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Mental Health Service Providers' Engagement Experiences of Homeless Individuals

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This is to certify that the doctoral dissertation by

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Abstract

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of the Requirements for the Degree of

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Abstract

Limited literature exists regarding best engagement practices of mental health service providers in encouraging the homeless individuals to participate in clinical mental health services in New York City. New York City has a population of more than 8.5 million, and in 2017 more than 129,803 homeless individuals slept in shelters. The purpose of this phenomenological qualitative study was to gain more insight and knowledge about the best engagement practices and experiences of mental health service providers in encouraging homeless individuals to participate in clinical mental health services. The conceptual framework used to guide this study comes from Kearsley and Shneiderman's engagement theory. The study employed a phenomenological method, utilizing a nonprobability sample design with a purposeful and criterion sample with 12 mental health service providers to reach saturation and to yield insights and in-depth understandings for the questions under research. Data were analyzed and coded to identify categories and themes. Findings from this research highlighted 3 themes based on participant responses: (a) building rapport, (b) medical and mental health, and (c) resistance to change. This study provides insight and understanding of the phenomenon of homelessness and provides information on engaging the homeless and how the participants encouraged homeless individuals to participate in clinical services.

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Dedication

I dedicate this work to my role models, my grandmother Beryl Wallace and my mother Pamela Thomas. Thank you for instilling in me the importance of education and keeping excelsior as my motto to push myself to meet and exceed my goals for reminding me that anything worth having is worth fighting for and that hard work brings success. You urged me to do all the good I can, in all the ways I can, for as long as I can. Your wisdom has guided and taught me valuable lessons, which I live by on my journey to make a lasting impression in this world. You have encouraged me throughout my life and have contributed to the person I am today, enabling me to instill the same values in my children and support those around me to facilitate positive social change. These humble yet influential words helped shape my purpose in life.

To my husband, Malcolm, your unwavering support throughout the years has been instrumental, and I thank you for always putting away my laptop when I fell asleep ☺. To my children, Naaquis, Mahkai, and Taejah, please let this accomplishment serve as inspiration that the sky is the limit; never give up!

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Chapter 1: Introduction to the Study

As social creatures, humans need to engage others and these engagement experiences are a direct reflection of growth and development. Researchers in applied psychology use the concept of engagement to include enhancing self-belief, fostering learning, investing in support services, committing emotionally, changing expectation, and becoming active citizens (Great Schools Partnership, 2016; Kruse, 2012). According to Lee and Donaldson (2018), engagement within social support services happens when service providers reach out to people to encourage them to partake in the services provided. Successful engagement of homeless individuals included ongoing engagement with the homeless person, kept appointments, established goals, steps to meet these goals, and related factors perceived and reported by the mental health providers (Lee & Donaldson, 2018). Despite several decades of research on the importance of engagement, homeless individuals often failed to commit to the services to end their homelessness (Hwang & Burns, 2014; National Alliance to End Homelessness, 2015; Norman & Pauly, 2013; Norman, Pauly, Marks, & Palazzo, 2015).

Meschede (2011) and Hauff and Secor-Turner (2014) speculated that homeless individuals might not engage in the clinical services offered because of the barriers they encounter, such as the inability to pay for services, negative service experiences with providers, feelings of being hassled during services, and possible confusion about services offered. Despite best efforts to improve engagement, limited research has been conducted on how mental health providers engaged homeless individuals to participate in the clinical services (Dixon, Holoshitz, & Nossel, 2016). Instead, researchers focused on global environmental factors, such as the lack of stable housing, physical and mental health problems, violent situations, and substance abuse treatment needs as both contributors to a lack of engagement and the need for improved engagement of the homeless (Corrigall-Brown, Snow, Smith, & Quist, 2009; Fazel, Geddes, & Kushel, 2014; Meanwell, 2012;). There remains a gap in the literature at the relationship or micro-level regarding the processes utilized by mental health providers to engage homeless individuals. Such an understanding was needed to determine engagement best practices to use in encouraging homeless individuals to commit to participating in the clinical services (Dixon et al., 2016).

The goal of this study was to gain insight into the engagement practices and experiences of mental health service providers, especially where perceived barriers to engagement with homeless individuals were concerned. The insight gained would provide researchers, policy-makers, mental health service providers, and the homeless community, with more information about engagement practices needed for successful engagement outcomes.

This chapter is organized by the background of this study, problem and purpose statements, research questions, theoretical framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance of the study before ending with a summary. The next section is the background, which consists of a review of the construct of engagement.

Background

In the mid-1950s, pharmaceutical companies introduced a variety of antipsychotic drugs that paved the way, in many countries, for eliminating asylum based mental health care and developing outpatient treatment, better known as community oriented care (Unite for Sight, n.d.). The Community Mental Health Centers Act of 1963 closed many state psychiatric hospitals (Unite for Sight, n.d.) and provided funding for the development of community based programs for mental health services. This deinstitutionalization of patients from psychiatric institutions was associated with a growing population of mentally ill homeless people (Mental Illness Policy, 2017). Eventually, Congress passed the Stewart B. McKinney Homeless Assistance Act of 1987, aimed at reducing homelessness by providing more community based services, programs, and service providers (United States Interagency Council on Homelessness, 2016).

The increase in community based programs for the mentally ill led to more service engagement between providers and the mentally ill, and to the application of Georgiana S. Tryon's (1990) concept of engagement. Tryon defined engagement as the client's return to treatment after intake. For instance, Tryon investigated engagement and the likelihood of a mental health client returning for a second session based on their first session. Tryon found that the length and depth of the client's initial interview played an integral role in determining the client's return, as influenced by their level of satisfaction, disturbance, and motivation. When clients and providers were engaged in a positive helping relationship, the clients in her study were more satisfied and more likely to return for services (Tryon, 1990). Despite this early and promising research on engagement, according to Canavan et al. (2012), Dixon et al. (2016), Fazel et al. (2014) and Hwang and Burns (2014) and many mentally ill homeless people failed to commit to participating in the homeless services. This was due to barriers such as a lack of trust in the service provider, alcohol and substance abuse issues, lack of health insurance and mental health outreach provision, and negative responses by service providers.

Additionally, Padgett, Henwood, Abrams, and Davis (2008) and Pahwa, Smith, Yuan and Padgett (2019) posited that engagement and retention were the most significant barriers for mental health providers trying to help homeless and mentally ill people. Padgett et al. and Pahwa et al. identified person-centered themes (i.e., mental illness and substance abuse) and system related themes (i.e., acts of kindness, access to housing, pleasant surroundings, lack of one-on-one, rules/regulations). These person-centered themes may result in engagement and retention in treatment services or may lead to termination of treatment services (Padgett et al., 2008; Pahwa et al., 2019). However, further investigation was needed to explore if the implementation of engagement strategies encouraged the homeless individuals to commit to participating in clinical services, where perceived barriers to engagement were concerned (Dixon et al., 2016).

Mental illness is the third greatest cause of homelessness for single adults in the United States, and when seriously mentally ill homeless individuals refused assistance or failed to commit to services provided by mental health and homeless service providers, the societal costs are high (National Alliance to End Homelessness, 2015). Being able to adequately engage and encourage the mentally ill homeless person to commit to services is a problem for many service providers, yet there exists a gap in the service providers, understanding of how to best engage the seriously mentally ill homeless individuals in this process. In the next section, the problem statement associated with this qualitative study is described.

