respected when their questions, ideas, and perspectives were heard, considered, and integrated. For example, Shanelle described:

I wouldn't say we have an equal say in things because obviously that's her [psychiatrist] job and she knew more about the medicine that I did... like if I disagreed with something, I'm sure she would [have brought] up another option.

Of particular importance was the way in which participants felt respected by mental health providers who successfully navigated working alliance power differentials. This was important for Maria who, despite having severe depression and engaging in self-harm, was often treated like a

"whiny pre-teen" and rarely taken seriously by the providers of her youth. Maria, now 20 years old, explained, "I don't feel like she's [counselor] like ever like acting more like superior than I am. I guess, I just feel like she's counseling me, like almost like kind of like a friend. But, you know, professionally."

The experience of genuinely being treated as a "normal" person who has a valuable perspective and lived/living expertise that they bring to services was novel for these often-marginalized participants. Most were quick to describe how disrespected they felt in their interactions with previous mental health service providers. Participants felt disrespected when their service options were limited and when they were forced to comply with a prescribed treatment regimen that they disagreed or felt uncomfortable with. Feeling like their perspective was not heard or valued occurred in relation to feeling forced to comply with prescribed medications. This was true for 18-year-old Courtney who spent time in psychiatric hospitals and behavioral health residential treatment programs throughout her childhood for mood swings, anxiety, and suicidal ideation. Courtney lamented:

"They [mental health providers] were just like, kind of like forcing meds down my throat in a sort of sense... It's just when I was younger, they just said, 'Oh, you know, go take your meds, go take your meds, go take your meds'... I didn't really have a choice in anything."

Participants felt disrespected when they were not informed about their prescribed treatment regimens. Twenty-two-year-old Nicole, who experienced multiple stays at inpatient psychiatric hospitals throughout her adolescence, best exemplified this: *"There was times whenever they gave me medicine and didn't tell me what it was for or didn't tell me how to recognize what's helping and what's not."* The lack of explanation and transparency about the process felt disrespectful, and paired with not being heard or valued, led multiple participants to stop taking potentially helpful medications. For example, Shanelle explained: *"I stopped taking my pills, because I didn't like that psychiatrist. She tried to accuse me of lying one time when I tried to tell her how I felt about like how the pills making me feel."*

Experiencing (Dis)Trust

As outlined above, feeling understood and being treated with respect were critical characteristics of participants' relationships with their mental health providers. While simultaneously distinct and interconnected, these characteristics also amounted to an integral relational experience between participants and their providers that influenced mental health

service engagement: trust. Participants described trust as their ability to be completely honest with their providers about their circumstances, needs, and choices. Twenty-four-year-old Alyssa, who experienced trauma and distrust with child welfare and juvenile justice system providers as an adolescent, described what made her feel like she could trust her current provider:

“My case manager, she’s one person who I can open myself up to and tell her anything, and she’ll try to give me like the best advice or best solution that she can. Or if I just need to vent and rant, she’ll have her ears open to listen.”

Provider accessibility and frequent communication was central to participants experiencing trust. Participants often described trusting their providers because they were reliably “there,” meaning that participants could contact their providers at any time, by any means, with any need—and that providers would not only respond, but also take action. For example, Destiny, a recently homeless 23-year-old single mother of three young children, often sought her case manager’s support in meeting her family’s needs (e.g., household goods, diapers). To this, Destiny remarked, *“Anything I need, she’s [case manager] gonna try to get it.”* Many participants felt that their current providers had their best interests at heart and were dedicated to their wellbeing because providers supported participants with a variety of issues (e.g., obtaining insurance, birth control, food assistance; navigating relationships with family or intimate partners; navigating work schedule challenges) in conjunction with their mental health.

