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Addressing the complexity of mental health care for youth experiencing houselessness

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Abstract

Children and youth experiencing houselessness have a unique set of mental health needs due to the traumatic experience of houselessness during childhood and the other adverse childhood experiences that often coincide with houselessness (van der Kolk, 2003; Wong et al., 2016). They face immense barriers in access to mental health care due to logistical factors as a result of their housing status and socio-structural factors (Krippel et al., 2020; Gallardo et al., 2020; Bradley et al., 2018). However, existing studies reveal a lack of evidence-based interventions for children and youth experiencing houselessness and a lack of insight from mental health providers for this population (Bassuk et al., 2015). Mental health providers having the best understanding of the needs of children and youth experiencing homelessness and the absence of their voices highlights the practice-research gap between providers and researchers. The qualitative research conducted in this project, in the form of interviews with two mental health care workers, demonstrates the importance of fulfilling basic needs and considering broader social context, specifically systemic racism, as the most significant factor in mental health concerns. The primary findings challenge researchers to take a macro level approach regarding how systemic racism plays a role in houselessness and to evaluate the role and impact of research.

Content Warning

This paper discusses the experience of houselessness, complex trauma, and the impact of adverse childhood experiences.

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This paper is a story of two parts, in which there are two chapters that play vastly different roles in my learning from this project. In the first chapter, I will outline my review of the literature regarding mental health needs of children and youth experiencing houselessness and the barriers they face in accessing mental health care. In the second chapter, I will describe the interviews I conducted with mental health providers to continue investigating this topic. Each chapter takes a different approach in studying the mental health of children and youth experiencing houselessness, and together they allow a broader, more comprehensive understanding.

Positionality Statement

Before outlining my learning regarding children and youth experiencing houselessness, I first acknowledge the ways in which my identities affect my lens on the topic. I am a White cis woman and I aim to work in the field of children's mental health and trauma. As someone who has not experienced houselessness, I do not intend to speak for the needs of those who have been unhoused. Additionally, due to systemic and institutional racism in the United States, marginalized and minoritized racial and ethnic groups disproportionately experience houselessness. Therefore, I am unable to fully convey the needs of this community, regardless of my best intentions to advocate alongside them. As a part of this work, I volunteer at the Listening House of St. Paul, a daytime drop-in shelter for people experiencing houselessness, which has also informed my lens on this project. Ultimately, since my personal experiences do not align with those of the group I am studying, I intend to approach the topic with an open and humble perspective, with learning as my main objective.

Chapter 1: Literature Review

Introduction

Children and youth experiencing houselessness in the United States are a group with widespread mental health concerns, and the current interventions are not adequately meeting their needs. According to Gultekin et al. (2020), over 1.3 million school-age children were houseless in 2019; this population constitutes approximately 2.5% of students enrolled in public schools (NCHE, 2021). Furthermore, 24% to 40% of school-aged children experiencing houselessness demonstrated mental health problems in need of clinical evaluation, demonstrating the prevalence of mental health concerns amongst this population (Bassuk et al., 2015). In the face of this significant need, Marcal (2017) notes that mental health outcomes remain poor, even when services are utilized at high rates, indicating the presence of barriers to care and the inadequacy of mental health services.

In this paper, I aim to investigate the current interventions for children and youth experiencing houselessness in the United States, including the key factors of who is involved in these interventions, such as the child or parents and families, and how they target the needs of children and youth experiencing houselessness. I will also consider the barriers and limitations to these interventions and how they could be addressed. To meet these aims, I will first discuss the impact of childhood trauma and houselessness, the barriers to care for this population, followed by an explanation of current interventions, the limitations of current interventions, paths for future interventions, and finally ideas for future research.

Definitions of Key Terms

In this paper, I will use several acronyms for the purpose of brevity. The focus groups of children experiencing houselessness and youth experiencing homelessness will be referred to as

CEH and YEH, respectively. The group of CEH consists of elementary-school-aged children who are experiencing houselessness along with their parents or families. YEH includes adolescents who are experiencing houselessness with or without their parents or families. The review of the literature will focus on interventions for CEH, although there is a comprehensive body of research on YEH, some of which will be considered in its applications to CEH.

Throughout this investigation, the terms “houseless” and “houselessness” will be used in place of “homeless” or “homelessness,” respectively. Firstly, Batterham (2019) synthesizes the literature about the definition of homelessness, pointing out the way in which homelessness is described as simply the lack of home. They acknowledge the complexity of homelessness through six dimensions: physical adequacy of the dwelling, stability and control, interpersonal safety, connection and belonging, financial deprivation/affordability and an affective/identity dimension (Batterham, 2019). The scope of the present paper will not allow the analysis of all of these dimensions, but will solely focus on the lack of permanent physical dwelling. Consequently, “houseless” is a more representative term. The substitution of “houseless” for “homeless” is also based on a comment made by a guest at the Listening House of St. Paul. This guest noted that they “don’t have a house, but they aren’t homeless” (Anonymous, personal communication, September 15, 2022). Thus, out of respect for this distinction, this paper will exclusively use the phrases “houseless” and “houselessness.” Although the majority of articles in the field of psychology use the term “homeless,” I will replace it with “houseless.”

Prior to further discussion, I must outline how I am using the term houselessness. For this paper, I will define a person experiencing houselessness as “an individual who lacks a fixed, regular, and adequate nighttime residence, such as those living in emergency shelters, transitional housing, or places not meant for habitation,” in accordance with the definition put

forth by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2021). This recent definition reflects the straightforward approach taken in this investigation, given that the scope of the paper will not allow a full consideration of the multidimensional nature of homelessness (Batterham, 2019).

Additionally, it is important to define the broad concept of trauma, as it is another key component of this investigation. Bessel van der Kolk (1987) cites Erich Lindemann's definition of trauma as "the sudden, uncontrollable disruption of affiliative bonds" (van der Kolk, 1987, pp. xii), explaining how trauma is an event or prolonged experience that obstructs individuals from forming secure attachments. Ongoing, repetitive trauma experienced throughout childhood is commonly known as complex trauma. These experiences could include emotional abuse and neglect, physical abuse, sexual abuse, witnessing domestic abuse, or experiencing houselessness, among many other potential adverse childhood experiences (Cook et al., 2005). Given the focus on CEH, this paper will use the term trauma to refer to complex trauma, as all CEH have experienced some form of adverse life conditions both before and while experiencing houselessness. Trauma is particularly significant in childhood because the nervous system and the brain have not fully developed, leading to more long term consequences as they grow into adulthood (van der Kolk, 1987). Thus, because it happens during this critical stage of development, trauma affects how children organize and process information (van der Kolk, 2003). As a result, this early experience becomes biologically ingrained in the way their brain functions, where the amygdala triggers a stress response too frequently due to overactivity in past experiences. This leads to a variety of negative consequences because their brain is consistently responding to a sometimes nonexistent threat as a result of evolutionary survival methods that developed to survive this trauma.

Another crucial consideration in the examination of houselessness is the way in which houselessness in the United States disproportionately affects people holding marginalized and historically oppressed identities. More specifically, race and ethnicity are a crucial axis of identity that plays a role in this discussion. Data collected by the National Center for Homeless Education (2021) demonstrates this disproportionate effect in the United States through the education system because Black and African American students comprise 15% of the student body, but they represent 27% of students experiencing houselessness. Similarly, Hispanic and Latinx students accounted for 28% of the student body, but 38% of those experiencing houselessness. Conversely, White students made up 46% of the student body, yet only 26% of the students experiencing houselessness. Additionally, of all students experiencing houselessness, 19% were students with disabilities, 17% were English learners, and 1% were migratory students, meaning that other marginalized identities in addition to racial and ethnic groups also have disproportionate effects. Thus, research demonstrates that children holding marginalized identities are disproportionately likely to be experiencing houselessness.

Impact of Childhood Trauma and Houselessness

As discussed, CEH often experience ongoing trauma both before and while experiencing houselessness. Thus, it is important to understand the impact of childhood trauma and houselessness, specifically how these experiences interact and lead to a variety of negative short-term and long-term consequences.

Educational Consequences

Many of the effects of houselessness and trauma in CEH are experienced in the classroom. The Council on Community Pediatrics (2013) describes the way in which CEH often experience a disruption in their education due to transience and housing instability. For example,

if a child's family moves locations frequently, it will be more difficult to attend school consistently, and it might mean switching schools is common. As a result, CEH are either not routinely attending school or not in one school long enough to build relationships; thus, in both of these scenarios, the sense of belonging in school is obstructed. They may lack a consistent social support system from an educational setting. However, a sense of belonging in school is crucial for children's wellbeing and academic success (Parker et al., 2022). As a result, not only are CEH dealing with previous and current traumatic experiences, but houselessness may further impede social development and academic achievement by obstructing a sense of belonging in schools. Furthermore, CEH are unable to engage in the same way as their peers due to the effects of trauma and houselessness on their socioemotional development (Chow et al., 2022). In elementary-aged children, these effects could present as difficulty with emotion regulation, difficulty developing peer relationships, or withdrawn behavior, amongst many other possibilities. For example, Brumley et al. (2015) employed the Problems with Classroom Engagement Scale, meaning the teachers identified the student's capacities to work cooperatively with peers, follow directions, and ask for help. Based on their findings, Brumley et al. (2015) drew a connection between houselessness and social engagement problems in 1st grade students, noting that CEH had significantly higher rates of problems with social engagement compared to their housed, low-income peers. Because these findings were based on the teachers' perceptions of their students, the findings raise the role of teachers of CEH as another educational factor to consider.

Similarly, Lafavor et al. (2020) found that teachers perceive CEH as less engaged and less competent compared to their housed peers, regardless of objective test scores. Furthermore, the teachers did not rate the students as having emotion regulation issues, indicating that they did

not attribute perceived problematic behavior to an emotional experience; they more likely viewed these behaviors as intentional and attributed the blame to the student, rather than to the student's life circumstances. Although these behaviors are often considered problematic in educational settings, CEH experienced disproportionate negative attributions as a result. Overall, due to their current housing status, CEH are disadvantaged in academic settings due to disruption in education, more difficulty establishing a sense of belonging, and teacher's biases.

Long-term Outcomes

The body of research on trauma and houselessness also reveals many long-term outcomes predicted by these experiences in childhood. For example, Davies and Allen (2017) found that adverse childhood experiences such as houselessness lead to increased risk of street victimization, compounding on the pre-existing symptoms of trauma. In addition to increased risk of victimization, people experiencing houselessness or people who have experienced houselessness in the past are also at increased risk of involvement in the criminal justice system (Edalati & Nicholls, 2019). More specifically, Edalati and Nicholls (2019) cite Fox et al. (2015), who found that amongst 22,575 youth involved in the criminal justice system, each adverse childhood experience led to a 35% increase in being a serious, violent, or chronic juvenile offender. Additionally, the criminal justice system serves as a site for further traumatic experiences, indicating the potential for additional trauma. Ultimately, due to the way in which houselessness acts as an adverse experience and frequently coincides with other traumatic experiences, CEH have an increased risk of becoming involved in the criminal justice system.

In part due to the mental health concerns amongst this population, people experiencing houselessness also endure circumstances that perpetuate the cycle of poverty and housing instability (Winiarski et al., 2021). Without access to adequate mental health care due to

immense barriers, people experiencing houselessness may have a more difficult time with finding stable employment and housing. As a result, CEH are also more likely to have the same experience in adulthood due to the profound consequences of adverse conditions in childhood. Thus, not only do CEH experience the consequences of houselessness while they are without a stable shelter, they also experience increased risk of other adverse outcomes in adulthood.

Consequently, interventions are needed at an early age to protect and prevent these long-term consequences. There is a large body of research on the long-term impacts, revealing experiencing houselessness and other adverse childhood experiences lead to a multitude of negative outcomes. For example, Flach and Razza (2022) also note the increased suicide risk for YEH, partially due to risk factors including history of abuse, negative coping mechanisms, and duration of houselessness. Due to the way in which all of these life experiences integrate together, the result is overwhelming life circumstances and mental health concerns, leading to the increased risk of suicide. Knowing this risk, it is important to intervene whenever possible, but also aim to address the mental health effects of houselessness and trauma in CEH in hopes of limiting the predicted consequences that are experienced in childhood, adolescence, and into adulthood.

Intersection of Trauma, Houselessness, and Mental Health

The issues of trauma and houselessness are closely interrelated and this connection has profound consequences for the mental health of this population. As a result, CEH are significantly more likely to have a mental health concern than their housed peers (Bassuk et al, 2015). The loss of stable housing can be particularly impactful for children because their brains are developing and they are learning their social role by interacting with peers and adults. However, their development is significantly hindered because during this critical period of social

growth, they must simultaneously manage the consequences of experiencing houselessness, such as a loss of possessions, changes in family or friend relations, and changes in daily routines (Gultekin et al., 2020). Due to the consequences during a crucial time of development, CEH are at risk for poorer mental and physical health, as well as diminished social and educational outcomes due to their housing needs and the impacts of housing instability.

CEH experience a variety of mental health concerns. In comparison to their housed peers, CEH and YEH have a disproportionate likelihood of experiencing many mental health disorders (Cauce et al., 2000). According to one study with houseless youths, the researchers found that 21% met the criteria for major depression or dysthymia (MDD), 12% experienced PTSD, and 45% reported attempting suicide in the past. These results demonstrate some of the mental health needs of this population, although the individual needs depend on the experiences of a specific person.

In many ways, it is helpful to regard these diagnoses as symptoms of trauma, as trauma is the most common underlying element behind these mental health concerns. Trauma is the most common risk factor among YEH (Winiarski et al., 2021). In a study investigating the impact of trauma before or since children have become houseless, 70% of the participants noted growing up in an adverse home environment, in which emotional abuse or neglect was the most prevalent (Wong et al., 2016). Consequently, YEH have a greater incidence of mental illness than their counterparts with stable living situations. Potential implications from this increased risk include substance abuse, victimization, PTSD, sexual abuse, survival sex, involvement in criminal justice system, or ongoing houselessness (Gultekin et al., 2020). Additionally, experiencing houselessness functions as another adverse experience that can compound on preexisting trauma. Thus, when the individual begins experiencing houselessness, they have a greater risk for mental

illness. Given the way in which trauma from before, during, and after the experience of houselessness all interact and compound, CEH have unique mental health concerns. Left unaddressed, this can perpetuate the cycles of poverty and housing instability among high-risk individuals or families (Winiarski et al., 2021). Overall, CEH are often exposed to traumatic childhood experiences before and during the experience of houselessness, leading to a series of maladaptive stress reactions. The experience of houselessness can exacerbate previous trauma, furthering the mental health needs of this population.

Role of Parents

Given that CEH are experiencing houselessness along with their parents or families, it is also important to consider the role parents play in the mental health of their children. The parents are significant both in their individual traits and their approach to caregiving. For example, the executive functioning of the parents, meaning their cognitive abilities, predicted symptoms of Post-Traumatic Stress Disorder (PTSD) and Attention Deficit Hyperactivity Disorder (ADHD) diagnoses in YEH, where decreased parental executive functioning was correlated with more PTSD and ADHD symptoms in their children (Lafavor et al., 2022). These findings suggest the importance of parents in the outcomes of their children due to biological influence and modeling behaviors. Ultimately, Lafavor et al. (2022) emphasizes how the parents have a significant impact on their children due to their genetics and environment. More specifically, parenting behavior in families experiencing houselessness could be affected by the parents' negative self-concept in the parental role, parental mental health, difficulty with self-efficacy, as well as availability of material resources, amongst other factors (Bradley et al., 2018).