Problem Statement

While researchers have addressed the concept of engagement for decades, a gap persisted in the research concerning its implementation and barriers to its implementation (Tryon, 1990). The problem I addressed in this study was the limited research regarding the engagement practices and experiences of mental health service providers in New York City when encouraging the homeless individuals to commit to clinical services, especially where perceived barriers to engagement were concerned. Meschede (2011) and Hauff and Secor-Turner (2014) speculated that homeless individuals may not participate in clinical services because of the barriers they encounter. These barriers included the inability to pay for services, negative service experiences, feelings of being hassled during services, and possible confusion about services offered. Although, these purported barriers and their relationship to engagement practices remained unexamined.

According to the members of the National Alliance to End Homelessness (2015), many people with untreated psychiatric illnesses made up approximately one third, or 250,000, of the estimated 744,000 homeless individuals in the United States, with schizophrenia and bipolar disorders being the most prevalent disorders in this population. Moreover, according to data from a 2016 census report, the New York City population had reached an all-time high with more than 8.5 million individuals (Clarke, 2017). Of those, more than 129,803 homeless individuals slept in shelters (Coalition for the Homeless, 2017).

This qualitative study addressed prior researchers' (Dixon et al., 2016; Hauff & Secor-Turner, 2014; Meschede, 2011; Tryon, 1990) recommendations that mental health service providers gain more understanding about how to best engage the mentally ill homeless, by evaluating engagement with mentally ill homeless persons based on the perspective of providers. In the next section, the purpose of this qualitative study is discussed.

Purpose of the study

The purpose of this phenomenological qualitative study was to gain more insight into the engagement practices, experiences, and perceived barriers of mental health service providers, in New York City when encouraging homeless individuals to commit to participating in clinical services. The insight gained from this study was intended to provide researchers, policymakers, mental health service providers, and the homeless community with more information about the resources needed for successful engagement outcomes. In the next section, the research questions are discussed.

Research Questions

Three research questions were formulated from an overarching consideration of engagement practices by mental health service providers with the homeless individuals they serve in New York City. They were:

1. What engagement practices do mental health service providers, in New York City, identify as successful when engaging mentally ill homeless individuals about provided clinical services?
2. How do mental health service providers, in New York City, explain their experience of engagement with mentally ill homeless individuals?
3. What barriers do mental health service providers, in New York City, face when engaging mentally ill homeless individuals about committing to provided clinical services?

Conceptual Framework

Tryon's (1990) concept of engagement, though associated with an important focus in the literature was narrow in scope and limited to how engagement affected the likelihood of a client returning to treatment after intake. The conceptual framework used to guide this qualitative study came from Kearsley and Shneiderman's (1999) engagement theory (ET). Kearsley and Shneiderman's theory was originally developed for learning environments; however, it had an application to the clinical setting as well. According to Kearsley and Shneiderman, the major premise of ET is that individuals must be involved with others in tasks that they believed were worthwhile and meaningful in order to create engagement resulting in successful collaboration. There were three primary means to accomplish engagement: (a) an emphasis on collaborative efforts, (b) project based assignments, and (c) a nonacademic focus. A mental health equivalent of nonacademic focus may be the individual focusing on other skills (i.e., vocational, medical health, wellness, and substance use). Kearsley and Shneiderman suggested that the extent to which these three variables were present in the learning environment increased the likelihood of successful engagement that is creative, meaningful, and authentic.

Drawing on Kearsley and Shneiderman (1999) in the academic setting, Machumu, Zhu, and Almasi (2018) examined how motivational factors related to engagement learning. Machumu et al. found that, consistent with Kearsley and Shneiderman individuals in their sample who were involved in learning tasks that they believed were worthwhile and meaningful were effective in creating successful engagement and learning strategies.

Kearsley and Shneiderman's (1999) ET works well as a framework for this study because its concepts were easily translatable to mental health services. For instance, mental health services were a collaboration between provider and client, were project based in that goals were designed to facilitate growth and wellbeing and were rarely didactic. Based on Kearsley and Shneiderman's ET, mental health service providers who could develop rapport (collaboration) and worked with the homeless individual to establish concrete, outcome based goals could report greater engagement. By contrast, barriers to engagement may include but were not limited to stigma, lack of insight, language barriers, abstinence, and treatment. These examples of barriers could be resolved by emphasizing the importance of collaborative efforts, based on one of Kearsley and Shneiderman's primary means to accomplish engagement. According to the ET, some examples of practices that might be project based that applied to this population may include clinical individual sessions with providers and clinical group sessions with other homeless peers. The next section will include information about why phenomenology worked best with this study.

Nature of the study

The nature of this qualitative study was phenomenological. Phenomenology was used to understand participants' experiences, through their feelings, related to the phenomenon in the real world setting (Ashworth, 2016; Moustakas, 1994). Phenomenology is a systematic and disciplined methodology based on knowledge, and its focus is on subjectivity and discovering the essence of experiences (Ashworth, 2016; Moustakas, 1994). A qualitative research method was suitable for this study because the research questions pertain to the identification, nature, essence, and accounts of the phenomenon shared by mental health service providers, as identified by van Manen (2007, 2016).

According to Creswell and Creswell (2017) and Golafshani (2003), researchers understand participants' experiences through a naturalistic approach, and the findings were not from any quantifiable or statistical methods. Furthermore, the qualitative method of inquiry used interviews, documents, and observations to gain depth and richness from a small pool of participants (Creswell, 2009; Creswell & Poth, 2017; Moustakas, 1994). The qualitative method works best for research when the researcher could use different philosophical assumptions, strategies of inquiry, data collection methods, analysis, and interpretations (Creswell & Creswell, 2017; Golafshani, 2003). Qualitative data was gathered through interviews with mental health service providers who worked with the homeless in New York City. This qualitative phenomenological research design allowed for the understanding of the experiences of mental health service providers as they engage the homeless to provide services. The next section provides operational definitions for the terms used throughout this study.

Definitions of Terms

The following operational terms and phrases were used throughout this study:

Barriers to service engagement: Service engagement refers to contact with a service provider (Lee & Donaldson, 2018). Factors that hinder the engagement of the homeless person, as reported by the mental health provider, were barriers to service engagement.

Mental health services: Services provided by mental health service providers at a homeless shelter are clinical services (i.e., care planning and diagnosis, treatment and follow up of persons experiencing homelessness) (Hwang & Burns, 2014).

Engagement: Engagement, for the sake of this study, is when mental health service providers reach out to homeless individuals to encourage them through trust to partake in homeless services provided by mental health providers (Lee & Donaldson, 2018).

Mental health service providers: Mental health service providers in homeless shelters included mental health service providers with different levels of training (Hwang & Burns, 2014). For this study, mental health service providers included all service providers with the credentials of a master’s degree, who provided services at homeless shelters. The mental health service providers had job titles, such as mental health counselors, program directors, case managers, peer specialists, and nurse.

Successful engagement: Successful engagement of homeless persons is ongoing engagement with the homeless person, kept appointments, established goals, steps to meet these goals, and related factors perceived and reported by the mental health provider (Lee & Donaldson, 2018; Olivet, Bassuk, Elstad, Kenney, & Jassil, 2010).

The next section will include a discussion of the assumptions of this study.