The sense that participants could bring whatever they wanted to their mental health provider and it would be accepted and not judged—and that they could reach out when they most needed support, and it would be responded to efficiently and effectively—was particularly novel for these participants who had long histories of distrusting adult service providers. For some, distrust in providers manifested through poor communication (e.g., providers are non-responsive or give vague and sometimes conflicting answers), privacy violations (e.g., providers sharing medical records with client’s family without their consent), and/or feeling emotionally and psychologically unsafe (e.g., providers not believing participants’ perspectives). For example, 23-year-old Cesar, who experienced manic episodes with psychosis, felt overlooked in a school-based counseling program:

...I never really felt like I was getting help. They [school counselors] would just tell my mom stuff. Like someone told my mom that I had like sociopathic

tendencies and stuff, but they never tried to work with me on these issues that they said I had. They would just kind of talk about it with my mom.

Some participants experienced negative consequences when sharing mental health struggles with providers, as it resulted in medication prescriptions, or at times, more intensive treatment (e.g., psychiatric hospitalization, residential care) or a placement change. This was true for 21-year-old Belinda who despite being maltreated and molested as a child, was fearful when the state child welfare agency intervened:

“...I felt like they were there to hurt us. I was scared to open up to them, to tell them anything, any part of the truth because I felt like they were going to hurt us. Like they just want to find out all our details just to take us apart, tear us down.”

After experiencing homelessness for three years, Belinda connected to mental health services through the agency’s rapid rehousing program. Because of her history of distrust with helping professionals, Belinda described how it was initially terrifying to be fully honest with her providers (e.g., informing psychiatrist about her daily tobacco, synthetic marijuana, and heroin use), but she felt she could *trust* them because they did not judge her, took her traumatic experiences into account (e.g., her current involvement with the child welfare system), and suggested treatment options that might be beneficial (as opposed to mandating them).

Discussion

Study findings highlight the importance of mental health service providers being relatable and actively relating to historically marginalized, multi-system-involved TAY in authentic, developmentally, and culturally attuned ways that make TAY feel heard, respected, and supported, rather than stigmatized, misunderstood, and disrespected. This study adds to the growing evidence that relational and interpersonal factors deeply matter for mental health service engagement for vulnerable help-seeking TAY who have reason to distrust adult professionals in care systems, such as those who have experienced homelessness, trauma, and/or system involvement (Cunningham & Diversi, 2013; Edidin et al., 2012).

Across interviews, study participants did not describe the evidence-based practices or medications that helped them; rather, they described the people who provided the services and the quality of those relationships. Given that many participants had longstanding mental health struggles, behavioral struggles in secondary school, and familial abuse/

neglect/rejection—in addition to trauma exposure and long-term system involvement—it is logical that participants valued when providers made them feel heard, cared for, and valued, and treated them as capable of making sound decisions about their care.

Participant engagement with mental health services was dependent, first and foremost, on whether and how providers valued and practiced: (1) mutuality and self-disclosure for *understanding* to be experienced; (2) transparent explanations and shared decision making for *respect* to be experienced; and (3) intent listening and prompt responses to TAY needs—regardless of their relation to TAY’s presenting mental health-related issues—for *trust* to be experienced. These findings echo research by Li & Julian (2012) who found that programs for vulnerable youth are only as effective as their ability to strengthen developmental relationships “characterized by attachment, reciprocity, progressive complexity, and balance of power” (p.157). It makes sense that, given their long history as a case on a caseload, TAY with histories of complex trauma and multi-system-involvement want to be treated “like a human, not a client,” as requested by Alyssa. Study findings reinforce the importance of cultivating reciprocity and finding ways to effectively bridge or mitigate power differentials between marginalized and vulnerable TAY and their mental health providers.

Implications

Study findings have implications for improving how mental health providers engage TAY with complex histories of homelessness and system involvement. The three-factor relational and interpersonal continuums that emerged from this study can inform system, program and provider practice reforms to better engage this population in mental health services and promote wellness and related positive outcomes. First, there must be a shift in provider philosophy to deeply value and promote the working alliance. Second, program leaders, managers and providers must be trained in strategic use of self and employ strategic sharing in their work with TAY and each other. Third, systems and providers must systematically integrate near-age peer roles. And, finally, providers must tailor services to individual TAY, and support their practitioners in doing so successfully.