Resilience is another factor in parenting, as Narayan (2015) highlights the immense importance of resilience in people experiencing houselessness. Their systematic review reveals

that psychological resiliency, determined by various behaviors and beliefs by the parents, supports positive functioning. This specifically applies to parents experiencing houselessness with dependent children, as they have a unique set of needs and challenges because they must manage many critical responsibilities simultaneously, including parenting. Therefore, the role of parents must not be understated when examining the mental health of CEH.

Barriers to Care

Given the clear need for adequate mental health care for CEH, the barriers to healthcare access must also be considered. There are both logistical and socio-structural obstacles that prevent accessible care.

Logistical Barriers

In terms of logistical barriers, it is first important to acknowledge the ways in which experiencing houselessness is in itself a barrier to care (Krippel et al., 2020). Mental health interventions require a trusting relationship between CEH and a safe adult, but given the high mobility of this population, their frequent moves between locations may be another barrier to consistent mental health care with an effective therapeutic relationship. Logistical obstacles can include transportation to facilities if they are not in a supportive housing unit, or physical location if the family or child is highly mobile due to housing instability. Another study found that the most common obstacle was the high-barrier healthcare service delivery system, referring to the documentation requirements and multiple steps needed to access care (Gallardo et al., 2020). For example, temporary shelters or services may require legal identification or documentation, which could be a barrier. Ultimately, the elaborate steps to receive care serve as an additional logistical obstacle for families and children in need.

Several researchers have investigated the barriers in access to mental health care for YEH on the one hand, while also acknowledging the facilitators on the other hand. Firstly, amongst other factors, Gallardo et al. (2020) describes how affordability can function as a barrier and facilitator for mental health care accessibility for youth. More specifically, they found that affordability often functions as an obstacle if there are limited free or low-cost services, but can serve as a facilitator when the opposite is true. Furthermore, the overall findings suggest that the way in which the healthcare system operates is not conducive to the adequate treatment of YEH. Additionally, another study examined the facilitators and barriers of use of drop-in shelters by YEH (Pedersen et al., 2016). They found that staff characteristics can play a large role in using resources, where staff described as warm and open facilitated the use of drop-in shelters, but staff who seemed judgemental dissuaded YEH from using those resources. They also found that YEH preferred drop-in shelters that had greater perceived confidentiality, less paperwork, and fewer rules and restrictions, in addition to other logistical factors such as transportation and cost. As a result, it is clear that there are many social and emotional components in a decision whether to seek healthcare services, but oftentimes it may not even be an option due to overwhelming logistical barriers to physically access care.

Socio-structural Barriers

In addition to these logistical barriers that prevent CEH from accessing care, social and systemic structures can also play a role in impeding mental health services. For example, wariness of mental health services and the requirements for care can further the inaccessibility of services. Wong et al. (2016) note that many YEH are disenfranchised from or distrustful of traditional mental health services. Therefore, effective trauma treatment must be embedded in service systems that have already proven to promote engagement from this population, including

programs taking place in schools or accessible extra-curricular activities. Additionally, for the younger population of elementary-age children, engaging the parents in their child's treatment is another key factor for implementing effective services.

Parents experiencing houselessness with their children are faced with a unique set of challenges, often juggling heavy financial burdens and their own mental health on top of caring for their children (Bradley et al., 2018). Thus, there are many determinants of parenting behavior. In addition to coping with limited resources and their own mental health, other factors could include lack of support, as parents experiencing houselessness may not have childcare support from extended family or friends. Additionally, challenges to autonomy could also influence parenting behavior, where others question the parent's ability to take care of their children and make decisions for their family due to their housing status. In other words, parents experiencing houselessness may not be perceived as competent in their parenting role, which could in turn affect parents' self-efficacy. Service context can also affect the parent's role, as the role could change depending on where families experiencing houselessness are receiving temporary housing services or mental health services. There are also challenges parents face specifically in temporary shelters. For example, cultural differences between parenting style and shelter rules could lead to an erosion of the parental role due to their inability to assert authority, leading to a potential undermining of their perceived self-competence in the role (Bradley et al., 2018). While being supervised by shelter staff, there could also be a threat of removal of children by social services, heightening the stress regarding parenting in a shelter setting.

On an individual level, parent and child characteristics can also play a role in predicting parenting practice outcomes, as studied amongst families experiencing houselessness in supportive housing (Holtrop et al., 2017). For example, parental depression predicts a poorer

treatment outcome, as does the perceived severity of child behavior problems. The attachment between the parent and the child is also an influential factor, yet results remain inconclusive regarding how this complex relationship plays a role in parenting outcome. This indicates a need to consider individual differences in mental health care, in addition to the many other factors, in order to maximize effectiveness and allow services to be accessible to all.

Current Interventions

Many interventions have been developed to address the mental health concerns of CEH. This section will first discuss interventions for housed children with common mental health concerns that also emerge in CEH, then interventions specifically for CEH, followed by interventions targeting parents and families of children with mental health concerns, and finally interventions for parents and families experiencing houselessness.

Children with Mental Health Concerns

Firstly, there are many interventions for children with mental health concerns that do not specifically focus on houselessness. Although CEH are the focus group for this investigation, it is also important to consider other interventions for children in general to gain insight into psychotherapeutic techniques that are effective for this population. Additionally, CEH experience common mental health concerns such as anxiety, depression, or ADHD as a symptom of trauma, meaning studies investigating these concerns in housed children have the potential to be applicable to CEH as well.

One common consequence for children with parent-related mental health issues is a high likelihood of internalizing, which means non-communication about the child's own feelings and experiences, and even internally taking emotional responsibility for their parents' emotional states (Graham-Bermann et al., 2021). However, multiple recent studies testing the effectiveness

of child-centered approaches have yielded promising results. For example, Graham-Bermann et al. (2021) employed a newly developed 12-session intervention program in school and community settings, titled Kids' Empowerment Program (KEP). KEP emphasizes emotional well-being by teaching children to build their emotional, social, and coping skills in group settings through developmentally appropriate activities such as games and crafts. This preliminary intervention yielded significant positive results on children's anxiety and depression. Additionally, the researchers found that children who attended more sessions experienced greater improvement in parent-related depression. This suggests that KEP effectively reaches children with parent-related mental health consequences who tend to internalize problems. Since internalization is a common symptom of children with traumatic experiences, this strategy would be similarly applicable to CEH.

The Bounce Back intervention is another school-based intervention for elementary-aged children exposed to trauma (Santiago et al., 2018). The researchers replicated this intervention with 52 students in 1st through 4th grade and primarily from low-income families. The Bounce Back intervention is a skills-building group led by a school social worker or psychologist that meets for 10 sessions. In these sessions, the students receive psychoeducation regarding the prevalence and symptoms of trauma, and then learn developmentally-appropriate strategies such as affect identification, relaxation techniques, and cognitive coping. During this timeframe, the child also meets individually with the same provider to create a trauma narrative to help process their experience. Finally, caregivers are also invited to receive psychoeducation by the same provider to explain what their child is learning in this intervention. Group sessions were delivered during the school day, which allowed high accessibility for the students, and about 84% of children had caregivers who attended at least one session of the program. Their results

found significant improvements in coping skills and emotion regulation and expression, demonstrating important growth in age-appropriate socioemotional behaviors. It also reduced symptoms of PTSD in children who were part of the intervention. Qualitatively, the researchers found that parents reported they were satisfied with the program and children reported enjoying it as well. Overall, these findings demonstrate a lot of success in the Bounce Back intervention in helping children with a history of traumatic experiences.

Nabors et al. (2016) took a different approach, gaining insight on treatment for trauma in young children through a focus group of counselors for children experiencing PTSD in a community-based setting. For this study, 11 clinicians were asked to discuss interventions used in outpatient therapy sessions with elementary-aged youth with PTSD. Their findings showed that play and art techniques were commonly used, and the sessions were child-led to allow the child to practice agency and control in a safe setting with a provider. They also noted that key components of therapy, according to the participating clinicians, were helping children manage triggers, cope with anxiety, promote safety and resilience, and manage dysregulation; another focus was to re-experience, release, and reorganize the trauma. Generally, their results demonstrated that there was some consensus amongst providers in the field of how to approach trauma treatment for elementary-aged children. However, there is limited consensus on how to effectively apply this knowledge for CEH, and the voices of providers have not been included in research specifically about CEH. Mental health providers have first hand experience with their clients and have a comprehensive understanding of their needs, and their insight on these topics is invaluable to inform the direction of the field.

Children Experiencing Houselessness

Although interventions targeting children with mental health concerns are relevant to the population of CEH, they do not specifically address the unique stressors associated with the experience of houselessness. Thus, there are also interventions that focus on CEH and YEH, aiming to reduce the harmful and traumatic effects of houselessness. For example, one intervention focuses on empowering children by enhancing their sense of independence. In this case, youth experiencing houselessness are integrated into the community through life skills training, emotional support, and social justice awareness (Sisselman-Borgia, 2021). As a part of this program, participants engaged in group meetings twice a week and met individually with community mentors to develop trusting relationships. These groups allowed participants to receive psychoeducation, to learn about the systems of society that contribute to their current experiences, and to consider their next steps in life. Following this intervention, the participants demonstrated improvements in coping and decreased symptoms of trauma. The qualitative data aligned with the findings of the quantitative data; youths felt more confident and hopeful about their lives, as well as more comfortable developing trusting and meaningful relationships with mentors, staff, and peers. This study was one of very few in the field that specifically tested an intervention for CEH, rather than just exploring paths for future research.

Schwan et al. (2018) furthers this body of knowledge on interventions for CEH through their research grounded in the belief that arts-based programming can promote mental wellness, social inclusion, and life skills. Their analysis revealed five key manners in which CEH use the arts as a method of coping and making meaning: manage mental health challenges, cope with stress and houselessness, recover from trauma and create ‘safe spaces’, explore themselves, and develop positive self-esteem and hopefulness for the future. Thus, these findings highlighted art

as a complex method of self-care and health-promotion, consequently portraying the importance of arts-based programming for CEH as another way to mediate the stress of their current life circumstances.

Finally, another study explored whether emotion regulation skills protect against interpersonal violence amongst YEH, which informs protective factors that should be incorporated into other interventions (Petering et al., 2018). The researchers gathered data from YEH in Los Angeles about violent experiences, emotion regulation skills, and their social network. As discussed previously, YEH experienced higher rates of violence than their housed peers and YEH were more likely to engage in fighting if they struggled with emotion regulation. The data demonstrated that YEH who scored better on emotion regulation and belonged to social networks were 60% less likely to report fighting. These findings suggest that emotion regulation is a key component of preventing violence, supporting the focus on emotion regulation in interventions. Thus, including emotion regulation skills as a part of mental health interventions for YEH and CEH could prove to make a difference in their outcomes.

Overall, the current body of research suggests that therapeutic approaches for CEH should include the opportunity to re-experience and reorganize trauma, as well as building resilience, self-esteem, and affect regulation skills (Nabors et al., 2016; Petering et al., 2018). Activities such as therapeutic play and art could be used to achieve these goals (Schwan et al., 2018). Additionally, working towards these objectives in social settings can also help facilitate healthy social interactions with peers in a way that lends itself back to the individual's development. In turn, more healthy social relationships and secure attachments can be formed, which could consequently prevent future interpersonal trauma, protect from the effects of interpersonal trauma, and help with long-term academic and socioemotional outcomes.

Parents and Families of Children with Mental Health Concerns

There are also a number of interventions targeting parents that are not specific to parents experiencing houselessness, but that still utilize an applicable framework for this investigation. For example, the Strengthening Family Coping Resources (SFCR) intervention is a manualized multifamily group intervention for people living in traumatic contexts (Kiser et al., 2015). This study tested two models of SFCR, one focused on trauma treatment for families with one child diagnosed with PTSD, the other focused on high risk children who have been exposed to trauma but do not meet the DSM criteria for partial or full PTSD. Both models employ a skills-based approach to emphasize building family coping abilities, which may have been impeded by traumatic experiences. Other activities involved in SFCR include sharing meals, storytelling, developing relaxation routines, and emotional regulation. In the trauma treatment model, the families also construct a trauma narrative together. Their results showed positive findings for the child, caregivers and families as a whole, suggesting this intervention could be promising for reducing trauma-related symptoms in kids and improving family functioning. The SFCR intervention was one of the first to focus on families rather than just the children or a parent-child dyad, and its positive results demonstrate potential success in targeting families. Due to its consideration of children with PTSD and the high prevalence of PTSD amongst CEH, this intervention is promising for families experiencing houselessness.

Similarly, Krippel et al. (2020) continued this avenue of research by examining the effectiveness of two family interventions, Baby TALK and Parents Interacting with Infants Model (PIWI), when they are applied specifically to children who are at risk due to trauma exposure. The researchers studied these interventions among 38 at-risk families of young children. As a part of this program, researchers conducted home visits approximately twice a

month for 3-4 months, as well as supplementary playgroups. The parents were surveyed before and after the intervention on a variety of measures, including those that assess social development, intellectual development, and language skills. The results found significant increases in parent knowledge of child development, meaning the parents had a stronger understanding of the needs of their child due to the psychoeducation in the home visits. For CEH, this could mean that parents have a stronger understanding of typical developmental stages for their children. At the same time, this study relies on home visits, and therefore would be difficult to replicate for CEH or highly mobile families. However, the study demonstrates that parents may identify situations in which their children do not meet those benchmarks if adverse childhood experiences, including that of houselessness, is negatively affecting growth.

Parents and Families Experiencing Houselessness

In addition to the interventions designed for parents with mental health concerns, there are also family-oriented approaches that specifically target parents experiencing houselessness to improve the well-being of their children. For example, one study examines the effectiveness of Triple P Positive Parenting Program (PPP), an evidence-based program in shelter settings for parents experiencing houselessness (Armstrong et al., 2021). The goal of the intervention is to build the knowledge, skills, and self-efficacy of parents in order to minimize social, behavioral, and emotional problems of children. PPP is a tiered service model, where parenting interventions vary depending on their current life circumstances and risk status. At a moderate level, PPP often entails discussion groups on how to improve parent-child interactions and applying positive parenting techniques to specific scenarios. Overall, their results indicated a positive effect of these discussion groups. The participants, primarily mothers, self-reported significant

improvements in parenting practices and high satisfaction with the program, demonstrating powerful implications for the potential of interventions targeting the parents of CEH.

Another approach, titled ‘Empowering Parents, Empowering Communities’ (EPEC), is a peer-led service model to communicate a parent training curriculum (Bradley et al., 2020). In this model, peers who have previously participated in EPEC act as peer facilitators and lead group sessions. Historically, this intervention has not been used for parents experiencing houselessness, but this study employed a modified version titled ‘Empowering Parents, Empowering Communities – Temporary Accommodation’ (EPEC-TA) to specifically target parents with housing needs. The curriculum includes content based on social learning, attachment, and cognitive-behavioral principles. Bradley et al. detected improvements in child behavioral difficulties and parenting knowledge and practices, but parental well-being and social support remained constant after the intervention. While improving mental health involves much more than improving operationalized “child behavioral difficulties,” the parents demonstrated engagement in their children’s care, with the goal of translating that engagement to action in the family to improve the lives of their children. Additionally, the peer-led model mitigated negative expectations of services and normalized parental experiences in challenging conditions. After this intervention, parents indicated they valued opportunities for group-based discussion of parental concerns without feelings of isolation or shame in these experiences. This study indicates powerful potential in parent- and family-focused interventions to indirectly improve the well-being of CEH.