Assumptions

According to Moustakas (1994), Patton (2002, 2015), phenomenological research consists of the assumption that there was an essence of shared experiences between participants. Moustakas believed that researchers must be open to many possibilities of paradigms. This phenomenological method fits this study's investigation into the engagement practices and experiences, of the mental health service providers, in encouraging the homeless individuals to commit to participating in the clinical services provided by the mental health service providers. It was assumed that participants were receptive to sharing their experiences with engaging homeless individuals about mental health services.

Further, it was assumed that participants, as mental health service providers, comprehended the interview questions and did not under or over report their experiences and that they had a comprehensive understanding of servicing for the homeless. Researchers assumed that the topic of the engagement practices and experiences of the mental health service providers was of current interest (Dixon et al., 2016). In the next section, there is a discussion of the scope and delimitations of this study.

Scope and Delimitations

Research on this specific problem was necessary because homelessness remains a significant social problem, and there are barriers to engagement for individuals with serious mental illnesses that included negative stigmas, lack of insight, and language, and cultural barriers (Easter et al., 2016; Lal & Malla, 2015). The location of the two local homeless shelters from which participants were drawn was Bronx County, New York City. There are approximately 1.385 million individuals in Bronx County, New York City (Suburban State, 2016). Moreover, one of the shelters accepted only women, and the other shelter only took homeless men and male veterans. The scope of this study included some mental health service providers with licensed master social workers (LMSW), licensed mental health counselors (LMHC), master of human services (MHS), yet, not required for engagement.

Creswell (2009) and Creswell and Poth (2017) stated that delimitations were the tools used to refine the scope of the research. The scope of this study was limited to the use of only licensed, masters level mental health service providers who had experience with homeless individuals. While numerous other mental health professionals or paraprofessionals with varying levels of education and experience might offer insight. Limiting participants to master’s level, licensed individuals meant they had met minimum and uniform standards at the master’s level for training and experience and ensured some homogeneity of this sample. In the next section, there is a discussion of the limitations of this study.

Limitations

The major limitation of this study related to the methodology, which used a qualitative, phenomenological design and interviews of mental health service providers from homeless shelters in Bronx County, New York City. The sample size allowed participants to tell their stories while avoiding redundancy of information (Moustakas, 1994). The sample size provided for quality (Creswell & Creswell, 2017). This research design yielded specific data with detailed information in a geographic area, but findings may not be generalizable to other homeless populations or mental health service providers for the homeless. Potential biases that influenced this study's outcomes included researcher biases and mental health service provider biases. The validity and reliability of the findings from this study were limited to subjectivity due to the nature of a qualitative study. To address the issue of validity and reliability and reduce the impact or influence of the phenomenological design on the interpretation of the findings from this study; all participant interviews were recorded and transcribed. Interview transcripts notes were compared to the notes with the actual interview transcripts to increase validity (Creswell & Creswell, 2017; Moustakas, 1994). In the next section, there is a discussion of the significance of this study.

Significance of the Study

This study was important because it would begin to fill the gap in the literature identified in the problem statement regarding the limited research about the engagement process between mental health service providers and homeless individuals. Specifically, the limited research related to the engagement practices of the mental health service providers, in encouraging the homeless individuals to commit to participating in clinical services. The significance of this study was to stimulate a needed positive social change by gaining more insight and understanding of the phenomenon and to reduce care and engagement barriers. This study was also important because it could help researchers, policy makers, mental health service providers, and the homeless community with more information about the resources needed for successful engagement outcomes.

According to Bussewitz (2016) and Nahmias (2016), the engagement of homeless and mentally ill individuals continues to be a fiscal concern for mental health service providers. For example, facilitating the commitment of mentally ill individuals to clinical services would decrease emergent care costs by billions (United States Interagency Council on Homelessness, n.d.), and reduce the estimated $36,000 to $40,000 annually American taxpayers pay for a homeless person to be on the street (Coalition for the Homeless, 2018; Moorhead, 2012). Similarly, these clinical services could potentially increase homeless and mentally ill individuals estimated life expectancy to over 40 years (Fazel et al., 2014).

Many shelter managers throughout the United States are struggling to figure out how to keep their shelters operating after the Federal Department of Housing and Urban Development (HUD) cut funding for transitional homeless shelters to allot more funding to permanent housing (Bussewitz, 2016; Nahmias, 2016). Members of HUD believed that it is the service providers’ responsibility to reduce homelessness, yet when service providers struggle through the engagement process to get the homeless individuals to commit to services funding organizations cut needed funds (Bussewitz, 2016). The next section is a summary of Chapter 1 of this study.

Summary

On average, homelessness in America affects over 1.1 million people (Cox, 2013), and most of those individuals were homeless for a year or longer (National Alliance to End Homelessness, 2015). The number of homeless people in New York City has increased by 30% since 2016 (Durkin, 2017), which was mainly due to the engagement process of getting individuals off the street. New York City officials speculated that it could take up to five months to encourage a single homeless individual to participate in homeless services (Durkin, 2017), and Bronx outreach teams engaged in conversation with over 1,400 homeless individuals monthly (Uniting for Solutions Beyond Shelters, n.d.). Homeless individuals faced a variety of mental health challenges in addition to their need for housing. This chapter included a few assumptions, and if managed correctly, the assumptions should not cause any problems. This chapter covered details about the importance of the engagement process between mental health providers and homeless individuals. The chapter also included information about how many Americans place stigmas on homeless, mentally ill individuals, which created barriers to engagement (Lal & Malla, 2015; Smith, Easter, Pollock, Pope, & Wisdom, 2013). The remaining chapters of this study include an in depth review of the literature, research method for the study, results of the data analysis, and a summary of the statistical findings that emphasize the importance of this study.

Chapter 2: Literature Review

Introduction

The engagement of homeless and mentally ill individuals continues to be a financial concern for mental health service providers. According to Nahmias (2016) and Bussewitz (2016), many shelter managers throughout the United States struggle to keep shelters operating after the HUD cut funding for transitional homeless shelters to allot more funding to permanent housing. Members of HUD believe that it is the service providers' responsibility to reduce homelessness, yet when the service providers struggled through the engagement process to get the homeless individuals to commit to services funding organizations cut needed funds (Bussewitz, 2016). The problem this research addressed was the limited research regarding the engagement practices and experiences of mental health service providers in New York City, when encouraging the homeless individuals to commit to clinical services, especially where perceived barriers to engagement were concerned. Homeless people who successfully engage with mental health service providers tend to have better health and housing outcomes (O'Toole, Johnson, Borgia, & Rose, 2015; O'Toole et al., 2011). Thus, the purpose of this phenomenological qualitative study was to gain more insight into the engagement practices and experiences of mental health service providers, in New York City when encouraging homeless individuals to commit to participating in clinical services, especially where perceived barriers to engagement were concerned.

This chapter includes the literature search strategy, the conceptual foundation, and a synopsis of the current literature regarding homelessness, outreach, engagement, and factors of the engagement process. The chapter ends with a summary and conclusions.