This requires a fundamental philosophical shift away from services being understood as transactions driven by a needs assessment conducted by an expert/practitioner to identify and treat problems in a patient/help seeker. Rather, to engage and support TAY effectively (in particular those TAY who have experienced histories of systemic injustices and related traumas, systems), programs and providers must value the cultivation and maintenance of an authentic working alliance between providers and TAY OVER diagnostic

assessment, evidence-based practice delivery and Medicaid/commercial insurance billing targets. The working alliance is composed of practitioner-participant shared development and mutual understanding of: (1) vision and goals for the work being done together, (2) tasks associated with the work being done together, and (3) a strong bond rooted in trust and respect that provides the foundation for communication and partnership (Bordin, 1979; 1989). Substantial literature documents the impact of the working alliance on evidence-based practice outcomes: the stronger the working alliance, the better the outcomes (Fluckiger et al., 2015; McLeod, 2011). Without this bond, a shared vision and accompanying tasks are difficult to achieve (Bordin, 1979; 1989). Study findings suggest that mutuality, shared self-disclosure on behalf of the practitioner and TAY, deep respect of TAY decision making, and responsiveness to TAY needs are integral for building strong working alliances. However, in today’s community mental health reality, practitioner time spent relating, validating, sharing and bonding with TAY is often beyond the scope of the strictly goal and outcomes-oriented billable service transaction. Provider efforts to build a strong working alliances with TAY, and sustaining strong working alliances should be a reimbursable activities and outcomes under Medicaid and commercial insurance fee-for-service and pay-for-performance systems.

Systems and agencies must embrace the philosophy that understanding, respect, and trust is not only to be established in providing TAY services, it must be maintained in order to promote engagement and positive outcomes. State administrators, agency executive leaders, program managers, team leaders and practitioners must participate in training and on-going professional coaching/supervision around building strong working alliances, strategic use of self, and appropriate use of self-disclosure if TAY are going to experience understanding, respect and trust within community mental health contexts. While our findings suggest that provider self-disclosure is an important factor in fostering a sense of being understood in TAY, social workers and counselors, as well as program managers and leaders, often feel unprepared to utilize self-disclosure with clients and families, hesitate to discuss it with colleagues and supervisors, and dismiss the role of theory and research in the use of this skill (Knight, 2012). Equipping mental health service providers with evidence-based guidance on the use of self-disclosure must be a priority for educators, supervisors, and administrators of those serving TAY.

State systems and providers must systematically integrate and employ peer roles to promote experiences of respect, understanding and trust among TAY in community mental health settings. Multiple study participants indicated that their positive mental health care service experiences were with providers that either were or felt like peers.

This finding is corroborated by existing literature, such as that of Hudson and colleagues (2009) who found that vulnerable TAY preferred service providers who share similar life experiences. Peer Support is an adult community mental health evidence-based practice (Substance Abuse and Mental Health Services Administration [SAMHSA], n.d.; Mental Health America [MHA], n.d.), and most U.S. states require Peer Support Specialists to earn a certificate and complete specialized training in a host of topics (e.g., recovery, advocacy, self-disclosure, self-care, maintaining healthy relational boundaries on-the-job) in order to bill Medicaid (MHA, 2019). Although the most valued shared characteristic/experience with Peer Support Specialists in adult community mental health settings is having a serious mental health diagnosis, study findings reveal that multi-system involved and/or homeless TAY especially value working with near-age providers who are able to relate to developmentally relevant TAY experiences (e.g., navigating career, independent living, and family and romantic relationships). Emerging research foreshadows beneficial outcomes: a recent study found that TAY with serious mental health needs working with near-age peers participated in more frequent visits with outpatient mental health providers (Ojeda et al., 2021). Similarly, Massachusetts' child community mental health system (serving up to age 21) found that both age and lived/living experiences as a TAY is crucial for validation and empathy, supporting TAY with their personal goals, and active engagement in care. Additional information on Young Adult Peer Mentoring and implementation guidance can be found at: <https://www.cbhknowledge.center/young-adult-peer-mentoring-overview>.