Finally, although not empirically tested, there are a number of adaptive strategies used by parents experiencing houselessness (Bradley et al., 2018). The researchers conducted a systematic review of the literature to explore how experiencing houselessness affected parenting

behaviors and how parents could mitigate the negative impacts of houselessness on their children. Based on qualitative findings, Bradley et al. (2018) found that adaptive strategies used by parents experiencing houselessness included positive reframing, where parents reframed their situation positively by viewing houselessness as temporary. Another idea was valuing the parental role because being able to see the value in this position reinforced parenting self-esteem. Spirituality was also found to be helpful for parents, as well as practical strategies like engaging in hobbies like reading. Finally, seeking support from others proved to be particularly important, such as building community in temporary housing shelters. While these strategies have not been empirically tested, they offer some insight into tools for parents in order to cope with the experience of houselessness and maintain a healthy relationship with their parenthood and their children.

Limitations of Current Interventions

There are also many limitations to the current interventions, leading to gaps in the body of knowledge. One primary limitation in the field is the lack of empirical support for the strategies used to fulfill the needs of CEH. For example, Davies and Allen (2017) note the lack of empirically-supported interventions for YEH. These studies can often be applied to CEH as well, demonstrating a widespread need for more research on people experiencing houselessness in general. Additionally, more evidence-based mental health interventions for CEH are needed as well (Bassuk et. al, 2015). More specifically, Bassuk and colleagues make the point that there is a lot of potential in the field for programs focusing on positive parenting and children's emotional regulation, the only limitation is the lack of evidence to support these developments. Thus, there needs to be a more rigorous evaluation of program models in order to empirically assess effectiveness (Morton et al., 2020), and thus use research-based methods in treating the

needs of CEH. Overall, more evidence is needed to support these interventions and thus justify their use with CEH.

Furthermore, the current interventions require some additional considerations in order to maximize their effectiveness of meeting the unique needs of CEH. One of the biggest factors that providers must understand is the impact of trauma and the way trauma can present in school-aged children. For example, counselors' interactions with the child should be focused on coping and healing from trauma (Nabors et al., 2016). They should be prepared to engage a trauma-informed approach to understand the ways in which complex trauma affects the mind and body, and how the experience of houselessness interacts with and compounds upon other traumatic experiences. Most importantly, providers need to consider the trauma history of the individual, their social identities, and the severity of mental health symptoms like suicidal ideation or behaviors, in order to maximize the effectiveness of treatment (Walsh et al., 2021). By doing so, providers will also gain an understanding of traumatic experiences that may have occurred before houselessness, as well as any compounding trauma that has occurred since their change in housing status, thus allowing a more comprehensive and necessary understanding of the individual's lived experiences (Wong et al., 2016). This understanding will also help to make the course of treatment feel more individualized and relevant to them, which could lead to increased likelihood of client engagement.

Additionally, interventions need to understand protective factors against the effects of trauma, including resilience, coping strategies, and a supportive school environment (Flach & Razza, 2022). By focusing on empirically-supported protective factors, interventions have a larger potential for impact. As well as these components that protect against the impact of trauma, it is also important to consider what prevents or motivates people to seek help. Thus,

given the previously discussed barriers to mental health care, it is necessary to consider facilitators, or factors that encourage or motivate people experiencing houselessness to use resources available to them, such as drop-in shelters (Pedersen et al., 2016). Pedersen et al. (2016) suggest that some of these factors on the individual level include opportunity to engage with peers, self-efficacy, or access to referral resources. Other barriers and facilitators on a more structural level could include staff characteristics and attitudes, as well as structural aspects of the service such as shelter rules or documentation requirements. Understanding the way these factors act as barriers and facilitators to service use could greatly improve the field by helping guide interventions to be more effective.

In addition to understanding these protective factors, interventions also need to understand the obstacles CEH encounter when in the mental health system. For example, effective intervention requires a trusting provider-client relationship, yet the high mobility of this population serves as a paradox preventing the development of that crucial relationship. Along with other barriers, interventions must have a comprehensive understanding of how to minimize the effects of these barriers. Ultimately, as previously discussed, trauma underlies many of the consequences of experiencing houselessness. Therefore, future interventions and research should focus on ways to address trauma more directly (Winiarski et al., 2021). As a result, interventions would be more effective in understanding and confronting the needs of CEH and intervention could continue to aim to mitigate the immense barriers that CEH face in seeking mental health care.

Finally, another limitation to research on this population is the high attrition rate in studies, consequently making it difficult to develop effective interventions tailored to this population (Winiarski et al., 2021). For example, in their study investigating the effectiveness of

Triple P Positive Parenting Program in shelter settings, Armstrong et al. (2021) had a 33% attrition rate, meaning almost one third of their participants either chose to stop participating or their circumstances no longer allowed them to participate. Because families of CEH are more likely to be transient or moving between locations more frequently, they may be unable to receive consistent care. As a result, the high attrition rate in studies amongst this population not only limits the body of knowledge on treatment for CEH and their families, but also represents the inconsistency in their care due to their housing status.

Conclusions from Literature Review

In reviewing the literature surrounding psychotherapeutic interventions for CEH, it is evident that these individuals, who are disproportionately children holding marginalized identities, simultaneously have urgent mental health needs and immense barriers to accessible care. There are a number of interventions employed for school-aged children, CEH, and parents and families, contributing important information to the field in terms of interventions for CEH. However, the literature investigating predictors of child and parent intervention outcomes, as well as the moderators of treatment response, is limited and largely inconclusive (Holtrop et al., 2017). As a result, there is no widespread consensus as to the best approach for addressing the needs of CEH. The research on the effects of experiencing houselessness at a young age, as well as the common co-occurring traumatic or adverse experiences, emphasizes the urgency with which the mental health needs of CEH must be addressed.

The literature review also highlighted a key limitation of the body of literature: the absence of insight from mental health providers for CEH and YEH. Although CEH, YEH, and their families are best equipped to speak for their needs, they are a highly vulnerable population and difficult to study directly. As a result, mental health providers are the next best equipped to

speak on behalf of their clients, as they have a comprehensive understanding of their needs and the barriers they face. Incorporating the voices of mental health providers could be critical to inform the literature about the needs of people experiencing homelessness, as well as using the insight of mental health providers to guide future research.

Conclusion

Overall, the research with CEH has identified many complex mental health needs, yet there is a lack of consensus regarding the most effective interventions. As a result, the proposed qualitative research is a crucial next step to bridge the practice-research gap by listening to providers and incorporating their insight into future studies. Because providers have the best understanding of the mental health needs of CEH and the barriers they face, incorporating provider's insight will be critical moving forward.

Chapter 2: Qualitative Research

Introduction

In my review of approximately fifty articles, I encountered only one study that incorporated the insight of mental health providers, and that study was not specific to YEH. Nabors et al. (2016) conducted qualitative research by holding a focus group with counselors for children with PTSD. Their results demonstrated that there was some consensus amongst clinicians regarding how to approach trauma treatment for young children, and their process of seeking insight from providers seemed to be effective. After reading about their work and given the otherwise absence of insight from mental health providers, qualitative research with providers seemed like the best next step to continue investigating the mental health needs of CEH and YEH and the barriers they face in accessing mental health care.

Following my literature review, my primary research question was as follows: what do providers believe is the best way to meet the needs of YEH? Although my research question evolved over time, I intended to explore different interventions and strategies used by mental health providers to fill the needs of YEH. The literature review revealed a variety of discrepancies between mental health interventions for YEH. For example, there was also a difference in where interventions took place. While Armstrong et al. (2021) examined the effectiveness of an evidence-based program in shelter settings for parents experiencing homelessness, Santiago et al. (2018) used a school-based intervention for elementary-aged children exposed to children. This also raises the question of whether interventions should target CEH and YEH, or if mental health interventions should incorporate their caregivers as well. The literature review also highlighted different foci of the interventions. Schwan et al. (2018) conducted research grounded in arts-based programming to promote mental wellness, social inclusion, and life skills, but other interventions focused on integrating youth into the community through life skills training, emotional support, and social justice awareness (Sisselman-Borgia, 2021). Overall, these differences between the mental health interventions designed to meet the needs of YEH informed my research question, where I seeked to investigate what providers think is the best way to meet the needs of YEH.

In designing my study to answer my research question, I was drawn to interviewing participants in order to center the conversation and my work on the mental health providers. On the one hand, I wanted an approach that aligned with what I learned in my literature review, so my initial questions for the participants were more logistical and stemmed from my training within research systems. On the other hand, I wanted to be flexible in order to learn what the participants thought was most important. Thus, I wanted to demonstrate openness in gathering

the information and encourage the participants to share what they value. Additionally, I was interested in learning about the qualitative research process throughout the trajectory of this project.

As previously outlined, this paper has two distinct parts. The first chapter was strictly informed by my academic training, and the second - guided by the wisdom shared by my informants - has taken a more holistic approach to the topic of mental health care for CEH. In some ways, the difference between these two chapters reflects the gap between research and practice. I will return to this analysis after discussing my findings.

Method

Participants

The participants of this study were defined as mental health workers for children or youth experiencing houselessness. I determined eligible participants based on both their job title and the mission of their organization. I recruited participants by contacting them directly via email or by reaching out to someone in the organization, asking them to forward my message to coworkers who may be interested. The recruitment emails are included as Appendix A. I contacted over 25 staff members from 11 different organizations. I was able to make contact with 6 potential interviewees, but I was ultimately only successful in setting up 2 interviews. The first participant, referred to as Participant 1, works at a nonprofit organization designed to serve YEH. Participant 1 is a Black-presenting, female-presenting[1] case manager who works with YEH. The second participant, referred to as Participant 2, works at another nonprofit organization with a myriad of different services, including mental health, supportive housing, childcare, and aging and caregiving services. Participant 2 is a biracial, female-presenting clinician who works with a

[1] Participants were not explicitly asked about their social identities.

wider variety of clients, some of whom are youth and some of whom are experiencing houselessness.

Interview Procedure

With each participant, I conducted an interview lasting around an hour. I initially requested a 20 minute interview, but the participants were happy to continue our discussion. The interviews were semi-structured, meaning I would occasionally ask follow up questions after the participant's responses. I entered the conversation with 6 primary interview questions [Appendix B], which were informed by my findings from the literature review. Initially, I had many questions about the logistics of mental health interventions, such as where the participants think interventions should take place and who should be involved. However, as I refined the focus of the study, I narrowed my focus to questions about their role, questions about the needs and barriers of YEH, and questions designed to elicit more open-ended responses about their work. For example, one of my primary questions included "how would you describe your role, specifically relating to children experiencing houselessness?" This question was intended to allow participants to describe their work and explain their role, which also provides insight on what kind of mental health care they provide to YEH. Another central question asked, "what questions do you wish researchers were asking to better help CEH, or what do you think researchers or academics might commonly misunderstand about your work?" Through this question, I aimed for participants to provide feedback to researchers regarding what research should study moving forward. As discussed earlier, my intent was to center the voices of mental health providers. Consequently, I intended to leave questions open-ended so that the participants could guide the conversation and bring up the most important topics for our conversation.

At the beginning of the interview, the participant read and signed an informed consent form [Appendix C] outlining the purpose of the study and that their participation is entirely voluntary. There was no debriefing form, as there was no deception involved in participation. Each participant was compensated $15 for their participation in this study.

Data Analysis

To analyze the qualitative data, I transcribed the interviews using Otter.ai software and edited the transcripts manually as needed for accuracy; the transcripts are in Appendix D and E. After familiarizing myself with the data, I tagged segments of transcripts to find larger themes or ideas. Additionally, another person read the transcripts and pulled out meaningful tagged units to add another perspective on the data. As a result, I was able to employ the process of triangulation to complement my own observations, boost the trustworthiness of my interpretations, and ensure my interpretations are not entirely my own.

Main Findings

The following sections will outline the central themes evident in the interviews, as well as my interpretations and reflections.

Systemic Racism and Injustice

The main idea underlying my findings and interpretations from the interviews is the central role of systemic racism and injustice in the experience and remediation of YEH. Both participants emphasized the necessity of looking at macro level systems, and I intend to reflect that in my analysis. As mentioned in the literature review, due to systemic racism, people of color disproportionately experience houselessness. Similarly, broader social factors, particularly racism, play a role in the other components because people of color are historically and systematically disadvantaged in a way that increases chronic stress and harms well-being

(Participant 2). Thus, the role of systemic racism will be a crucial lens through which I consider the findings and conclusions.

Entering the interview process, I understood, to an extent, that race and identity would be a topic of discussion because people experiencing houselessness are disproportionately people of color. As stated in my positionality statement, I approached the interviews intending to listen, have humility, and let the participants guide the conversation. Especially as a White researcher, I was particularly aware of how I brought my identities to the space and how that could impact my findings. Thus, I was prepared and willing to sit with my perspective, and be eager and open to have conversations specifically about race. At the same time, I did not fully understand the core centrality of systemic racism, and the interviews quickly made it clear that systemic racism is the root of many of the other factors at play. Throughout my analysis, I will routinely connect back to the impact of race, identity, and positionality, due to its immense importance in conveying the rich conversations from the interviews and to the reality of the situation of houselessness in Minnesota.

Needs of YEH

Symptoms of trauma and chronic stress. The first finding regarding what YEH need relates to the symptoms they are experiencing, and why they are experiencing those symptoms. As discussed in the literature review, the experience of being houseless is traumatic, and that often coincides with other adverse childhood experiences. Therefore, many people in this situation have experienced chronic stress. As Participant 2 described, chronic stress is "significantly connected to trauma" and medical issues as well. Consequently, chronic stress and trauma underlie YEH's needs because they have been in a high-stress environment. In addition to houselessness, financial instability, interpersonal conflict, housing instability, and educational

disruption are all common forms of adversity. Additionally, the identities of who is experiencing chronic stress are determined by historical factors, as will be further explored throughout the paper (Participant 2). Furthermore, people who are unhoused are experiencing financial strains. Participant 2 described how financial strains impact the entire family, meaning it can also influence interpersonal factors within a family, which can compound as another aspect of chronic stress.

Ultimately, trauma and chronic stress can present many different ways in YEH. For example, Participant 2 noted that "there's such a significant amount of overlap in symptoms when it comes to trauma and ADD, ADHD, other developmental disorders, anxiety, depression, because when every single night, you're not sure where you're gonna get your meal, that's gonna make you sad, naturally." Through this quote, Participant 2 demonstrates how situational factors such as finances or housing status contribute to that high-stress environment, and consequently the number of different diagnoses that can be attributed to the common experiences of YEH.

Basic needs. In relation to chronic stress, the basic needs of YEH are not being met. When I asked the participants about what they do for YEH, both mentioned key ideas relating to helping their clients meet their basic needs. When asked this question, the first priority for Participant 1 was to make sure their clients find suitable housing. There are a lot of factors that affect whether a youth can find a bed at a shelter or find an apartment, including whether they have documentation, or whether they have a medical or mental health diagnosis. However, Participant 1 clearly had an intimate knowledge of the different resources available in the Twin Cities to help their clients find a place. In an extreme situation, Participant 1 explained that their organization purchased a hotel room for a mother and her child for the night because there were no beds available in shelters amidst deadly winter conditions. Participant 1 noted they also play a

role in “making sure that [their clients] have clothing and making sure that they have food, making sure that they have support as far as medical insurance, IDs, social security cards, birth certificates.” Participant 1 explained that their organization has showers and laundry available on site, as well as a mental health therapist if the youth is interested in speaking to someone other than a case manager. Ultimately, Participant 1 made it clear that sometimes meeting their clients’ basic needs is all it takes; that is, all a youth needs at that moment is a shower and meal. However, the youth can be in survival mode, understandably, and thus there is limited room for mental health when their housing status or food security is in question. Therefore, it was clear that when a youth arrives, Participant 1 and their peers are focused on meeting the youths’ basic needs first, with the understanding that the staff will be able to provide further assistance after that immediate concern is addressed.