Literature Search Strategy

The literature search strategy included gathering articles from peer reviewed journals, mostly within the last five years from databases and search engines, such as PsycINFO, JSTOR Archive, ProQuest, and Google Scholar. Articles were gathered from reputable online sources, such as the National Alliance to End Homelessness and the U.S. Department of Housing and Urban Development, regarding existing outreach and engagement programs for the homeless. Keywords used for the search included: homelessness, engagement, outreach, engagement theory, mental health, homeless shelter, veterans, social services, services to the homeless, and engagement and outreach programs. To keep the data current, the scope of the literature review included an initial search with dates from 2014 onward, followed by a search of all years to further explore the topic. Reference lists were used from the few journal articles that consisted of the limited current literature to locate other potential peer reviewed or credible journal articles relating to homelessness, engagement theory, and engagement. By using those referenced sources more literature was located quickly, which made the searching process for credible sources for this research, conceptual framework and the literature review sections, in Chapter 2, more seamless and in turn saved time.

Conceptual Framework

The conceptual framework used to guide this study came from Kearsley and Shneiderman's (1999) concept of ET. According to Kearsley and Shneiderman, the major premise of ET was that individuals must be engaged in tasks that they believed were worthwhile and meaningful to create successful collaboration groups. The three primary means to accomplish engagement are: (a) an emphasis on collaborative efforts, (b) project based assignments, and (c) nonacademic focus. Kearsley and Shneiderman suggested that these three methods resulted in learning that was creative, meaningful, and authentic.

ET was applied by facilitators to help students learn (Isaacson & Riley, 2009; Shum, 2017). Use of this theory to devise interventions was associated with improved test scores, attitudes, and achievement in students (Isaacson & Riley, 2009; Shum, 2017). Isaacson and Riley concluded that ET needs to be applied by facilitators and curriculum designers to all types of learners, including those from low and no income backgrounds. Students, staff, and community members at Seattle Pacific University utilized ET in making attempts to help the homeless learn how to make life changes and address barriers. (Seattle Pacific University, 2015). According to Ivey, Ivey, and Zalaquett (2010, 2013, 2015), and Okun and Kantrowitz (2014) service providers could also improve engagement strategies by decreasing barriers experienced by homeless individuals and developing alternate means around potential barriers that individuals may encounter (Ivey et al., 2010, 2013, 2015; Okun & Kantrowitz, 2014).

According to Kornhaber, Walsh, Duff, and Walker (2016), when practicing person-centered care with engagement, healthcare service providers must pay close attention when responding to patients’ emotions and unmet needs, because the lack of adherence could produce negative clinical outcomes. The application of ET allowed individuals to activate their levels of motivation to make changes that yielded positive outcomes (Kornhaber et al., 2016).

The application of ET could be used to build motivation for providers who engaged and delivered services to the homeless, which may be associated with positive health behavior changes for the homeless and a commitment to clinical services because of ET methods. The concept of ET could help providers address the issues of engagement and the application of ET methods, by the services provided; ET could also allow the homeless to activate their levels of motivation to make changes that yielded positive outcomes (Kearsley & Shneiderman, 1999; Kornhaber et al., 2016). ET could prove beneficial to encouraging the homeless individuals to commit to participating in the clinical services provided by mental health service providers, by gaining more insight and understanding about the phenomenon and to possibly reduce care and engagement barriers.

ET was a concept that researchers do not link to any one field of study, discipline, or role, and works well as a framework for this study because its concepts were easily translatable to mental health services. The goal of this study was to gain insight into the engagement practices and experiences of mental health service providers when encouraging homeless individuals to commit to participating in clinical services. ET was used as the conceptual framework for this research to answer the research questions focused on learning about the best engagement practices from the providers who would deliver the services to the homeless, to construct the literature review, to guide this study, and to explore major themes from previous research about how the engagement process could assist in helping the homeless. Based on ET, it can be predicted that mental health service providers who could develop rapport (collaboration) and worked with the homeless individual to establish concrete, outcome based goals would report greater engagement. In the next section, there is a discussion of the literature review of this study.

Literature Review

The literature review for this study included current studies related to engagement, service providers, mental health, homelessness, substance use and abuse, and poverty. The topics that were presented in this literature review were consistent with the research questions and study variables of engagement of the homeless in community responses to homelessness and related factors (i.e., engagement, homelessness, poverty, geographic locations, mental illnesses, health conditions). There were numerous factors related to homelessness to include environmental factors that contributed to the engagement process from service provider attempts at engagement, existing outreach programs processes, need for engagement of the homeless, meaningful engagement, acts of kindness and respect, peer support for engagement, technology and engagement, money and tobacco, and disengagement of the homeless.

Engagement

According to the Homes and Communities Agency (2015), data from a case study by the Quaggy River Action Group in South London, provided an example of a resident led group of people who engaged other residents to clean up a river in Lewisham. Members of the Quaggy River Action Group engaged residents in an open forum to discuss best practices and to share decision making, which gained the residents' trust and resulted in them selecting the best environmentally friendly and cost effective method for them to clean up and protect the river and their local environment (Homes and Communities Agency, 2015). The engagement process could work well in any area, and with the application of ET to develop insight into the role engagement plays in an individual or a community's interaction with others could result in positive changes that could benefit the individual and community at large (Health Science Institute, 2017). When considering the community at large and how to encourage a population, like the homeless, to participate in and commit to using provided services, there were some factors that may impact the engagement process to include individuals' trust, shared decision making, therapeutic alliance, and accessibility of care (Dixon et al., 2016; Health Science Institute [HIS], 2017). It was important to optimize recovery oriented skills and emerging treatment strategies, including the use of electronics and internet, peers, and a cultural formulation interview to deliver essential services to the mentally ill (Dixon et al., 2016). Moreover, homeless individuals may struggle due to rigid appointment systems, inability to navigate a complex health service system, and difficulty forming relationships with healthcare professionals (Dixon et al., 2016).

According to Ngo et al. (2016), healthcare professionals highlight roadblocks and identify minimal formal documents (e.g., anecdotal reports) about the role specialists play in promoting the engagement of homeless persons in healthcare. Ngo et al. conducted a study to compare the effectiveness of a community engagement program versus a technical assistance approach. Ngo et al. referred to the technical assistance approach as resources for services to deliver depression care for low income ethnic minority women. In Los Angeles, California, Ngo et al. conducted a secondary analysis of intervention to determine the effects for largely low income, minority women (a subsample with 45.1% Latino and 45.4% African American).

Between 2010 and 2012, Ngo et al. (2016) conducted a matched, clustered, randomized control trial in two low resource communities and found no intervention difference for depressive symptoms. Yet there were statistically notable effects for mental health quality of life, resiliency, homelessness risk, and financial difficulties at 6 months; in addition to missed workdays, self-efficacy, and care barriers at 12 months favoring community engagement program relative to resources for services. Findings indicated that engaging health care and social community programs may offer modest improvements on key functional and socioeconomic outcomes, reduce care barriers, and increased engagement in alternative depression services for ethnic minority women with low incomes, which may reduce homelessness (Ngo et al., 2016).