Lastly, systems, programs and practitioners, must increase flexibility around their assessment and service provision procedures for TAY with histories of system-related trauma. State systems, programs and practitioners must acknowledge the subjectivity of each participant's experiences and how each highly vulnerable TAY perceived their mental health provider's behaviors through the lens of their own history. Therefore, other than state monitoring/funding bodies prescribing specific strategies for providers to solely use with TAY, an important lesson from this study is one for tailoring services and approaches to individual TAY. What feels emotionally and psychologically safe for one TAY can be very different for the next TAY. This requires not only different techniques on the part of providers, but a genuine willingness to connect, share and support TAY in creative, non-judgmental ways. This requires staff and agency flexibility, but also a stronger system and agency focus on promoting staff wellness and resilience. If staff are to think creatively and employ new strategies with TAY, and also deeply bond and align with TAY experiencing serious struggles, then systems and agencies must fund and

support staff wellness and professional development programs. TAY provider workforce resilience effort examples include all agency staff having and employing on-the-job wellness plans, and requiring staff engage in regular reflective supervision.

Limitations

Although shedding light on the complex phenomenon of TAY engagement in mental health services, this study relies on a convenience sample that may not be truly representative of all highly vulnerable TAY. Because the findings reflect only the needs of TAY who at one time received services, the perspectives of those who have never received mental health services are not reflected in study findings. What's more, TAY who participated in the current study were disproportionately more likely to identify as female, have children, and report histories of homelessness and systems involvement, compared to their peers receiving services at the provider site. Given the complex trauma and multi-system-involvement observed among this sample, the importance of quality provider relationships may be particularly relevant for youth who might be especially disinclined to avoid seeking mental health services.

The study also was retrospective and aimed to explore all aspects of service (dis)engagement from a TAY perspective, thus limiting the extent to which the three key relational findings highlighted were specifically and deeply explored in real-time. Future research should incorporate standardized measures of (mis)understanding, (dis)respect, and (dis)trust with larger samples to better understand relational factors and their interaction with other (dis)engagement factors (e.g., transition from child to adult systems, ambivalence or denial, social support). Further, mental health professional and key social support perspectives may shed further light on reasons for service (dis)engagement for this very vulnerable population.

Conclusion

Study findings reveal that for multi-system involved, homelessness and historically marginalized TAY, relational and interpersonal factors significantly influence engagement in mental health services. Study findings call for TAY-serving system, agency and practice reforms. First, mental health services providers must re-imagine their working alliance with TAY and utilize a spectrum of culturally attuned practices that promote understanding, respect, and trust. Agencies must recruit, hire and retain staff who: enjoy being around and partnering with TAY and families, are patient and creative, can build and maintain strong working

alliances with TAY, and do not take TAY behavior personally. All mental health professionals across disciplines (e.g., social work, counseling, psychology, psychiatric rehabilitation, vocational rehabilitation, etc.) employed in TAY service settings must complete trainings in TAY development, working alliances cultivation, cultural humility and stigma, antiracism and anti-ableism, strategic sharing and mutuality, and sustaining on-the-job resilience. All TAY-serving programs and policies must integrate *Peer Support* roles both to provide direct peer-to-peer support services, and to ensure a lived/living experience representation in team meetings. And, finally, state administrators, agency executive leaders and program managers must shift the focus from prioritizing fee-for service productivity, diagnostic assessment and symptom-focused treatment to instead valuing the provider practices of deep understanding and validation, cultivating mutual respect, and establishing trust with TAY. Through re-imagining community mental health systems, programs and practices through a relational lens, TAY will engage in mental health services and experience improved wellness and related positive outcomes.

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