Participant 2 echoed the message of Participant 1, as they noted that it is “hard to talk about your feelings when you don’t have a meal or when you get cold and such.” They also described how some clients may just walk until they find a safe place to sleep, and there is no guarantee on how long that will take. Therefore, not only are the youth experiencing stress about their lack of housing, but they are not getting quality sleep or nutrition. As a result, it is also necessary to consider their client’s medical health, because all of these factors play a huge role in mental health (Participant 2). Thus, basic needs must be met first because effective mental health care cannot take place while the YEH is in pure survival mode.

Accessibility. Accessibility was another key idea that emerged as something that YEH require as a part of their mental health care. Accessibility is important from a logistical standpoint, and also from a broader organizational perspective. The interview participants’

observations aligned with the findings of Chapter 1, emphasizing accessibility as a critical consideration in mental health care for YEH.

Many logistical barriers impede YEH's access to mental health care. First and foremost is the cost; depending on the organization or service, psychotherapy is not affordable, so that is a clear obstacle that makes it more difficult to seek mental health care (Participant 2). Additionally, attending therapy appointments requires coordinating transportation, getting time off of work, or missing school. Another complicated aspect of accessibility is therapist availability. There are lots of waitlists right now for mental health services and there are not enough mental health clinicians to fill the need, according to Participant 2. They clarified that "it's a great thing that therapy is becoming more widely known and widely used," but at the same time, there are not enough clinicians to meet that need as of right now. Even if a youth in need is able to connect with an available therapist, there is another layer regarding the specialization of therapists. Participant 2 described how they have worked specifically with clients about houselessness, domestic violence, adoption, and foster care. They have a permanency adoption competency certificate, certifying their competency in treating clients with that experience. This level of specialization is rare. Thus, in addition to being able to afford therapy, go to an appointment, and find a therapist who can take a new client, there is also the question of whether that therapist has enough knowledge or experience so that they would be able to provide suitable, adequate, and holistic care.

Beyond these logistical factors, there is also a broader organizational accessibility that could either facilitate or prevent youth from reaching the care they need. For example, Participant 2 talked about the organization policy level, such as the consequences if a client does not show up to a scheduled session. They noted that some organizations may have rigid policies

that the YEH cannot see their therapist again if they miss a session, or they may have to go back on the waitlist. This policy ignores the realities that may preclude a YEH from attending an appointment and serves as a crucial example of how accessibility and flexibility are necessary on a larger scale to ensure everyone can reach the care they need. Participant 2's organization does not have this policy, and instead the organization focuses on making their services as accessible as possible to YEH.

Race, identity, and positionality. Finally, both interviews conveyed the importance of identity in terms of what YEH need. The first theme that emerged in relation to race and identity was representation in their care. Participant 2 clearly stated how "clients need to see people who look like them when they're seeking out help." YEH may feel safer or feel more understood when they can see themselves in their therapists. Thus, representation in the mental health provider can be critical in building the therapeutic relationship, which plays a large role in the effectiveness of therapy.

Participant 1 also brought up their own identities, and how they have experienced similar situations to the youth they work with. As a result, youth may feel more comfortable asking for help or receiving help because they are asking someone with similar lived experiences. This idea surfaced in the interview with Participant 2 as well, as they mentioned the misperception that clinicians have not endured the same experiences as their clients. This explicitly connects to race, as the culturally available model of therapy involves a more privileged, often White, therapist who has received higher education and is the "expert," and they have not experienced the same hardships as a client. On the contrary, Participant 2 noted that it is important to remember therapists sometimes have the same lived experiences and that can serve as a strength in building a therapeutic relationship.

Additionally, as discussed regarding accessibility, even if clients finally find someone who shares their identities, their schedules might not align or they may not be specialized in their experience or in a technique they want to try. Therefore, Participant 2 made it explicit that they "need more Black and Brown clinicians in this field" so that clients can see people who share their identities, specifically their racial or ethnic identities, when they are seeking help.

Furthermore, it is also important to consider how race and identity intersect with the experience of trauma and chronic stress. Because of historical and systemic racism, people of color are continually disadvantaged in numerous ways, which contributes to a higher likelihood of them experiencing trauma or chronic stress than their White counterparts. Ultimately the needs of YEH are not only determined by their individual situations, but also by broader social factors, such as racism and poverty (Participant 1). These have huge impacts on youth's mental health that require a more systemic or macro level approach, as their stress stems from discriminatory systems. Participant 1 described one example of this discrimination in action, where they see discrepancies in inner city housing versus suburban housing. They noted that one company has lots of suburban buildings that are well-kept and well-regarded, and yet the inner city buildings are more rundown and often have other problems such as pest infestation. "How can that be? Well, that's purposely done" (Participant 1). In this way, a person's experience with this housing company is determined by where they live, which is related to race. This demonstrates the impact of policy and funding distribution on people of color. As a result, people of color are continually at risk for increased stress.

In regards to mental health concerns for people of color, Participant 2 noted that "it's just kind of a vicious cycle," referring to how chronic stress worsens health and well-being, and makes it hard to maintain relationships and self-care. Similarly, Participant 1 also remarked that

they “don't see [mental health concerns] thinning out too quickly here” due to the cyclical nature and because it all goes back to rules, regulations, and policies set by those in power. When people of color are consistently disadvantaged by systems of power, it is clear that the racist system is the root of many of their mental health concerns through chronic stress and trauma.

How Providers Serve Clients

Being a consistent adult. There are many ways in which the participants help YEH or their clients, one of which is maintaining a consistent relationship with their clients. The experience of being unhoused inevitably frays relationships, thus having mental health care workers or caseworkers who provide a steady source of connection is particularly important for this population. Creating an environment of trust and communication is the first step of mental health care (Participant 1). Participant 1 described how they “get to learn from [the youth], build relationships with [the youth], so [the youth are] comfortable enough” to say what they need or what they are experiencing. “It's not just to give a resource out and then… [the youth are] on [their] way.” It is important to follow up, and make the environment welcoming so that YEH feel safe coming back again and they are confident they will get the help they need if they return.

Participant 2 also conveys the importance of the therapeutic relationship. Most clients are choosing to be there, but some may have been mandated to go as a part of child protection services, and Participant 2 aims that the clients “stay for the relationship” that they build together. It is most important to “be there with them,” as creating trust and creating room for people to comfortably express themselves is a critical first step in helping people deal with mental health. Mental health care means “acting as a constant for people” and modeling a healthy relationship through being reliable and trustworthy.

Part of being a consistent adult also means showing belief and faith in their clients. Participant 1 noted that their role is to uplift and motivate, and Participant 2 stated that they intend to "empower my clients to stick up for themselves and their needs." These findings reveal the importance of showing their confidence in their clients. They believe in their clients, and they build the therapeutic relationship in order to convey that belief and hopefully activate the self-confidence within their clients as well.

Connecting to resources. Mental health providers also play a crucial role in connecting the youth with other resources. In some cases, this might mean identifying shelters or a safe place to sleep to make sure their basic needs are met (Participant 1). In other cases, it might mean ongoing conversations with schools, caregivers, county workers, or foster parents to help a client get the support they need (Participant 1). As discussed earlier, each individual has different needs, and the participants each work behind the scenes to guide each client to the resources necessary for their circumstances.

Educating. The participants' roles as educators emerged as one of the most important ways that they serve YEH. Knowledge is often generational; parents or caregivers pass along knowledge about how to navigate situations in life (Participant 1). For YEH, they may not have caregivers who convey these messages, and thus people in social service roles such as mental health providers may fill that role. For example, Participant 1 described how they have helped their clients learn about how to look for an apartment, because they may not know what questions to ask in that process. Teaching their clients might also involve helping them learn to be organized in day-to-day life and how to keep a schedule (Participant 2). It could also mean explaining to youth, caregivers, or educators in schools how trauma can be a barrier to success in

school. In all of these examples, it is important to give the youth as much information as possible so that they can learn to navigate situations themselves and allow them to take more control.

On a broader scale, educating clients can also mean discussing important topics like historical racism or generational trauma. It is imperative that clinicians understand trauma on an individual and systemic level, especially when it comes to communities of color (Participant 2). Participant 2 described how they talk about "racial violence with [their] clients just because of who [the clients] are and what it means to be a person of color every single day." Oftentimes, this could involve discussing "generations before and how that connects to their current symptoms" and being candid about the experience of generational trauma under systems of power. Historical discrimination and marginalization have a large impact on mental health, and the participants ensure that YEH understand how those social contexts play a role. In this case, education means "keeping it real, like telling the truth about things" (Participant 1). Mental health providers have to be honest so the youth can both understand circumstances that are beyond their control, but also regain a sense of control. Honesty from clinicians can help the youth develop skills and build resilience so they can navigate the world.

Advocating for policy change. Advocating for their clients is another component of how the participants serve their clients. Supporting an individual's mental health involves investing time and effort into their communities and working with the already established structures to ensure individuals are accommodated for and that their needs are being recognized and met (Participant 2). It requires an understanding of what YEH need to succeed and thrive, and advocating to make sure that is possible. In the framework of accessibility, this could mean adjusting cancellation policies to ensure YEH are not excluded due to scheduling difficulties. Participant 2 described how depending on the organization, if a client does not show up, that

could mean consequences such as not being able to receive care there or returning to the waitlist, as discussed in relation to accessibility. Thus, advocating for policy change at the organization level can make a difference in whether people can access the care they need.

How Providers Show Up

Genuine care for clients. One of the most important ways in which mental health providers show up for their clients is by offering genuine care. Demonstrating this care can manifest in a variety of ways. First, showing care means listening to clients (Participant 1). They are the experts on their own life and it is important to have conversations with youth about their circumstances and figure out how best to help. Each situation is different, so these interactions look different as well. Participant 2 also mentioned the individualization of this process, noting that "clients are looking for different things." As a result, mental health providers need to listen and understand.

For Participant 2, this means being flexible with clients and seeing the best in their clients. They "tend to try to be really flexible with [their] clients knowing that they truly are trying their best," showing an understanding of their circumstances and recognizing their effort (Participant 2). They went on to say that "it's one thing if a client just doesn't show up, and they kind of ghost, but it's another thing if they're talking with us and explain what happened, and can talk through what they still need." In this way, the communication and relationship between therapist and client is crucial. Care for clients also means learning from them (Participant 1). The relationships are multidirectional, meaning clients learn from their therapist, and therapists learn from clients. It also allows therapists to continue developing professionally by learning how to best serve clients and working on new strategies and resources to best suit the needs of each client as an individual.

For Participant 1, their genuine care means doing whatever is necessary to help, including addressing basic needs or connecting them with other resources. In their words, "[their] duty is to make sure that [they] can give [the youth] some relief to the mental health issues that [the youth] are having." Participant 1 described how each time the youth walk in the door, they can see the change in their clients, and that's what motivates them to continue this work.

Self-care. Another critical way in which mental health providers show up for their clients is by taking care of themselves. Both participants discussed the difficulty of their role and the importance of self-care in order to make their work sustainable. The capacity of therapists is limited, and it can be hard to manage secondhand stress and trauma, where therapists experience symptoms of stress and trauma from their work with clients (Participant 2). Participant 2 stated that if they do not engage in self-care, "that means [they] can't show up for [their] client in the way that they need … and the way that [they] hope to show up as a clinician." Serving their client requires taking care of themselves as well. Boundaries within these relationships are one critical way to practice self-care (Participant 2). Setting boundaries can help prevent burnout and ensure that the clinicians are doing their best work with clients by preserving the clinician's mental health. Participant 2 explained their most prominent boundary was not connecting their work email to their cell phone, in order to limit their attention to their work email outside of work hours. Ultimately, clinicians also need to be getting mental health support because teaching their clients how to manage their mental health does not mean that clinicians do not struggle with it as well. In fact, in order to best show up for their clients, self-care is a crucial aspect of their work.

Race, identity, and positionality. In terms of race and identity, a primary way the participants show up for their clients is by bringing their own identities into the space. Participant

1 discussed their own life experience, and how they can relate to many of the experiences in a way that allows them to show up for their clients. Participant 2 made a similar point and stated that they "do this work in part, or some people do, because they know what it's like to experience some of the stressors that [their] clients have experienced." Additionally, clients want to know "they're being seen by another person," which requires the clinician bringing their identities to the conversation as well and not trying to be objective (Participant 2).

Beyond bringing their own identities, it is also important that mental health providers have a strong understanding of the broader social systems at play that influence their client's lived experiences. Investigating bias is one component, because if clinicians are not taking time to "look at that power dynamic, and do work with [their] biases, that can really be really consequential to [their] clients who don't have as much power as [they] do in [their] space" (Participant 2). Thus, another component is understanding the role of power structures and how different power dynamics show up in a therapy setting as well as everyday life. Additionally, it is important that mental health providers have a strong understanding of power systems in order to resist the savior mindset that can come from social service work (Participant 2). Participant 2 explained how it can be a pervasive mindset in nonprofit work, as people are coming in with their best intentions despite inadequate pay. However, the savior mindset can be extremely harmful to clients, and boundaries can help to maintain a safe relationship. Overall, clinicians "have a lot of power in [their] space with [their clients]," and therefore need to understand broader social structures to resist replicating those harmful power dynamics in a therapeutic setting.

Role of Research

Gap between research and firsthand experience. In response to a question about research and in the flow of conversation, both participants expressed frustrations with researchers and the limitations of their work. The primary finding across both participants was that researchers do not ask people with firsthand experience for their insight. For example, Participant 1 explained how some shelter connection centers will make rules and regulations without asking the opinions of social service organizations. Therefore, these centers lack insight from those working directly with people experiencing houselessness, meaning the decisions they make may not be the best for the people they are trying to help. Research can act in a similar way because they decide what to study without incorporating insight or guidance from people who have firsthand experience. By not soliciting the opinions of those directly involved, research studies are less relevant and less effective.

This divide can also foster a sense of frustration, in this case from mental health providers towards researchers, because providers recognize their knowledge is not valued or respected (Participant 1). Thus, researchers need to be more curious and ask more questions (Participant 2). On the one hand, it is also important to be direct, otherwise researchers risk missing important information that is left unsaid. Researchers need to have the flexibility to have follow up questions and adapt to the conversation. On the other hand, Participant 1 made it clear that researchers should not ask questions if they are not going to help. “If you can't help with the situation, then what are you researching about it for?” This raises the question of the purpose of research, because research should aim to bring attention to the problem at hand, in addition to finding solutions.

Race, identity, and positionality. There are also gaps between communities and organizations that are directly involved in social service work and researchers who are more

“removed and just write about it” (Participant 1). More specifically, researchers often “haven't done direct service for a good amount of time,” and that prevents them from connecting with the work they are doing (Participant 2). Furthermore, “that can allow people to stay disconnected from the real humans who are experiencing trauma or chronic stress. And that can allow researchers to cut corners in ways they maybe wouldn't, if they actually had like names and faces and stories behind what they were searching [sic].” In other words, researchers “don't always have that direct real human in front of them” and that limits their ability to make a difference through their work.

A critical factor in this gap is the power dynamic between those in power and those who are historically marginalized and willing to share their stories. Participant 2 discussed the power of someone being willing to share their stories and their lived experiences in order to change policies. However, they also acknowledged it “shouldn't have to be at the expense of people retraumatizing or hurting themselves to have other people that have more power to understand. But [they] think, in some ways, that's what it's taken.” If people in power, such as researchers or policymakers, do not make an effort for firsthand knowledge, then either they remain distanced from the people who are subjected to their power or they extract stories from people unilaterally, which can cause further harm.

Central Findings

Despite the limitations of this study, there is a lot to be learned from my interviews with these two participants. The qualitative data are thick and rich, and they provide a solid foundation for the investigation of mental health care for YEH. The participants provided information regarding what YEH need, including an understanding of trauma and stress, fulfillment of their basic needs, accessibility, and an understanding of how race and identity play

a role in their needs. They explained how they serve their clients, such as being a consistent adult, connecting their clients to resources, educating, and advocating for policy change. They also made clear the effort needed to show up for their clients, specifically by building relationships through genuine care, engaging in self-care, and understanding how the identities of the clinician and the client intertwine. Finally, each participant raised concerns regarding the research process, most notably the gap between researchers and firsthand experience. Because researchers often lack firsthand experience with YEH, their privileged identities may limit their understanding of the systemic forces that create houselessness in the first place.