Homelessness

The study of homelessness and factors related to the engagement of the homeless, began with an understanding of homelessness and related statistics. According to the

Social Services Law § 42 (2015), a homeless person “is an undomiciled person who is unable to secure permanent and stable housing without special assistance, as determined by the commissioner” (p. 1). Georgiades (2015) conducted an ethnographic study on survival strategies and needs of a group of 56 homeless people living in South Florida of various racial backgrounds. Georgiades’ study determined that the strongest reasons for homelessness were substance abuse issues (63%), unemployment (32%), being underpaid (23%), and relationship or marriage breakups (13%). Additional reasons included mental health issues (5%), bankruptcy or business failure (5%), foreclosure (4%), domestic violence (4%), illegal immigration (2%), and disability (2%). The causes of homelessness were multiple and included an interaction between individual and structural factors (Fazel et al., 2014). There were individual factors, such as poverty, mental health, substance misuse, and family problems (Fazel et al., 2014). For example, changes in the economy both nationally and locally could create challenges for people to earn an adequate income, pay for food and housing (Fazel et al., 2014). Structural causes included a lack of low cost housing availability, low wages, and unemployment (Fazel et al., 2014). Fazel et al. (2014) noted that between 2010 and 2013, homelessness in the United States decreased by 6%. However, the American black population, which is only 12% of the American population makes up 39% of the shelter population. Individuals with low or no income were unable to pay for housing, and around 3.5 million Americans experience homelessness annually due to poverty (Fazel et al., 2014).

Poverty and Homelessness

According to Martin (2015), service providers need to understand the link between homelessness and poverty to develop appropriate engagement techniques because poverty was a major factor that could lead to homelessness. Martin noted that there was a lack of affordable housing for some of the poorest members of American society. Other factors that impacted poverty and homelessness included an inability of the homeless person to work, a lack of job skills, training, education, and work experience, mental illness, and drug and alcohol abuse (United States Department of Health and Human Services [USDHHS], 2016; United States Department of Housing and Urban Development [USDHUD], 2014b). Despite the numerous reasons that a person could become homeless, increased poverty in the United States was considered a key factor that impacted all other factors (Martin, 2015; USDHUD, 2014b). A loss of low income housing contributes to homelessness, and during the late 1970s and early 1980s, low income units declined by 30% in 12 of the 20 largest American cities (Martin, 2015). The loss of low income housing continued through the 1990s as the number of the poor increased by 36% (Martin, 2015; USDHUD, 2014b). Martin concluded that poverty, hunger, and homelessness continue with a poor outlook for the future. Martin also noted that those attempting to engage the homeless population would need to understand this issue while other researchers believed that homelessness was related to where individuals were geographically located.

Geographic Locations and Homelessness

National Low Income Housing Coalition (2019) reported that there were 671,859 people experiencing homelessness on any given night in 2014, and these numbers represented the homeless geographically found in big cities and small towns countrywide. Community members in the big cities and small towns collected and reported data to the HUD that included information about how nearly 77% of the U.S. homeless population was in urban areas (National Low Income Housing Coalition, 2019; USDHUD, 2014b). Also, urban areas have the highest rates of homelessness with limited mental health services, and most of the chronically homeless were living in unsheltered places unfit for human habitation (USDHUD, 2014b). Cities with populations of over 500,000 people account for 51% of the homeless population and a large portion of the mentally ill (Curtis, Corman, Noonan, & Reichman, 2014; Martin, 2015; USDHUD, 2014b). According to members of the National Low Income Housing Coalition, it was important to understand the geographic locations of the homeless and the available mental health service providers; who could best assist the mentally ill and the homeless population while developing plans to eradicate homelessness.

Mental Illnesses and Homelessness

Martin (2015) reported that many of the homeless individuals in the United States suffer from mental health issues and that chronic mental health disorders were key factors in homelessness. According to Martin, individuals with untreated psychiatric illnesses, like schizophrenia or bipolar disorders, make up about one third (250,000) of the estimated 744,000 homeless individuals in the United States. Martin reported findings from a study of people with serious mental illnesses who had been seen by mental health specialists in California's public mental health system and found that 15% of the mentally ill participants were homeless at least once in a 1 year period.

Another problem associated with poor mental health was that when individuals were not able to manage their mental health they risk their physical health with conditions that could lead to skin diseases, respiratory infections, or exposure to tuberculosis, and HIV (Elliott, 2017; Fazel et al., 2014; Henwood, Cabassa, Craig, & Padgett, 2013; Martin, 2015; Padgett, Henwood, & Tsemberis, 2016; Tsai, Kasprow, Kane, & Rosenheck, 2014; Zur & Jones, 2014). Fazel et al. (2014) noted that the rates for tuberculosis among the homeless population was 40 times higher than that of the general population. Additionally, other risk factors among the mentally ill homeless population, such as substance abuse and dependence may lead to illnesses resulting from a compromised immune system.

Curtis et al. (2014) explored maternal depression as a risk factor for family homelessness. Curtis et al. conducted the Fragile Families and Child Wellbeing longitudinal study among urban and primarily low income mothers to determine the effects of maternal depression during the postpartum year, as a risk for subsequent homelessness. Of the 2,974 participants in the study, 375 experienced depressions during the postpartum year. Findings from logistic regression analyses, after controlling for factors such as maternal and family history of depression and prenatal housing problems, risk factors for homelessness were evictions or frequent moves, moving in with family or friends, and failure to pay rent. These factors revealed that mothers who experienced depression were more likely to become homeless (6%) than mothers who did not experience depression (2%) (Curtis et al., 2014), thus showing a strong relationship between maternal depression during the postpartum year and risk for subsequent homelessness.

Oh and Devylder (2014) used data from the National Latino and Asian American Survey to determine that mental health correlated with past homelessness in Latinos and Asians. The study consisted of 4,864 participants, and 3.8% reported experiencing past homelessness of one or more weeks, and 3.5% reported experiencing past homelessness of one or more months. Oh and Devylder noted that mental illness and addiction were related to homelessness and that Latinos participants who experienced a history of substance abuse were almost three times more likely to repost homelessness for one or more weeks. The researchers also found that clinical and institutional factors related to homelessness varied by ethnicity, comparing participants who experienced one week or more resulted in 4.7% among Latinos and 1.3% among Asians (Oh & Devylder, 2014). For example, alcohol abuse or dependence, conduct disorder, and intermittent explosive disorder were found to be risk factors for homelessness in Latinos, and mood disorder, and health problems, as well as previously receiving welfare were risk factors for homelessness in Asians (Oh & Devylder, 2014). Oh and Devylder concluded that ethnicity was a factor in the relationship between mental health and homelessness.

Purohit et al. (2015) used data from the 2007 National Health Interview Survey, which described characteristics of 23,393 mentally ill adult respondents who reported that a mental health provider diagnosed them with serious mental illnesses (bipolar disorder, mania, psychosis, or schizophrenia). Purohit compared the adult participants' sociodemographic and health characteristics, health care utilization, and participation in government assistance programs for those with and without serious mental illnesses and found that 2% of the adult participants reported a diagnosis of serious mental illnesses and 35% of the adult participants reported having a history of homelessness. Moreover, Pratt found that less than two-thirds of the serious mentally ill adult participants reported having seen a mental health provider in the past year and concluded that there was a link between serious mental illness and homelessness. In recent years, structural factors such as availability of low income housing or social programs played a greater role in explaining homelessness than earlier research that focused more on examining personal traits of the homeless persons (Blasi, 1990; Shinn, Gibbons-Benton, & Brown, 2015; Tompsett, Domoff, & Toro, 2013) or on homeless persons who were chronically mentally ill (Hagen, 1987). However, Bahr (1973) speculated that American culture had credited homelessness to laziness, immorality, wanderlust, alcoholism, and other character deficits indicative of those on the fringes of society.