Limitations

Number of participants. One of the most salient limitations to my work is the number of participants I was able to interview. I intended to interview approximately 5-10 participants. My IRB application was approved in January, and thus I began contacting participants in late January. For the duration of February, I continued emailing potential participants in hopes of getting a response. In the recruitment process, I reached out to over 25 staff from 11 different organizations. Many never replied, and 6 replied expressing interest or willingness to participate, 4 of whom did not reply to subsequent emails. I reached out multiple times to each person who expressed some interest, but often still received no reply. I was ultimately able to interview one participant on February 15, 2023, and another on March 1, 2023. Due to the small sample size, I recognize I am not able to reach theoretical saturation. As a result, there is still much more to be learned from mental health providers of YEH.

The difficulty in reaching mental health providers also raises a broader question regarding the capacity of these workers. Mental health care work can be incredibly stressful and time-consuming, so their work may not leave much time or energy to engage in research such as

this project. It also raises the question of the impact of the research, meaning that if a prospective participant does not believe the research will make a difference, they may be less inclined to participate. This speaks to the role of research, as mental health care workers with first hand experience likely prioritize this first hand work over participating in research.

My positionality. My identities also played a role in our conversations in a way that could be a limitation. As discussed earlier, I entered this conversation understanding that as a White researcher, my Whiteness would impact our interview. At the same time, I did not fully understand the centrality of race. Therefore, in speaking with mental health providers who are people of color, I began to consider even more deeply the ways in which my identity influenced the conversation. The participants could have been more uncomfortable speaking to a White researcher about this topic as compared to a person of color. Ultimately, this led to a lot of reflection on my part regarding my role in research, as someone holding privilege from my identities.

Interview questions. As explained in the Methods section, I wrote my interview questions based on my findings from the literature review and my training. As a result, the questions were more focused on logistical aspects of mental health care, such as what mental health needs the participants notice and what they do to help. However, the direction of both interviews made it clear that my questions lacked a macro level perspective. The participants emphasized that the most important factor in evaluating the mental health needs is not what interventions should be done in response, but rather what historical systems are in place that led to these outcomes.

Conclusion

My interviews with both participants led to deeper reflections regarding the role of research, specifically by highlighting the inadequacy of research and questioning the ethics of research. Throughout the analysis of the data, it became clear that the research question I answered was different from the question I intended to answer. Initially, I designed this study to answer the following question: what do providers believe is the best way to meet the needs of YEH? However, by centering the voices of providers, I was ultimately challenged to take a broader perspective about the mental health concerns of YEH. AS a result, this research answered the following question: what do providers think is most important in mental health care for YEH?

It became clear that the current systems of research are inadequate because they often lead researchers to ask the wrong questions. In my case, this meant asking questions designed for logistical answers, such as which mental health interventions are most effective. However, my questions did not explicitly ask about macro level issues, such as how systemic racism plays a role in these mental health concerns. I extend my gratitude to the participants, as they were generous in sharing their thoughts and in conveying what was most important: the ways in which many YEH are historically and systematically disadvantaged through racism.

When asked about what researchers should consider, Participant 2 also discussed the barriers that researchers face due to the rigidity of research guidelines. They asked, what is “the barrier for [researchers] in making space to do this kind of interview?” In other words, what obstacles do researchers face in engaging in qualitative research? Participant 2 commented that there is pressure to deliver a product, which affects the research process. As a result, researchers may not be able to fully explore their ideas and do them justice due to external pressures.

Additionally, the participants also raised the question of research ethics, as in who is doing this research, who does the research really help, and should the research be conducted. Participant 1 made it explicit that doing research without a way to help is just "being nosy," in their eyes, because it is an attempt to understand an experience without putting in effort to improve the situation. Ultimately, Participant 1 issued a call to action by stating "use your connections or maneuver your language and your education to bring it forth in a way to get more services and help for the youth." If you are going to do research, use the privilege from involvement in academia to continue to bring attention to those who need it, which includes those who are practicing mental health care every day. Most importantly, Participant 1 said to "make it count." Make sure something meaningful comes from your research, from your work, or from your life. Take the time to follow up, to bring attention to the work of others and to think about the impact.

Following the interviews, I further reflected on my positionality and my role as a White researcher entering an organization designed to serve YEH, who are predominantly people of color. Who am I to be doing this work? Why do I have the opportunity to do this research? How am I going to make an impact with my findings? None of these questions have concrete answers, yet all these questions, among others, were brought to the forefront of my mind. As a result, my learning from this project went far beyond my expectations. Not only did I learn about the mental health needs of CEH and YEH, I gained a better understanding of how larger systems, specifically systemic racism, play a role in mental health. I was challenged to consider my identities in a way that only enhanced my growth as a researcher and as a person.

Overall, my most important takeaway is appreciation for the two participants. I feel the deepest gratitude towards their willingness to share their perspectives, their experiences, and

their insight with me. Our conversations have not only shaped the trajectory of this project, but they have shaped the way I think about my career and my life. I aim to make it count.

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Appendix A
Recruitment Email

Below is the recruitment email to be sent to specific staff.

Hello,
My name is Sarah Hamilton and I am a senior undergraduate researcher at Macalester College in St. Paul. I am currently conducting an honors project in which I am interviewing mental health providers for children experiencing houselessness about their work. Given your role as (job title) at (organization name), I believe you would have some valuable insight on my project and I am wondering if you would be willing to participate. I anticipate that the interview will take approximately 20 minutes but, with your permission, could extend longer. You would be compensated $15 for your participation. The interview could be conducted in person at your work or virtually over Zoom/Google Meet. If you are willing to participate, I would provide you with the interview questions in advance of our meeting.

I am excited about the possibility of hearing your perspective. Thank you for your consideration and let me know what you think!

Best,
Sarah Hamilton

Below is the recruitment email to be sent to a general contact email at organizations.

Hello,
My name is Sarah Hamilton and I am a senior undergraduate researcher at Macalester College in St. Paul. I am currently conducting an honors project in which I am interviewing mental health providers for children experiencing houselessness about their work. Given your mission and work at (organization name), I believe your staff would have some valuable insight on my project and I am wondering if someone would be willing to participate. It would be an interview lasting at least 20 minutes and the participant would be compensated $15 for their participation. The interview could be conducted in person at your organization or virtually over Zoom/Google Meet. I would provide the participant with the interview questions in advance of our meeting. Would you please forward this email to staff who might be interested? I would love to discuss this possibility further with anyone who may be interested.

I am excited about the possibility of hearing a perspective from your organization. Thank you for your consideration and let me know what you think!

Best,
Sarah Hamilton

Appendix B

Interview Questions

Below are the questions that participants will be asked by the researcher.

Questions:

1. What service does your role or organization provide to children experiencing houselessness?
2. How would you describe your role, specifically relating to children experiencing houselessness?
3. Based on your work experience at (organization title) or previous positions, what kind of mental health needs do children experiencing homelessness experience?
4. Based on your work experience at (organization title) or previous positions, what are common reasons why CEH are unable to receive mental health services?
5. Tell me about a child with whom you worked where something worked really well and the system worked well for them, and a child where it didn't go well and the system did not work well for them.
6. Based on my literature review, I realized that the voices of mental health providers doing work like yourself are often excluded. Given that, the primary goal of my research is to understand your perspective and the work that you do. In thinking about how the insight of mental health providers is not included, what questions do you wish researchers were asking to better help CEH, or what do you think researchers or academics might commonly misunderstand about your work?

Additional Questions, Time Permitting:

1. How are parents or guardians involved in your work? How would you like them to be involved?
2. My research has revealed a lot of interventions taking place in different settings, including schools, temporary shelters, or in mobile units. What do you envision as the best setting for service delivery for CEH, or what do you see as the strengths and weaknesses of those settings?
3. How does your organization or your services mitigate the barriers that children experiencing houselessness face in accessing mental health care?
4. Based on your education, training, or work experience, would you say you feel prepared for working with children experiencing houselessness? Are there any additional training or skills you wish you had?
5. In addition to researchers' misunderstandings, do you think the general public has any misunderstandings about your work with children experiencing houselessness?
6. When working with CEH, how often are you able to see them?
7. What do you do when a child is living in a shelter or they have very inconsistent sleeping arrangements?
8. What do you do when a child doesn't come to school? (if applicable to the role)
9. What does your communication with parents or guardians in the child's life look like?

Appendix C

Consent Form

Mental Health Care for Children Experiencing Houselessness

You are being asked to participate in a research project that seeks to understand the perspective of mental health providers on the mental health needs of children experiencing houselessness and the barriers they face in accessing mental health care, as well as what is being done to fulfill their needs.

Sarah Hamilton, a senior undergraduate researcher, is conducting this research project under the guidance of Professor Jaine Strauss.

Procedures:
If you agree to be in this study, you will be asked to participate in an interview regarding your work with children experiencing houselessness. I will record the audio of this interview for later processing. Your name will not be associated with the recording. We anticipate that interviews will take approximately 20 minutes but, with your permission, could extend longer.

Voluntary Nature of the Study:
Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Macalester College. If you decide to participate, you are free to not answer any question or withdraw at any time without consequence.

Risks of Participation:
The risk in participating in this study is minimal, although it may involve recalling work with children experiencing houselessness that could have been secondarily traumatic. Your participation will be a valuable contribution to the psychology community.

Privacy:
The records of this study will be kept private. I will not include any information that will make it possible to identify a subject in any paper or presentation I make based on this research. Research records will be stored securely and only the investigator, her advisor, and one additional researcher will have access to the records. The audio recordings will only be accessed by the three previously stated individuals. The recordings will be deleted after the conclusion of the project, along with any identifying information.

Contacts and Questions:
You may ask any questions you have now. If you have questions later, you are encouraged to contact the investigator Sarah Hamilton (shamilto@macalester.edu) or Professor Jaine Strauss (strauss@macalester.edu, 651-696-6114) at any time. If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, you are encouraged to contact the Macalester College Institutional Review Board at 1600 Grand Avenue, Saint Paul MN 55105, by email at irb@macalester.edu or by phone at 651-696-6872.

You will be given a copy of this information to keep for your records.

Statement of Consent:

I have read the above information. I have asked questions and have received answers. I consent to participate in the study. This form will be signed if the interview is conducted in person. If the interview is being conducted virtually, I will provide time to read the form and ask questions, and then ask for verbal assent to the conditions in this form.

_____ _____

Signature of Participant Date

_____ _____

Signature of Investigator Date

Appendix D

Participant 1 Transcript

Sarah Hamilton 0:01
Okay, perfect. So first, I guess in your own words like what does [site name] do to help youth experiencing homelessness?

Participant 1 0:21
There's a lot to say that we do. I'll just start by saying when a youth comes in, and they're without a home, alone, along with trying to find them somewhere to be, first and foremost, we get their basic needs met, making sure that they have clothing and making sure that they have food, making sure that they have support as far as medical insurance, IDs, social security cards, birth certificates, all your vital docs and whatnot. We make sure they have those things, we provide them here with showers, and spaces for them to wash their laundry. We have a mental health therapist on site just in case anybody's going through anything. And that's just straight from coming in the door, those things are provided immediately. As far as somebody coming in, and they don't have a home and they're looking for resources to be housed or to find shelter. We basically utilize all of our resources that we know of, we contact these organizations on their behalf, we look for shelter, every situation is different. There's different reasons why people are without a home. So every youth's encounter with us is different. And there's different programs or different ways that we'll deal with different cases. So, you know, we have a conversation, first and foremost. We want to find out, you know, how long have they been in this position? What caused them to be there? And what information do they have themselves, to help themselves? What do they know themselves? So, and then when we assess that, then we basically start giving them information on how to move forward and making a goal plan to accomplish getting them housed. That comes with many different things in so many different situations. So I can't just say broadly, but if someone was to come in, we definitely call shelters for an emergency if they needed that right away. We would call shelters. We look for transitional housing, we might get a CE assessment of Coordinated Entry done. We would also, we would look - okay, so depending on the situation, we will contact subsidized housing apartments, we will put them on Section eight and public housing waiting list.

Yeah, I don't know how to categorize it broadly, because there's so many different things we do for individuals that are not the same for others, depending on what their situation is when they come in. But the process to helping someone getting housed is like finding the background information, hooking them up with the shelter, if that's an emergency basis, but then having them come back in putting them on subsidized housing, waiting lists, making contacts depending on - because some people may have you know, medical diagnosis or mental health, you know, diagnosis. So those things qualify for different type of housing programs are different resources that they may utilize that others may not. So it's a process but our basic thing is to just gather all the information. And then from that, use our resources, but then also inform them of everything because that's the problem too. We want to make sure that they're informed because a lot of situations for the youth are due to a lack of knowledge and not knowing anything or not having those specific resources. So we definitely inform them along the way. And these are basically things - I've had youth that are 25 years old and they've never - they don't know how to properly seek out an apartment or what they should look for if they shouldn't move into that apartment because this apartment has this, that, and the third wrong with it they don't know that that's a red flag to not possibly utilize that apartment. You know what I mean? So it's just a lot of exchanging of information. And from there, we just try to find the best, the best situation for them based on who they are, what they want, and their experiences in life and everything along with that.

Sarah Hamilton 5:25

That makes a lot of sense, how could be different depending on the person. And then how would you describe your role, specifically?

Participant 1 5:38
My role is to support, to motivate, you know, to uplift and to give out information and then follow up. Follow up with the information that I give and help the youth step by step along the way, in the process. It's not just to give a resource out and then you know, you're on your way. My job, well I take it - I'm very passionate about it, because I come from the places a lot of these youth come from, and I faced some of the same barriers, and lived in same - and came up, I would say, from the beginning of poverty. So I understand the struggle, I understand, you know, I can really relate. So with that, I try to use the skill sets that I have, and the talents and the passion that I have and the experience to guide and direct them and give them their basic needs on top of that, but then guide and direct them to a space that they were - a different space. So when they come in, I want to make sure that when they leave [site name] they're in a whole different space. And they have a whole different outlook on life in their situation, because my duty is to give back and to help and to support and whatever that takes. That's whats got to be done.

Sarah Hamilton 7:13
And when you say leaving [site name], does that normally mean - do you mean like physically leaving the space or like when they're no longer using your services?

Participant 1 7:21
I mean, like when they leave out the door, so they come back again. So And usually, they come back again, and they keep coming back again. So then that's a good sign that we're getting somewhere. And they're utilizing the resources and services that we have. Sometimes they don't come back for a long time. And then they come back again. The point of the matter is that they know that we're here, and we're always here to support and they know that based on the experience that they had here while they were here, so.

Sarah Hamilton 7:54
And then based off of your work here, or previous positions, I suppose what kind of mental health needs, the youth experiencing homelessness experience? There's a lot of - I'm sure there's a lot to cover there, and also still interested in hearing, I guess, what comes to your mind?

Participant 1 8:11
What kind of mental health needs?

Can you, like, elaborate a little bit?

Sarah Hamilton 8:22
Yeah, I think I'm just mainly curious, like, what - what exactly - when - after those basic needs are met, how does mental health care fit in to their next steps? Or does that really like not fit into the scope of [site name]? I'm just curious, like, what, how [site name] and like after those basic needs are met how mental healthcare fits into the picture, I guess if that makes more sense.

Participant 1 8:55
So when their basic needs are met, sometimes that can just be it. And you know, a lot of times it's not, of course, but sometimes that's a temporary relief. So they're content at the time, but we all know that there's underlying issues and that comes from a lot of different things. And like, that'd be a deep conversation to go into. But I would say, like for example, the majority of the kids we serve here are BIPOC. So we're talking about racial systemic abuse, we're talking about poverty, we're talking about - we're talking about the reason why they have these mental health issues and their experiences in life, and what brought them

to, you know, needing that type of help. After their basic needs have been met, we don't force anyone to speak to a therapist or anything like that. So, but we do make a lot of referrals and a lot of people ask and a lot don't. So when they don't ask, and we know that it's necessary, that it may help them, we definitely engage with them a little more, we try to get to learn them, build relationships with them, so they're comfortable enough to tell us what type like what they're going through, or what they need in a different way. A lot of times after their basic needs are met, that's not enough. Because when they leave here, the same thing repeats over again, you know, until they come back, so it's like a temporary thing. But once they do, and they go, and they get there, they meet with a therapist that we have here. We have a social worker from Hennepin County, we also have an in vivo, a mental health therapist. But you know, the things that - the reasons why they face some of these things, these mental health issues, are due to - majority of the clients, not all of the youth, but majority of them are due to, you know, things that are happening in the world that we all see every day, on an everyday basis, that have been happening since the beginning of time, which is you can actually go outside and you can pinpoint where a certain demographic of people will live at, what schools and what type of food they're eating, or what type of information they received, or housing or poverty, you can actually pinpoint that without even knowing much information because around the world - and I don't know, if I'm the best person to talk about this, because I'm too, I'm a little too deep. And this might be too deep for your paper, but -

the racism, the unfairness against the BIPOC community, the lack of resources for them, the lack of care for them. It's going to be a continuous thing, regardless, until you know. Corruption and everything that happens in the world starts on the top, and then trickles down to the little stuff we're dealing with here. So there are ways for things to be, for us to be healed and for mental health to be, I wouldn't say non-existent, but definitely not as much as it is due to simple things that the world does not want to change. So we're talking big stuff, so and then the world knows that as well. So we all can see that every day. So basically, am I going off topic?

Sarah Hamilton 13:28
No, you're right on topic.

Participant 1 13:29
Okay.

Sarah Hamilton 13:30
I think none of this is outside the scope of my paper, because, at least what I've been thinking about a lot recently is I feel like all - like reforming the mental health system means abolition, it means a lot of like social justice work. So I don't see any of this as outside the scope.

Participant 1 13:48
I don't see how - like I have the youth here that struggle every day and come in here every single day, and they fill out 25 applications a day, and they do not get hired. And it's like, you know, you motivate them and you try to help them out. But it's like, I know why, you know what I mean? And it's to me, it's set up that way, because if it wasn't set up that way, there'd be changes. That's how I feel about it. That's how I personally feel is it's set up that way. Because I could take it back so far that most inventions created on the earth were created by BIPOC people. And I can take it as far as back to say that there's a lot of inventions that we're not even getting credit for, that have been taken away. So every time that the BIPOC community or the youth or anybody dealing with mental illness that fit [site name]'s demographic then we're talking about, we're just talking about unfairness in the world. And it's just like not going to stop because at the end of the day, to be treated unfairly or to not have the same resources or have to live a certain way in certain areas that other people don't is mind blowing.

I personally have seen, and this might be a little off topic, but I've personally seen well known housing companies that have buildings, or yeah, big companies that have buildings and suburbs, and whatnot all over Minnesota. And then they have the same buildings and Minneapolis. And we're talking about either North Minneapolis, South Minneapolis, and there's infestation of, you know, really bad - I'm talking about roaches, mice, all that type of stuff. They're not fixing up the building properly, but the same company will have way nicer buildings, and you'll never experience infestation, in the suburbian areas and this and that. So. And that alone, that's just another angle to look at it. To me, now, if I have to look at that, outside looking in, that's purposely done. That's purposely done, because the people that are in the inner city, that are living in poverty, and in those areas, they will take whatever they can have, they will take whatever they can get, which will further develop their mental stress, and that discomfort because at the same time, they need to be somewhere but at the same time, they know that it's not fair. So you're battling and fighting like, I mean, I have to live like this. I don't want to live like this, but you really have no choice but to live like it because this is all that you're being offered. You know what I mean? So you're settling for whatever it is that you're given. But do you see how that same company has all these buildings and a well-known nice company, but then when it comes to this particular area, your buildings aren't kept up, there's infestation? How can that be? Well, that's purposely done. Because you can't put that to me any other way, logically speaking, you can't let that fly by me any other type of way, because I can see what that is, because that doesn't make any sense. So there's not a care for the people that are in the inner city and then dealing with the poverty and that alone, their mental health is on high. I mean, I still, I'm able to cope and able to do things. I mean, I'll be 40 next year, I'll be 39 in a few months. So me personally, just having to deal with stuff and see my parents and see the struggle. Yeah, we can make it to a point to where we're surviving. But as you can see, the way I'm talking, I still have, you know, baggage that I still feel because it's never ending, you know what I mean? It's never ending. But here our [site name] we do do our best to accommodate the youth, and to get them to the right resources and referrals so that they're able to express themselves. So they're able to meet with certain professionals in their areas to evaluate certain situations that may help them, we're all for it. I just don't see the mental health, you know, going, you know, staying down, you know, I don't see it thinning out too quickly here, just because it's one thing after another, and it's a continuous cycle. And it all is leading back to rules and regulations and policies that are set by the uppers, the higher ups, that are still set like that and there's just nothing that we can really do about that. It doesn't matter how much you march, it doesn't matter how much you do this, that, and the third, there's still nothing that you can really do about it. I mean, it's not doing anything. So I mean, you can get in a different space and you can be in a better space. And that's why I am very passionate about working at [site name], because like I told you before, I've experienced a lot of these things. I literally grew up where - if you know Kendrick Lamar, well in a song, he said, I grew up eating syrup sandwiches and crime allowances, and that's in his "be humble" song. And so, that was really true. That's like, a really true thing. And I remember having five kids in the house, and really making syrup sandwiches, but not knowing as a youth, not known as kid like, we were dead poor. Because, you know, I had to eat, and I was happy to eat it. But, you know, now looking back, we were very - we didn't have anything, I remember my mom using powdered milk, and putting it in a 2% milk and, you know, shaking it in a jug trying to trick us like, it was 2% milk and we hated it, we used to call it made milk, but that was our life. And my mom worked a job. It was hard for my dad to get work, but he did every now and then. But you know, when you grow up like that, you know, you never forget about that type of stuff. And then, when you see the youth, when I see them coming in, that's just my personal experience. Well, when I see them coming in, and they're lacking all of this knowledge, and then they're so fired up about it, you know, but then they also don't know what to do, because their parents didn't know what to do. So they weren't properly given the rules and guidelines to how to properly maneuver through life and barriers, and this, that, and the third. And if I keep backtracking to why that they don't have this, then I gotta go all the way back to in slavery, they didn't want us to have anything. They didn't even let us read. We had rights to coming up and this, that, and the third. So it's like it was set up for us to fail and not to have anything, that's just what I look at it. So it's tough. It's tough. So when they do come in, I definitely am putting my all in. And they know me as we're gonna get it done. I mean, nothing lasts forever. So, you know, my

duty is to make sure that I can give them some relief to the mental health issues that they are having. I mean, it's not going to completely go away, but relief. And then another thing about it is keeping it real, like telling the truth about things. Yeah, that's one thing that I would prefer people to do with the youth, is to be straight up. Because that way we can build strength, so that they're able to handle, you know, certain things and see it coming when it does, so that they can maneuver through it in a different way and use their different skills that they have to be able to attack that in a different way so that they're still able to stay afloat and not sink so much to the bottom to where, you know, mental health is becoming a problem. I just said a lot of stuff. I'm just talking.

Sarah Hamilton 23:49
Yeah, thank you I really appreciate it. We're at - I think we're past 20 minutes. Do you have time for one more question? Okay. I think, like, given all of that, and also given that all of the education systems that I'm coming from and that are all around the world are also institutions, I guess, like, what do you - this last question like, what do you wish researchers were doing? Like, what are you thinking about me or other professors or students? What do you wish that we were thinking about? Or what would you want us to know about your work?

Participant 1 24:30
As a case manager, what I want you to know about my work? It's - what I want you to know about it?

Sarah Hamilton 24:39
Yeah. Or like anything that you think that people who are in education who don't see the work, like, what do you think they might misunderstand? It's just kind of an open - it's very open, just anything else that you kind of want me or other researchers to consider?

Participant 1 25:00
Consider the differences, the barriers that the youth face. But as far as case management and who I am and the work that I do -

I'm so sorry, I'm gonna try to enter this the best because I know that deep down inside, I really want to say other things to you. Because I'm really deep. Because I don't believe in a lot of different things. I'm very cutthroat when it comes to organizations and people doing research and things like that, because I feel like - who do I wish researchers were asking to help better? Do you think researchers or academics might commonly misunderstand?

I think that if more people asked, if they did ask us more questions, I think we would be able to get ahead of certain things that are going on because like you said, we're the ones down here on the low level doing the work, like prime example. You know, there's adult shelter connect, there's these shelter connection centers and they make these rules and regulations and whatnot. And they don't even ask when they do their surveys or research, they don't even ask us. And we're the ones that have to call and get them to shelters every day and find out they don't even ask what our opinion is, what is a different way to navigate that so that we can serve, you know, people and so that no one's left behind and this and that, they just make rules just without even finding out. That's crazy to me. So that's kind of what you're asking me like, what do I wish researchers were asking to better help - I think - I think I want you to ask -

I need you to say something else. Because I'm thinking to everywhere like - what else? Like what do you mean, as far as ask, like about, about you? You want to know what do I think as a case manager working with homeless youth? What would I like you to ask me?

Sarah Hamilton 28:06

Kind of more like, what if someone was going to design - if someone was going to do more research, like, what questions should they be asking in their research?

Participant 1 28:18
That kind of is like, you're doing research, but what is the research for? What is the purpose of the research?

Sarah Hamilton 28:27
I think that's, I think that's what I'm asking you, is what do you think the purpose of the research should be? If that makes sense?

Participant 1 28:33
What do I think the purpose of the research should be? To find a solution, to find a problem, to - the continuous needs of the youth. That's what I think because I don't see, I don't see why people do research on things and they can't help. They can't help with the situation. So don't research and you can't help with it. Otherwise, to me, that's just being nosy. You know what I mean? If you can't help with the situation, then what are you researching about it for? Well, if you're going to research it, bring it to a big audience. If you're going to research, get the information, the real information, and bring it to the attention. Use your connections or maneuver your language and your education to bring it forth in a way to get more services and help for the youth. I don't feel like research should be done just for no reason, just for research. If you're not going to help I feel that's just being nosy or just wanting - that's that's just being nosy to me. That's how I feel about it. So if you're not going to help or try to provide Some type of resources that could help with the work that I do, then to me, you researching about what I'm doing is pointless. That's how I feel. I think that as researchers, you should use the information that you find and use your college education to connect with other organizations or other, you know, whoever, and just put a spotlight on the fact that, you know, this is a continuous thing happening in the community that we all drive through every single day. And things are happening under people's noses that they really don't realize that are happening. But just bring light to it, and some form of, you know, relief. Yeah.

Sarah Hamilton 31:15
Thank you. I really appreciate it. And that's, yeah. I get it. That's something that, you know, as I'm a young person moving forward in my career, that's something that I have been sitting with a lot, so I really appreciate you saying it.

Participant 1 31:33
Okay. Like, don't research if you ain't gonna help?

Sarah Hamilton 31:36
Yeah.

Participant 1 31:36
For sure.

Sarah Hamilton 31:38
Exactly. Sometimes people need to hear it, and I'm one of them. So, thank you.

Participant 1 31:41
Yeah, you're welcome. I'm serious.

Sarah Hamilton 31:47
No, I know.

Participant 1 31:48
Yeah, I'm serious about that. Right. But, you know.

Sarah Hamilton 31:53
Yeah.

Transcribed by https://otter.ai

My conversation with Participant 1 continued for approximately a half an hour after I stopped the recording. Below are my notes, from memory, of what we discussed after that point.

- Overall takeaway is to make it count. Don't come interviewing organizations if you're not going to bring light to their mission and work, or if you're not going to do anything about it or help.
- They can see the change in their clients. Filling the basic needs and showing some care for their wellbeing is enough to see a visible change in their demeanor. You need a big heart to do this work, but it helps to be able to see the change. Researchers are removed and just write about it, they can't tangibly see the change. It's hard, but that's the most rewarding piece of it.
- They told a story of a news organization who came to [site name]. The news organization donated some blankets. They came in and interviewed clients and made their organization restructure the whole day to make it work, but then only used a clip of people unloading the blankets. Participant 1 says this shows the performative aspect because really all the news organization wanted was footage of them helping, but they didn't really honor the information they gathered from the interviews and didn't even promote [site name] as a resource for youth.
- A woman with a young baby needed help and they couldn't find a spot for her in the shelter or anywhere else, so they paid for a hotel for her for the night. That kind of thing shouldn't be happening, especially in MN where winter nights are genuinely deadly. There's also an empty hotel nearby because they are selling it right now, but imagine how transformative that would be to use it to shelter people while they get things together. It's a waste to have that sitting there empty.
- This comes from systemic racism. The system was set up to disadvantage BIPOC communities, and it's working. It's clearly deliberate too - Participant 1 mentioned the difference between organizations' facilities in the inner city vs in the suburbs.

Appendix E

Participant 2 Transcript

Participant 2 0:01
I apologize, I realized I didn't sign off the form, so I'll make sure to get that to you today.

Sarah Hamilton 0:06
Okay, and since we had to adjust into virtual, we can also, if you want to just like verbally consent, I think that's okay, too. If you had a chance to look over it, and if it all looks okay to you.

Participant 2 0:20
That sounds good. I can verbally consent.

Sarah Hamilton 0:21
Okay, perfect.

Awesome. Well, first, I'm going to give you a little spiel, I guess, to kind of give you a little bit more insight about me and kind of what led me to this project just so you have a little bit more context. So I'm a senior at Macalester. I'm studying psychology. In the summer of 2021, the summer before my junior year, I was an intern at the Washburn center for children. And, that was really like my first interaction with children experiencing houselessness, and watching how the clinicians navigated those situations and worked with parents and worked with the kids and how emotion regulation and all those different factors played into that was really inspiring to me both career wise, and academically, and just as a person of what, what I want my life to look like. So that's kind of what initially sparked my interest. So then the opportunity to do a research project this year - that was kind of what drove me to be here, studying the mental health needs, barriers, that children experiencing homelessness face, or youth as well. So kind of both. So that's a little bit what led me here. And then I also did a literature review as a part of this project in the fall. And I reviewed probably about 50 sources, and only one of them had any mention of mental health providers, or like, included their perspective in any way. And so that really stuck out to me, because I think you all are the ones doing the direct work on the ground, doing what you can every day. And so for me that felt like a gap. And that's what I'm hoping to fill because I think you guys have the best insight, the most valuable insight. And that's something that I kind of want to try and bring back to the table here through my project and see how it goes. So that's, that's where I'm at right now. Yeah.

Participant 2 2:18
So the results of this are going to be taken and then you'll be presenting them or how does this work at the end?

Sarah Hamilton 2:24
Right. So essentially, I'm interviewing a few other people. It'll kind of be a case study. It'll all be anonymous. But I'll write about, kind of what we talked about and what I talked about with other participants. And then I'll kind of pull out the main themes to come to some conclusion, I don't know what yet, we'll see. And then I'll also send my notes from our discussion today and my final paper back to you, in case you want to correct anything, if you want to comment on it. That part is totally optional, but I just wanted to provide that and to make sure I'm accurately representing your words or your insight. And then I'll write a final paper and ultimately defend my thesis in April. So that's the brief outline. Yes. Very exciting, a little bit overwhelming, but I'm up to the task.