Similarly, research of the homeless was on homeless persons which were in large metropolitan areas, mentally ill, residing in emergency shelters, receiving psychiatric evaluations, and in need of food (Hagen, 1987). Lee, Jones, and Lewis (1990) conducted a study in Nashville, Tennessee that was a systematic random sample of 471 households who were selected to participate in a telephone survey created to determine what beliefs participants had about homeless persons. More than half of participants believed that homelessness was caused by mental illness (53.1%), bad luck (51%), and structural forces beyond their control (58.6%), for example housing shortages or economy changes (Lee et al., 1990).

Birgenheir, Lai, and Kilbourne (2013) and Schinka et al. (2016) reported that homelessness and severe mental illness were risk factors in early mortality for many Americans, to include veterans with severe disabilities (traumatic brain injuries and posttraumatic stress disorder) which were factors linked to homelessness. According to members of the National Alliance to End Homelessness-Veterans (NAEHV, 2015), since 2010, there has been a 33% decrease in the number of homeless veterans. However, findings from data collected during the 2014 Point-in-Time Count revealed that 49,933 veterans experienced homelessness on a single night in January (NAEHV, 2015). Birgenheir et al. used data from the Veteran Affairs National Patient Care Database to examine mentally ill veterans who used homeless services, years of potential life lost (YPLL) over an 11-year period. Birgenheir et al. and Schinka et al. found that on all causes of mortality which compared differences by age and gender as well as homelessness and severe mental illness status; homeless veterans died younger than nonhomeless veterans in all years, regardless of a severe mental illness diagnosis. Also, both homeless and nonhomeless veterans with severe mental illnesses died younger than those without severe mental illness (Birgenheir et al., 2013; Schinka et al., 2016). Birgenheir et al. concluded that having a diagnosis of serious mental illness, regardless of the veterans’ housing status could lead to poor health conditions and increased YPLL.

Health Conditions and Homelessness

According to Chen (2014), Fazel et al. (2014), Lee and Donaldson (2018), members of the National Health Care for the Homeless Council (NHCHC, 2019), Oh and Devylder (2014), and Olivet et al. (2010), many of the homeless population suffers from a mix of substance use, social problems, and physical and psychiatric health conditions, more so than the general population, and the risk factors for homelessness were also associated with poor health outcomes. For example, poor mental health and substance misuse disorders were risk factors for homelessness and poor mental and physical health (Chen, 2014; Fazel et al., 2014; Oh & Devylder, 2014), and homelessness exacerbates these factors. Some of the harsh living conditions of the homeless included poor nutrition, exposure to disease, victimization, and injury, and increased rates of tobacco use (Chen, 2014; Fazel et al., 2014; Oh & Devylder, 2014). Some homeless individuals were more likely to have poor health, little or no access to health care, and they tend not to adhere to taking medication (Fazel et al., 2014). This poor health may be a factor that influenced not only homelessness but also an inability to take part in the engagement process.

Many of the homeless have tuberculosis (0-8%), Hepatitis C (4-36%), HIV (0-21%), and high rates of Hepatitis C (17-30%) (Fazel et al., 2014). Fazel et al. (2014) also noted that between 27% and 52% of homeless individuals experienced physical or sexual assault. Furthermore, Fazel et al. found that homeless individuals present psychiatric disorders associated with brain injuries (8-53%), psychosis (3-42%), depressions (0-49%) and personality disorders (2-71%), drug dependence (5-54%), and alcohol misuse (8-

58%). Some of the homeless population also had high rates of unintentional injuries, morbidity, and acute health care use, such as emergency department visits, and hospital inpatient admissions (Fazel et al., 2014).

Mortality rates have also increased in the homeless population, and the life expectancy was about 40 years (Fazel et al., 2014; Roncarati et al., 2018), with more and more younger people and women dying due to infections, ischemic heart disease, substance misuse, and external factors (injuries, suicides, homicides, and poisoning). Risk factors for mental disorders, alcohol, smoking, and illicit drug use, contributed to this mortality rate (Fazel et al., 2014). According to members of the Roncarati et al., some of the homeless suffering from environmental influences, such as the exposure to harmful weather and malnutrition especially when poor health conditions already existed (i.e., high blood pressure, diabetes, and asthma), may experience worse symptoms as the exposure could lead to further illness and even death.

There were many other environmental factors related to homelessness, such as poverty, race/ethnicity, and socioeconomic status (SES) (Fazel et al., 2014; Martin, 2015). Hardin and Wille (2017) conducted a study on 103 homeless individuals to determine the cause and resources required to leave the shelter. The common denominator for most homeless individuals was that a lack of income contributed to their homelessness (58%), addiction (45%), lack of family support (35%), incarcerated or health problems and inability to manage money (21%), mental illness (19%), lack of education and long term poverty (18%) and physical disability (1%). Locating affordable housing on a minimum wage salary was also a struggle for many participants (Hardin &

Wille, 2017). Factors such as SES and poverty were linked with race/ethnicity and were also related to homelessness (Cubbins & Buchanan, 2009; Martin, 2015). Fazel et al. (2014) provided insight into the health conditions faced by some of the homeless, which was important information that could provide more insight into the service providers' struggles to connect with and engage this population. Moreover, despite efforts to assist the homeless the problem of engagement remains and was a threat to the homeless population and the public, because of environmental concerns (i.e., the spread of communicable disease, alcohol and drug abuse, and mental health conditions) (Fazel et al., 2014; Roncarati et al., 2018). Many of the homeless population faces unique environmental issues that must be understood to facilitate the engagement process (Corrigall-Brown et al., 2009; Fazel et al., 2014; Meanwell, 2012).

Environmental Factors Contributing to the Engagement Process

Mills, Burton, and Matheson (2015) conducted a qualitative study of primary care provider specialists to examine the process of engaging the homeless with health services. Mills et al. noted that homeless individuals have many health needs and that there was a lack of research that investigated the engagement process of the homeless from the providers' perspectives. Mills et al. conducted semi-structured phone interviews, with a purposive sample of 13 health providers with experience working with homeless patients and found that there were systematic barriers to engagement; problems engaging with providers, and both system and relationship approaches were needed to help with engagement. Mills et al. concluded that practices must promote engagement with flexible and encouraging relationships between homeless patients and the whole service provider team, but how to develop these relationships and factors that influence the process, remained unclear. These findings provided support for the current study designed to examine the experiences of the service provider to identify these practices and fully comprehend factors related to the attempt to engage the homeless.

The providers of services to homeless individuals must be able to deal with the unique concerns of the homeless individuals, such as the lack of stable housing, physical and mental health problems, violent situations, substance abuse treatment needs, and more (Corrigall-Brown et al., 2009; Fazel et al., 2014; Meanwell, 2012). Chen (2014), Lee and Donaldson (2018), and Olivet et al. (2010) noted that outreach service providers must be respectful, empathetic, flexible, non-judgmental, committed, persistent, and understanding of issues faced by the homeless persons when attempting to engage.

Service Provider Attempts at Engagement

Mental health service providers attempt to engage multiple populations, such as the homeless, mentally ill, and substance abusers (Chen, 2014; Dixon et al., 2016; Fazel et al., 2014; Mills et al., 2015). Dixon et al. (2016) reported that healthcare professionals find it difficult to engage and provide services for individuals experiencing mental illness accompanied by substance abuse. According to Dixon et al., those with serious mental illnesses tend to be hard to engage in any types of ongoing treatments, and when in treatment, there tend to be high dropout rates of about 80% during the first year of care. Moreover, when there was poor engagement between the patients and the healthcare professionals, the patients may experience worse clinical outcomes, symptoms, and rehospitalizations (Dixon et al., 2016). Dixon et al. also reported that there were factors that impacted treatment engagement, such as access to person-centered care and outreach program processes.

Dixon et al. (2016) presented the notion that person-centered care with shared decision making would meet clients' goals and increase engagement. Dixon et al. based their conclusions on literature findings and then used literature to explore different populations and outline how techniques have been shown to enhance the engagement process. Dixon et al. explained that the use of electronics and the Internet, the involvement of peer providers, and the use of a cultural formulation interview all helped to provide culturally competent and person-centered care. According to Dixon et al., person-centered care was an approach that allowed the providers to view clients as equal partners in planning, developing, and monitoring care to make sure it meets the clients' needs. Person-centered care was expected to increase complex treatment engagement and outreach program processes (Dixon et al., 2016).

Furthermore, members of the Department of Family and Support Services, in Chicago noted that initial steps in outreach program processes included engaging the homeless in the process of helping them (City of Chicago, 2015). The engagement process was difficult for many homeless individuals who were anxiously seeking housing and was problematic for many homeless individuals who had a history of living on the streets or in and out of shelters as a survival method (City of Chicago, 2015). Many times, service providers took outreach and engagement programs to the streets to increase engagement and participation of the homeless by using mobile clinic outreach programs with medical and social services to make services more accessible to homeless people

(City of Chicago, 2015). Outreach service providers in Chicago also went out on the streets, visited airports, and even boarded trains late at night to engage homeless individuals in conversation and helped make them aware of available resources (City of Chicago, 2015).

Henwood et al. (2013) and Padgett et al. (2016) reported on an outreach and engagement program, called Permanent Supportive Housing (PSH). PSH was an intervention designed to address long-term homelessness. According to Henwood et al. and Padgett et al., there had been a shift in U.S. policy that involved using PSH instead of shelters and transitional housing to end long-term homelessness and build healthy communities. However, individuals transitioning from homelessness to PSH who experienced limited access to affordable healthy food and recreation areas reported high rates of chronic diseases and health problems that correlated with smoking, substance use, and poor diets (Henwood et al., 2013; Padgett et al., 2016). Henwood et al. and Padgett et al., argued that healthcare managed programs have increased engagement in preventive primary care. Although, there were factors, such as stigmas and discrimination related to homelessness, scarcity in resources, criminal actions, and mental health systems that impede engagement in health behaviors that must be understood.

Another type of outreach and engagement program was the HUD-Veterans Affairs Supportive Housing Program, which was developed to help end veteran homelessness by providing housing choice vouchers and the VA providing case management as well as outreach services (US Department of Housing and Urban Development, 2014a). The program targeted homeless veterans and provided around 35 rental vouchers, which were tenant based (US Department of Housing and Urban Development, 2014a). The Rural Housing Stability Assistance Program (RHSP) was another program developed to improve housing for the homeless, individuals in substandard housing conditions, or individuals in danger of becoming homeless by helping them to afford stable housing (US Department of Housing and Urban Development, 2014b). With the RHSP, rent, mortgage, and utility assistance–recipients could receive up to two months of rent, security and utility deposits, moving assistance, mortgage, utility assistance, emergency lodging for up to 3 months (US Department of Housing and Urban Development, 2014b). In addition, RHSP offered other supportive services like acquisition training for new home purchases and rehabilitation for substance abusers to provide the homeless individuals the best chances of transitioning into permanent housing (US Department of Housing and Urban Development, 2014b).

Outreach programs link vulnerable populations and healthcare; and engage homeless persons with social and housing services (Knopf-Amelung, 2014). One of the least understood direct methods of engaging homeless individuals was street outreach that meets people where they are at to reconnect homeless individuals to resources in the community and provided the support they need to survive and prosper (Knopf-Amelung, 2014). Tsai et al. (2014) conducted a study on 70,778 homeless veterans engaged in Veteran's Affairs (VA) homeless services from 2011 to 2012, where the homeless participants used provider referrals (41%), self-referrals (28%), and street outreach (12%). Tsai et al. posited that more extensive histories of recent homelessness, chronic homelessness, and referral and admissions to the VA's housing program were present when veterans engaged in street outreach. Tsai et al. concluded that veterans who engaged, via street outreach were more likely to be admitted into the VA’s supportive housing program.

Morandi, Silva, Golay, and Bonsack (2017) asserted that individuals with severe mental and substance use disorders were challenging to engage in care, which affected their health and social conditions and increased treatment costs due to an increase in emergency department visits. Morandi et al. further asserted that case management was a successful way of promoting care for people with severe mental and substance use disorders. The application of an Intensive Case Management for Addiction (ICMA) model improved the engagement of individuals with severe mental and substance use disorders. Morandi et al. observed the influence of ICMA on service use, treatment adherence, quality of support networks, psychosocial and mental functioning, and substance use throughout the interventions of the 30 participants in the study; with 56% of the participants remaining in the program after 12 months, and 40% completing the program. Morandi et al. concluded that participation in ICMA improved engagement with care, substance problems, and the psychosocial situation of people with severe mental and substance use disorders. Also, Morandi et al. findings were consistent with findings of Malte, Cox, and Saxon (2017), who asserted that homeless veterans entering VA substance use treatment and intensive addiction/housing case management showed improvement in housing, substance use, mental health, functional outcomes, and lower acute healthcare utilization. Malte et al. reported that over 70% of VA homeless participants, who received treatment for twelve months, entered long-term housing and approximately 50% maintained long-term housing, thus indicating that VA housing programs were successful in addressing the needs of some homeless veterans. Malte et al. findings may also prove beneficial for other individuals suffering from mental health and substance use disorders.

According to Dixon et al. (2016) and Stewart (2013), approximately one-third of young adults suffering from a first psychotic episode defer treatment for one to three years, and 80% dropped out within the first year of care; thus, disengagement rates from mental health services remained high (Dixon et al., 2016; Stewart, 2013). The Housing First program quickly and effectively formed links between homeless individuals and families and sought to figure out the importance of engaging the homeless based on the goal of transferring the homeless to permanent housing without preconditions or barriers to entry (e.g., abstinence, treatment, or service participation requirements). Providers of the Housing First program engaged individuals who were the hardest to reach, individuals who experienced long-term homelessness, and individuals who experienced co-occurring disorders. Baxter, Tweed, Katikireddi, and Thomson (2019) and Stanhope (2012) and utilized the ethnographic method to investigate the need of service engagement within Housing First, concentrating on how social processes contributed to program effectiveness, used symbolic interactionism as the theoretical framework, and conducted observations and interviews to explore meaning-making within social exchanges. The homeless individuals shared narratives about their experiences as residents as related to housing, while the structural aspects of Housing First provided the context and opportunities for needed engagement (Baxter et al., 2019; Stanhope, 2012).