Participant 2 3:15
That's good.

Sarah Hamilton 3:18
Yeah, do you have any other questions for me before we kind of just dive into things?

Participant 2 3:27
No, I don't think so. I think I'm good.

Sarah Hamilton 3:30
Okay, perfect. And also, I have the questions as kind of a skeleton. But the biggest part of my project is I want to hear what's most important to you and kind of what you want me to know. So I have the questions as a fallback. And also, if the conversation takes us elsewhere, that is also totally okay. So that's my disclaimer.

Participant 2 3:52
Okay sounds good.

Sarah Hamilton 3:52
Yeah. So my first question is, I guess what like service would you describe your role or [site name] providing to children or youth experiencing houselessness?

Participant 2 4:04
Yeah, I think to start, I should make it clear just for liability purposes, probably. So I am not a spokesperson for [site name] but obviously I do work for [site name] as a clinician, as a therapist. And so these are definitely just my opinions. I know there's a lot of values and opinions [site name] people share, but not a spokesperson for that. So with that in mind, I think [site name] does a lot of - out of the other nonprofits I've been at, I think [site name] does a really great job of making services as accessible as they can be, you know, there's still many barriers to getting mental health support. But I think [site name] is more intentional about going about that to serve clients of all different needs. Especially, granted I've only been at [site name] since, well, almost a year now, so I'm still getting to know everything and all the departments and branches and other funding works. But from what I've seen, and what I've heard from my clients, it's extremely accessible. And so that means that [site name] gets and brings in clients who are experiencing things like homelessness, or clients who are highly mobile, whether that's families, youth, older adult individuals, it's just quite a wide spectrum. And I think that accessibility is, again, what allows them to see so many different types of clients. And that allows me to see all different kinds of clients. And I think [site name], in St. Paul at least, is pretty well known for serving Southeast Asian communities. And they're also doing a really great job of expanding to work with a diverse group racially of clients as well, that again, just creates a wider spectrum of different types of like, mental health symptoms, trauma symptoms, including houselessness or homelessness. And in regards to my role, specifically, so I worked with clients who have experienced homelessness or who are highly mobile for a long time, at least, let me do a quick math here, like, seven, eight years now. Because I think it's a population, especially in Minnesota, that tends to be overlooked. You know, that people who are highly mobile or homeless, those disparities are increasing over time in Minnesota, especially and I saw that pretty quickly in my research in undergrad, working with children and families, and in Minnesota because of the health disparities, racial disparities, we see a lot of clients for who are also clients of color experiencing homelessness because of assumptions, generational trauma, chronic stress and whatnot, we'll go into that later. But, so part of what I do, I don't advertise it, necessarily, but I say I specialize in is homelessness or clients who are highly mobile, because I've done the research and I've been working with clients for many years. And so that means I show up as a therapist, but then - not only with my clients who are highly mobile but clients experiencing other types of chronic stress, is to be there with them. And finding resources and getting some of those basic needs met sometimes because it can be hard to talk about your feelings when you don't have a meal or when you get cold and such. I'm also very flexible in supporting my clients

getting access to those resources or getting access to the people who can find them those sources. And so I think my role and one other tool could be a connector, in addition to doing that case management, outpatient work. And I think really that just means they have this support within the community. And they want to expand that even further. So they're more well known. And it's all different kinds of communities. But there are certain pockets that they have focused on, again, being Southeast Asian clients, clients who are highly mobile. I hope that answers that question. I was looking at that question earlier. Oh, I think that's kind of tough, but [site name] does so much. And because it's not only that direct service work, I should mention [site name] also engages in research in regards to homelessness, or clients are highly mobile. And addresses some of that macro level systems that we need to look at too when it comes to clients who are experiencing homelessness, or what's necessary for affordable housing.

Sarah Hamilton 8:40
Right? Yeah, it's interesting how you guys are kind of bridging that practice and research gap within yourselves, which is really cool, within [site name]. Also, how would you describe I guess your role, you've kind of already touched on this a bit, relating to your work with your clients?

Participant 2 8:58
In my role? So technically I'm on the child case team within our outpatient therapy group at [site name], however, I work with clients across the age spectrum. So I'm able to work with clients from ages zero up to one hundred plus. And so, again, I think that will look like being a traditional mental health worker. So I should expand on that more. So that can mean attending IEP meetings and being an advocate with families, supporting schools in understanding mental health and all the different ways that can present, understanding trauma, that's really big. Trauma tends to be really misunderstood, especially when it comes to youth and communities of color, so it's acting as an advocate as well. Sometimes it's for the families, sometimes it's for the youth within their families, if they have adults in their life who are having trouble listening, or they maybe don't have any consistent adults than it's supporting them and getting connected to those adults outside of me. So in a lot of similar ways to you, I'm also acting as a bridge like [site name], for my clients and with my clients. I think a really big part of my role is to empower my clients to stick up for themselves and their needs. I think, because I am a clinician of color, a biracial black clinician, I tend to bring in or attract clients who are also people of color or who are Black. I think another role that I that I show up in is kind of underneath the heading of representation. And safety, I think for some clients, clients need to see people who look like them when they're seeking out help. And we need more Black and Brown clinicians in this field. So I act as a person who represents just one aspect of culture, knowing that we're not a monolith, but I'm an option. Let's see. In some ways I act as a teacher, I get in supporting teachers and learning but parents and learning as well, kids and learning about themselves, or at least learning about their family, now, but also generations before and how that connects to their current symptoms, sometimes. I'm a learner, too, I think that's a really big part of my role. I learned every single day from my clients, and I tell them that because I feel really lucky for the people I work with. And it's really important also for me to continue learning so that I can bring into my sessions and serve a greater range of people. I'm a secretary, it feels like, helping people organize their day to day stuff, support consistency in their mental health, in their schedules, and also helping in the long run too because then they're more consistent with me, sometimes. For teenagers, that changes day to day, but we're working on it. Sometimes I'm acting as a specifically sexual education teacher, there's been a lot of talk about sex this last year and sexual safety. And so that's part of my role. I think another big part is me just acting as a constant for people. Because I work with a lot of clients who experience significant grief and loss throughout their life and they don't necessarily have a lot of people who show up consistently for them. And so I tried to really make that central in my work to build that trust for my clients while explaining that I'm human. So there are some days where I'm gonna have to unexpectedly work from home or call off, and they understand that for the most part, and if they don't, we talk about it. I think we could probably go on and on about that, because there's so many different ways my role could be interpreted, but I think those are some of the key points.

Sarah Hamilton 12:58
Definitely. Yeah. And I see how as you're like, building relationship with clients, it could look obviously different with each client. So it's interesting to see all the different -

Participant 2 13:06
Clients are looking for different things. Yeah, exactly.

Sarah Hamilton 13:10
Very cool.

And then, I guess more generally, based on your work experience here at [site name], or, you know, in your previous research or positions, what would you - how would you describe like the mental health needs of children or youth who are experiencing homelessness or highly mobile?

Participant 2 13:29
This is one of the reasons why I do the work. I'm very passionate about this. But I think, it's hard to summarize them, I'm gonna try. I think some of the biggest impacts on mental health or struggles, it has to do with chronic stress. And chronic stress is extremely connected, like significantly connected to trauma, and medical health issues and all the other things that we see that when it comes to like research on ACEs, for example. So chronic stress and trauma are larger headings, I think, and then we can break that down into, lots of different headings, sub headings, I should say. I think that, let's see, if we start with chronic stress, like if you can go back to a lot of those basic needs that aren't being met, I work with a lot of clients that are experiencing homelessness or who are highly mobile and so that means they might not know what their schedule looks like the next day or where they're going to be staying or if they're going to be able to sleep. Some clients just walk and walk until they find a spot and that may take all night. And so with that again, comes with now okay, medically how are you doing. Do we need to get you connected with a doctor if you don't have a registered provider, connected with resources to even go to the doctor and I chat with them about how they're doing there so we can get to more of the emotional aspects or emotional impact on experiencing chronic stress. For parents, I tend to hear so much because parents, for the most part, never want their kids to experience trauma as a whole but they don't want them to experience homelessness. And I think, in the last couple years, especially, people have been feeling those financial strains, and so we're hearing more and more about financial impacts and how that impacts the whole family. So I talk a lot with parents about how to take care of themselves, and so that they can take care of their kids. So they're all connected. And I think when you're experiencing chronic stress, it's harder to hear those things and have capacity to hear those things, but then to do them as well. And so there's a lot of repetition involved, and a lot of patience involved there. But then we also, again, know chronic stress tends to lead to more medical health issues, which then leads to more consistency and showing up to appointments sometimes, be consistent in scheduling. And so it's just kind of a vicious cycle. And I know that and so I tend to try to really flexible with my clients knowing that they truly are trying their best. And for the most part, when clients sign up for therapy, they want to be there. There have been exceptions, of course, in the past, usually with kids whose parents have signed them up for something or clients have been mandated to go therapy as a part of Child Protection involvement. But even so, I've tried to really build that relationship. So even if they initially didn't choose to be there, they stay for the relationship, but that doesn't always happen. It's a really important part of therapy, and it changes the whole trajectory of the therapeutic relationship, and whether they go to therapy. Okay, and then when it comes to trauma, gosh, that is such a big topic. But I think trauma can, in my role look like, actually lately talking a lot about ADHD and ADHD. Because there's, there is a connection there. And there are a lot of kids and even adults not who are over diagnosed, essentially black and brown kids and adults. And so we talk a lot about is this ADD, ADHD? Or is this a trauma symptom? Or is it an anxiety symptom? And we have a lot of conversations to try to piece that apart. And that usually takes a

significant amount of time, because there's such a significant amount of overlap in symptoms when it comes to trauma and ADD, ADHD, other developmental disorders, anxiety, depression, because when every single night, you're not sure where you're gonna get your meal, that's gonna make you sad, naturally. And there's a lot of normalization, and validation that happens within that process. I think, even though it seems simple, if we mean the world to clients who are constantly told they're not doing enough, or they're lazy, they're being victim blamed for getting themselves in that situation. And it's almost never that simple. There are sometimes generations of trauma that have led up to this. And that, again, I guess, goes back to my role as a teacher, as a pensive to her clients, and seeing or understanding that there might be other options for them than to continue what they're doing. But I'd have to be open and receptive if they choose to hear that too. Let's see. I guess more specifically, not - it's connected to trauma, for sure. I think it's just more connected to my work. When people are chronically stressed, there tends to be more arguing and bigger things that come up because of they're in fight flight respond mode more often or all the time and so I do a lot of work in domestic violence as well. And I started in homelessness at Tubman, which is a domestic violence specific emergency shelter, for the most part. Domestic violence is another aspect of mental health or trauma that I specialize in. So I work with a lot of clients who have that experience or we're currently going through that. I talk a lot about domestic violence and its connection to trauma and the cycles that happen there with my youth and families. I talk a lot about racial violence with my clients just because of who they are and what it means to be a person of color every single day. I'm definitely missing a huge part of this. Oh, I talk a lot with the families about how their mental health symptoms or their trauma can sometimes act as a barrier for success in school. And not necessarily because it's a client's fault. But because I think a lot of times school systems, the classroom aren't set up for people who have experienced trauma, or anything. That's not like cookie cutter. I think we're learning as a whole. But there's still a lot of room for growth. And I just have seen kids go through kind of that pipeline in schools and not be supported. They talk a lot about the stress that can come from school and being in a space that is basically, they don't feel supported, and how that interacts with mental health symptoms, and sometimes exacerbates trauma. Let's see. Something I'm sure I'll remember later. But, yeah.

Sarah Hamilton 20:53
I totally understand I know, trauma is often the underlying factor, and there's, it looks different for everyone. So it's kind of, it is very hard to pin down. So thank you for explaining all the different nuances, I suppose. And the education piece is really interesting, too. Have you seen, or I saw the documentary "Paper Tigers." Talking about the school in Washington. It talks about there's a high school in Washington, Lincoln High School that like, changed their entire, I don't know what it's called. Not like, it's almost like their detention system, their discipline, like their they changed their entire, like, what discipline looks like? I don't know. Anyway, it was really interesting. So I, I see the point about education as well. And I suppose you've already touched on this a bit, and being highly mobile, obviously, is a barrier in itself. But I guess what are like common reasons why children or clients that you work with are facing like barriers to receiving mental health care?

Participant 2 22:02
Yeah. I mean, a lot of times it comes down to cost, it feels like it's not affordable. And it comes down to connection and client availability, openness. There are waitlists everywhere right now, there aren't enough mental health clinicians to support the need. And it's a great thing that therapy is becoming more widely known and widely used. But I just haven't seen the people there yet. And I think places are realizing that and are trying to hire a bunch, but there's a shortage and we can talk about sustainability for therapists and people in healthcare fields another time, but I think that's part of it, and why there's a shortage. But there's not enough people to provide services, there's not enough people who look like people who want those services. So I talked about earlier that representation, it's really important to - and I've worked with clients and seen clients who have taken a year, two years to find a therapist who looks like them, and only to have that therapist not fit with their schedule, or have a therapist not specialized in something that they

want to try. I have a permanency adoption competency certificate. So I work, I also have essentially been working with clients who have adoption in their stories or have been in foster care. So in connection with the child welfare system, and there aren't enough clinicians know enough about adoption and permanency in the foster care system. And I knew that I saw that in research when it comes to homelessness or people who are highly mobile. There's an overlap there too, with those clients in the system, and over representation. And there are specific needs that come with having that specific type of loss or trauma in your life. And so clients will sometimes wait, they need to find somebody who can understand them and who has the tools to support them, and they shouldn't have to sacrifice by working with a therapist who is not a good match. For whatever reason, whether that be personality, that's identity. And so that's a barrier, and I think again, some clients truly want and need therapeutic and mental health support and they don't have capacity to do or to go to it consistently. So I've done a lot of, I've had a lot of discussions, done a lot of advocacy, to make sure my clients have access to therapy when they no-showed or when they are super late to an appointment. After certain amount of times and every clinic, every agency is different in terms of their policies here. A lot of clinics and agencies level policy of like, oh, if you don't show twice, then you could put on our waitlist to get in or you can't work with that clinician, or you can't come here anymore. And when it comes to trauma, chronic stress, there are oftentimes barriers to transportation to get to appointments, there's a difficulty in getting off enough time of work to go, taking time on a lunch break. Outside, there's just like cost and other basically logistical barriers. And I just had a lot of discussions with people who have the power to make some of those changes to just say, hey, like, listen, I talked to my clients about why they don't show and we communicate, that's really important. It's one thing if a client just doesn't show up, and they kind of ghost, but it's another thing if they're talking with us and explain what happened, and can talk through what they still need. So. And so I just talked with higher ups, about what that looks like in terms of policy changes. And not everyone has ever had the capacity to have those conversations with the people making those policy decisions. And I do my best to use my voice. Because again, it's important to me, and the clients I work with, I know it's important to them, too. And I don't want to be one more person that abandoned my clients in their time of need because it's very vulnerable to ask for help. Those are some of the main barriers. So capacity, cost, general access, then public transportation to and from.

Sarah Hamilton 26:45
Yeah, thank you. Um, and then we're past 20 minutes. Would you have time for one more question? Okay, sounds good. I think this kind of, this one kind of gets more to the, a little bit beyond logistics, and more to my main question of trying to see what, what like you think is the most important for me to consider in my writing, or just generally for researchers or professors to be thinking about, but since, like the voices of mental health providers aren't included, I guess my main question is like, what do you wish that researchers were considering? Or kind of what questions do you wish they were asking in their research to better help children or youth experiencing houselessness or who are highly mobile? Kind of anything that comes to mind in that realm, I suppose.

Participant 2 27:42
It's a tough question. And maybe I should have prefaced this for the meeting but I tend to go to the overarching like macro level implications of stuff like this, because I do think that's generally where all of this comes to stem from, and I think a band aids over some things can be nice, but we really need to look at the root in order to address the problem to make like lasting change. And so I'm gonna approach this at a macro level. So it might not be exactly like concrete answers, apologies for that.

But I think that I think - I also I went to the U for undergrad and grad school, and I saw firsthand just, sometimes people in research -

I think oftentimes, people who are in research, haven't done direct service for a good amount of time, or that they have. And I think that can allow people to stay disconnected from the real humans who are

experiencing trauma or chronic stress. And that can allow researchers to cut corners in ways they maybe wouldn't, if they actually had like names and faces and stories behind what they were searching. I could say for policymakers as well. They don't always have that direct real human in front of them. And that just leads to … sometimes. And whether that's intentional or not, I think a lot of people mean well but we need to look at impact, not just intention, impacts can include people continue to not get the support they truly need. So I don't know, thinking in real time, but I do think people do the research generally need to connect with the people more often, like doing more things like oh, gosh, now I'm going to forget all my research terms, doing this type of research versus like, looking at the data. I at one point in my career needed to remember so many - between numbers research and story research and now I'm forgetting all of the terms, but you will know, I think I think you know what I'm talking about. And I think that you really need stories to, not everyone needs stories, but I think a lot of people need stories in order to make the connection with the therapy lane. And we've understood that more as we've been trying to get policies change. And so that's great to see more people sharing their lived experiences. It shouldn't have to be at the expense of people retraumatizing or hurting themselves to have other people that have more power to understand. But I think, in some ways, that's what it's taken. I think that researchers, therapists, people in policy, changing positions, policymakers, they could generally be more curious. I think it's wild sometimes. When I hear the questions people ask and not see that someone has a follow up question afterwards. If people are way too accepting, sometimes, especially in Minnesota, and even if they disagree, people will do like the Minnesota nice thing not saying they don't wanna ruffle feathers, or they don't want to come across as rude or too direct. And sometimes that's necessary in asking a direct or brief questions and not necessarily, to be rude or disrespectful. And so I think, ends up leaving a lot to be said, or there's a lot of unsaid questions that aren't asked that need to be asked. And so if researchers have the capacity or the flexibility to have follow up questions. Again, like, maybe it's just research or data for the researcher, but this is a person's real lived experience. And oftentimes, they're willing to tell you their story. They want you to know it for a reason and that means you need to look at what you're giving back to the participants in an ethical way because obviously you know, there are boundaries when it comes to, like in terms of compensation and things, but hearing, and leaving space for people's stories and what they feel the need to tell you is one way to be extremely validating and respectful of the people who are making time to give you their information and pay them, or when they may not have capacity to really - if I was highly mobile or homeless and I need space for someone to see my vulnerabilities, like it will feel really disheartening that someone asked me some certain several questions and leave and to not hear what happened with that ever again. And I've heard people have experienced that. And so I think those follow ups afterwards are also important. I guess what I'm addressing is more of that the setup as a whole of research needs to be looked at, so that it's inclusive of people, there's as much space left, so then people can adequately share what they need or what they want. And I think that, then address people of color, or people in the LGBTQ community not being included in research as much as they should. That was looked at at the very beginning and there was no space left and we were rushing through it, and we did the work to include the people in between groups to ensure that research is, make sure that people are represented in an accurate way when it comes to like our demographic driven society, there'd be a lot less of these issues that come up now. I feel like I need to give you like one answer though that at least like this is what they need to ask. I feel like -

reading the question on my page here -

I think, it can be absent what is the, what is the barrier for you if you're talking to a mental health provider or the barrier for you in making space to do this kind of interview? And then not only asking that question, but bringing that to whoever has power to make those changes is really important. Because I think oftentimes people know, what's getting underway, but then when it comes to actually doing something about it, or..

That's not really fair. And at the end I think so asking just what is a barrier for you to participate is important. And then -

Participant 2 35:43
Oh, I didn't see this, what do you think researchers or academics commonly misunderstand as well? Is that right?

Sarah Hamilton 35:49
Yeah, those are kind of all in the same realm. I suppose I just kind of reworded things to I don't know, I felt like the question was kind of confusing. So I just kind of added follow ups to add, I don't know some starting points, I guess.

Participant 2 36:03
Okay. Oh, yeah, I guess I can answer that part a little more concretely, what's misunderstood. I think it's misunderstood that all therapists generally, act as just a therapist. And like I explained to you before, like, there are many different pieces of my day and parts of my role. I'm on the phone a lot, talking to schools, talking to parents, talking to county workers and foster parents, not just going to an hour session and calling it a day. There's prep work and other behind the scenes work that's involved in being a therapist, I think that's misunderstood. Granted, I'm at a nonprofit, private practice is very different. So I think even that in itself needs to be known, that there's a difference in therapists in private practice versus nonprofit and what they have capacity for, what they're required to do as part of their day. Just in terms of licensing differences there and such, and funding differences. And I think that -

Oh, I also think it's misunderstood, maybe not just amongst researchers, but as a whole that therapists aren't, we're not our own people, that we don't have other parts of our life. I'm a therapist and a social worker, but that's not all of who I am. And I also struggle with mental health somedays, too. I talk about mental health every single day, but when it comes to doing things about it, it's a whole other situation, it's harder. And so a lot of therapists, I think, don't talk about with their clients or outside of that space, either, how important it is for us to be going to therapy or getting help, and we're just seen as like, oh, they have things together and they don't need help. That's absolutely not true, we do this work in part, or some people do, because they know what it's like to experience some of the stressors that our clients have experienced. And that gives us at least, more of an ability to support my clients in a direct way, in a significant way. And it gives back into the spaces to connect with clients, to give examples and to move their work really forward. I think maybe more traditional therapist would say, like, the only human in a therapy space is my client and I'm here to reflect back everything. And I think there's a time and place for that approach for sure. That's not typically my approach with my clients, they want to see that I'm there and see that they're being seen by another person. And so I think that's another big piece just, it's misunderstood that we don't have our stuff, we're not, you know, we don't need therapy like our clients do. And that's absolutely not true. We a lot of times need the exact same resources and support our clients are seeking out. It's one thing to take it or have the capacity to take it but it's just as important. And even you probably see this in academics, there's a separation between people experiencing the issue of what's written in textbooks, like oh, your clients might experience it in this way. There's no talk about how clinician might have experienced or be experiencing that as well. And that's been very real, like, I'm also a younger clinician, and so working with families and youth like sometimes youth are maybe 10 years younger than I am. And so I remember what it's like to go through younger adulthood and to not acknowledge that in the space would just be odd to me. And so maybe just because of my intersectional identities as a Black woman, being younger, that requires me to express some of these things and to not have so much disconnect between myself and my clients. But that doesn't mean I don't have boundaries, it just means that I bring that into place and use it in a appropriate therapeutic way. Some people just choose not to do that, I guess. And I think that's led to misunderstanding that therapists never be that and that's just not true.

Sarah Hamilton 40:35
Right. I see kind of the thread of like self-care, and, you know, like making sure clinicians are taking care of themselves, I guess, just like, as a follow up, is there like a lot of talk about like, how to prevent burnout at [site name]? Or like, what are those conversations look like for you all?

Participant 2 40:54
Yes, it is extremely important. There's a lot of discussion, I think, as a whole in the field about secondhand trauma and being exposed to trauma, not only with our clients. I have a lot of clients who have been exposed to trauma, they haven't experienced it directly. But for ourselves as well. It's a necessary part of the work to take care of yourself throughout your day. For some conversations, some client situations just hit harder on some days compared to others. And if I don't take care of myself, that means I can't show up for my client in the way that they need me to, and the way that I hope to show up as a clinician. So I think it depends on the clinician. Everyone has their own learning journey when it comes to taking care of themselves and prioritizing that. But I do that by not having my email connected to my home phone, some people do their emails all throughout the day. And I know I would if I had it there, but I specifically cut that off so that they don't go there. So sometimes self care looks like setting a very firm boundaries in terms of communication or connection. Especially, like for me working from home.

Oh did my video go off?

Sarah Hamilton 42:12
I think it just turned off yeah, but it had been on for the majority for the record.

Participant 2 42:16
It's like setting those really firm work life boundaries are important. When you can, there are some random like, outliers, like if a client truly is going through a health crisis, and you're actually available. I supported clients through those moments. While explicitly saying, this is not a normal thing, like do not make this a pattern please and we joke about it, we laugh but those boundaries are extremely important. I'm still working on it myself as a newer clinician, it's hard to stop it, especially when certain documentation needs to be done. I think that within the workday like I've had a lot of conversations and a lot of advocacy actually at [site name], to make sure we have space like cut out or intentionally left in our day to take 15 minutes to calm down, get some coffee, drink some water, go to the bathroom. Because some days you have meetings back to back to back to back, just with how scheduling works. Especially working with kids like more often than not you don't want to have the kid miss school for an appointment and so in the evening especially like I could usually be back to back from three to like seven or eight if I allowed it, but I can't do that every day. My clients realize that even if they'd like me to sometimes, that can't happen. So setting boundary on your work hours and if you have multiple clients in a row, I've advocated for making space so that you get 15 minutes because if you don't make that space sometimes people take it and that's not necessarily their fault, people need support and there's a lot to do, but you can't do everything, and I think that needs to, you know, that also goes into like different savior pieces of this work that come up and that's what helps me keep my boundaries is I know that going into a savior like role or having some of those beliefs can lead to a lot of harm and I've seen that harm happen and I've heard about that harm from clients in their work with their previous clinicians or previous county workers and such. I'm talk about that a lot too with my clients. Even more so specifically like my clients in foster care and the adoption system and transracial adoption. Boundaries are important for many different reasons. And that is the biggest, I think part of self care. A lot of work to do when it comes to caring for clinicians and their mental health? You know, that saviorship is kind of built in to these systems in that we're, you know, caught insulted. I mean, I know I was told many times before that, like, we don't do this for the money, we do this for the clients, because it's heart work. I'm sure that's true. Like, I don't know,

anyone who is in it for the money and money is nice. Like, we also have needs, again. And so if you're just in it, to support others, but have no aim, it can be a weird dynamic there that again, isn't always healthy and makes it saviorship tendencies and cycles.

Participant 2 42:16
I'm sure that's plenty. There's probably more but yeah. Self care is a very important part of this. And I know I make the space and apologize later doing it, but sometimes you just need to. Yeah.

Sarah Hamilton 46:08
Yeah, I feel like boundary, everyone needs to learn how to do boundaries. Like, that's just an ongoing, at least that's what I've been learning about myself, I guess. It's it's just a learning process, I think for me, but it comes and goes and just see how it all unfolds.

Participant 2 46:27
Yeah, if people like professors and other people in higher up positions, who don't have their boundaries set, that tends to trickle down, to the people they supervise and watch over. They're messaging you or emailing you at whatever hour and there's a push or pull to respond. And it's not necessary, usually. And so that's why I think so much of it goes back to the people who have more power, making sure that they see the importance of this and that it influences everyone who has less power within those systems, below them potentially. Weird to say below them, but people who have less power. Whether that's a supervisor, Professor, CEO, director, clinician with the client. Yeah, it all trickles down.

Sarah Hamilton 47:21
Okay, well, thank you so much for everything that you've shared, I feel like all of your answers were so rich, and there were so many different like facets to each part of it. And I'm just, I'm just really excited to be able to hear your insight and be able to hear more about [site name]. And it's really cool that you guys are so nearby and doing the work. And I'm just grateful I got to get to hear about it, so thank you.

Participant 2 47:44
No problem. And I'm really passionate about all of this. So I'm glad that this is happening. I'm excited for the results to see how this goes. And I also know like, I'm looking at the full list of questions. There are lots of questions on here. So if you need me to follow up with any other information, let me know.

Sarah Hamilton 48:05
Oh, yeah, no worries. I started with a big list, knowing that conversation would just, you know, go for it. And then that's just the way, that's just the way it goes. And that's what I obviously I want to hear the most from you, not really, from my, like what I wanted to ask questions about, you know, that would, that would be hypocritical of my entire deal. So.

Participant 2 48:27
Right, and I also know, within, with how research works, or something, you have to get an answer. So like, if you end up needing something or you're getting push to get other answers, or there's a gap, just let me know. Lots of directions this can go in, and lots to explore. And I only covered a handful of questions on the list, so just let me know, I know it's important.

Sarah Hamilton 48:53
Okay, thank you so much. That's very helpful. So as I mentioned, the beginning, there'll be two more like optional opportunities for input. If you want to add more comments. I'll send you the notes from our discussion specifically. And then from my overall findings. Again, those are totally optional. There's no need to respond, you can totally just see the email and delete it if you want to. You can read it and see what you think or really whatever feels best. Yes, and then you will be compensated $15. That's our little,

what we've got, that's the system we've got going right now. So is it okay, if I just mailed that to the [site name] Foundation with your name or is there a better address?

Participant 2 49:38
Yeah, whichever. [site name] would be easy. The address is in my email and yeah, you just put my name on on it and it'll get to the mailboxes.

Sarah Hamilton 49:49
Perfect. I will do that. Anything else, or any other questions you might have for me or comments, I guess?

Participant 2 50:06
I want to, I guess I didn't highlight this explicitly, but I wanted to get that it is in terms of like, self care, and in terms of providing the best care for clients, and making sure they have access to people who represents different pieces of them that they feel like they need to work out or want to work on. Doing your own work as a clinician is extremely important. And I mean, I mentioned I go to therapy myself, like, it's important that you, for instance, use that resource. If you have a supervisor, get support, use that space for consultation, if you don't have a supervisor, find someone to talk to about this. Because burned out therapists, social workers, can also cause harm. And we have a lot of power in our space with our clients. And if we aren't taking time to look at that influence, look at that power dynamic, and do work with our biases, that can really be really consequential to our clients who don't have as much power as we do in our space. And when it comes to working with clients who are experiencing homelessness, or who are highly mobile, you need to be able to check yourself so that you're not putting more onto your clients when they're coming to that space. And I guess I've heard, so much harm happened for people from people who are well intentioned, who aren't taking care of themselves, try to show up for the clients. And so that's also a really important aspect of all this is just making sure you're doing that internal work as a provider, as a researcher, then you can look at those biases, try to find what you're missing, before it becomes an issue. We're only human, so we're going to miss things. But some people could do more of that work than they'd like to admit to themselves. And when people have bad experiences in therapy, that a lot of times will prevent them or act as a barrier also, from them seeking out help in the future. And you don't want to be that person. You don't want to be that horror story for somebody. And I've been the person that heard horror stories, and I may have even been a person who has caused harm, and I don't know it. This is a human field. It's an imperfect field. So things do happen, but you can help me in that kind of work.

Sarah Hamilton 52:46
Right. That makes a lot of sense. Like it's not only working with the client, but it's ultimately working with yourself so that you can work with the client more effectively. That's a good point.

Participant 2 52:56
That self awareness is very important. It's key.

Sarah Hamilton 53:02
Yeah, that's a very, that's a good, good thing to be keeping in mind. Thank you for bringing that up. Okay. Well, I think that's all I have for today. Thank you so much again, I really appreciate it. And I'm really excited to be able to honor your insight and your perspective. So thank you.

Participant 2 53:20
For sure. It's no problem at all. Thank you for reaching out and for doing this research project. Again, best of luck. I know it's not easy, I think, it takes a lot of work and time energy on your end. So I hope it goes well. Feel free to reach out if you need anything else too.

Sarah Hamilton 53:35
Okay, perfect. Thank you so much.

Participant 2 53:38
Thank you. Bye

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