Need for Engagement of the Homeless

O'Toole et al. (2011) conducted a study with 457 patients to examine the need for engagement of the homeless by conducting a quasi-experimental pre-post study to explore the application of a patient-centered medical home for homeless veterans (71), female veterans (145), cognitively impaired elderly (167), and patients with serious mental illness (74). The enhanced engagement was a factor in this program, and O’Toole et al. focused on the patients assessed for care use and outcomes six months in each year studied. The findings revealed significant increases in primary care use, improved chronic disease monitoring, and diabetes control for all groups (O’Toole et al., 2011). On the other hand, the homeless increased emergency department use and hospitalizations, and O'Toole et al. concluded that an enhanced engagement resulted in improvement in patient conditions despite the increased use of emergency and hospital care. Fazel et al. (2014) further supported the need for engagement of the homeless to combat problems such as mental disorders, injuries, suicide, and premature mortality. Fazel et al. found that many of the homeless continued to suffer from higher rates of mental and physical problems. Fazel et al. suggests that the results from positive engagement outcomes from the homeless population may encourage providers to engage the homeless population more aggressively.

Fazel et al. (2014) examined key factors that might be related to the engagement or disengagement of the homeless persons in communities’ responses to homelessness. There were many homeless persons and environmental factors that might impact the engagement of the homeless persons; however, there were also engagement process factors that needed to be understood (Fazel et al., 2014; O'Toole et al., 2015; O'Toole et al., 2011). For example, while a factor such as mental illness in a homeless person might render this person emotionally unavailable to engage, there were additional process factors such as a respectful and caring attitude of the service provider that must be understood (Chen, 2014; Padgett & Henwood, 2012; Sprenger, 2015). As noted by Hwang and Burns (2014), Norman and Pauly (2013), and Norman et al. (2015), the struggle of service providers to engage the homeless continues. Homeless individuals present with complex needs, and the service provider must understand factors related to this process to provide meaningful engagement for the homeless individuals to make a difference in their lives (Hwang & Burns, 2014; Norman & Pauly, 2013; Norman et al., 2015).

Hwang and Burns (2014) conducted a review of the literature and reported that engagement of the homeless was a critical factor in helping this group, yet how to engage the homeless remained unclear. According to Hwang and Burns, there were many interventions to help the homeless such as primary health-care programs tailored to homeless individuals, case management, assertive community treatment, and housing initiatives such as Housing First, which provides housing in independent units with support. Hwang and Burns further reported key factors involved in the engagement relationship included respect for the individual, upholding the person's dignity, building mutual trust, showing warmth and caring through 'acts of kindness. Additionally, Hwang and Burns stated that peer support workers with similar life experiences to the homeless client had a strong ability to develop these positive and meaningful engagement relationships.

Meaningful Engagement

The voices of the homeless were needed to understand what they experienced and how they find relevant solutions. Therefore, Norman and Pauly (2013) and Norman et al., (2015) pointed out the need to provide meaningful engagement to help the homeless overcome homelessness. Based on their review of the literature, Norman and Pauly provided an overview of the findings regarding recommendations for policies and best practices that promoted meaningful involvement of the homeless person. These recommendations included information about how the processes of social exclusion and inclusion needed to be understood by providers to provide meaningful engagement to homelessness (Norman & Pauly, 2013; Norman et al., 2015). An important factor in this social inclusion effort was to foster dialogue between service providers and the homeless person, to develop guidelines for social inclusion, which may help to determine obstacles and challenges faced by the homeless due to unequal power relations (Norman & Pauly, 2013; Norman et al., 2015).

To ensure successful engagement, trust and recognition of what the homeless person experienced were needed, and future guidelines and policies need to foster meaningful and respectful engagement of the homeless, as part of community responses to homelessness (Norman & Pauly, 2013; Norman et al., 2015). Housing policies must include information from people with experience of homelessness to gather information about barriers and challenges involved in the engagement of the homeless, and dialogue with service providers that consider social inclusion at the organizational (Norman et al., 2015). To encourage participation, members of organizations and municipalities must display kindness to make the client feel respected, have policies in place for social inclusion, and provide material resources such as housing, income, and supports to ensure meaningful engagement (Norman & Pauly, 2013; Norman et al., 2015).

Acts of Kindness and Respect

Padgett and Henwood, 2012 presented findings from studies with homeless adults with serious mental illness and substance abuse. The results from the New York Services Study, which was a Federally-funded qualitative study that took place in practice settings serving homeless adults with serious mental illness and substance abuse, revealed themes, such as cumulative adversity, discordant views of case managers, and benefits of permanent housing (Padgett & Henwood, 2012). These themes showed that case managers have different views, which supports the need for the current study to explore individual service provider perspectives. A final theme found that individual acts of kindness were important for the engagement process. Padgett and Henwood concluded that respect for individuality, sensitivity to previous traumas, and working to achieve housing security as quickly as possible, were factors related to the encouragement of engagement. Padgett and Henwood recommended that a future study explore factors related to the encouragement and inhibition of engagement of the homeless in care.

Buchanan and Bardi (2010) and Mongrain, Barnes, Barnhart, and Zalan (2018) reported that acts of kindness have great potential to impact the lives of everyone involved and found that intentional acts of kindness to other people could increase their happiness. The Yukon Status of Women Council (2015) presented findings from a project funded by the Federal Homelessness Initiative. This project resulted from the need to understand the plight of homeless women. This need arose from a coalition of women's organizations in the Yukon, Northwest Territories and Nunavut. The study took place in 2005 and 2007 and included in-depth conversations with interviews or focus group sessions, with 21 women who were or had recently been homeless, and the Government and non-government personnel who provided services to these women. The researcher analyzed data for themes (Yukon Status of Women Council, 2015). Findings revealed that determinants of homelessness included: female vulnerability, partner's behavior and circumstances, forced eviction from property owners, relocation, personal wellness, cost of living, and societal indifference, punitive measures, and inadequate support system to include peers (Yukon Status of Women Council, 2015).

Peer Support for Engagement

There have been multiple studies that validated the use of peer support to increase engagement in vulnerable populations by identifying with a personal experience that complements effectiveness. For example, Simpson, Quigley, Henry, and Hall (2014) used peer support workers to assist those suffering from mental distress because they found that over 30% of the psychiatric patients failed to take their medication or relapse, which lead to the patients' re-admittance to the hospital. The use of trained peer support professionals was a key factor in helping patients after their release from the hospital, and over 50% of the patients in this study reported missing the peer relationship when it ends (Simpson et al., 2014). Aldridge (2015) and Story (2013) reported that marginalized groups were excluded from health services and routine health statistics, because they were not actively engaging in the process of gathering health services utilization data. Besides using peer support, a key challenge was to understand the marginalized group, such as the homeless, to focus on prevention and treatment activities in a meaningful way (Simpson et al., 2014).

Aldridge (2015) and Story (2013) conducted a cross-sectional health survey of homeless people who attended 27 low-threshold services in London, such as soup kitchens, hostels, and day centers. Findings from the study revealed that homeless people experienced a significantly disproportionate burden of morbidities, such as asthma (2-46%), heart disease (5-87%), stroke (4-93%) and epilepsy (12-40%) (Aldridge, 2015; Story, 2013). Peer support services were an evidence-based mental health model of care that consisted of qualified peer support providers who supported individuals with their recovery from mental illness and substance use disorders (Simpson et al., 2014).

Ellison et al. (2016) researched patterns and predictors of engagement in peer support services of people receiving services from the Veterans Health Administration housing program. Veterans, peer specialists, received training on how to deliver sessions that concentrated on mental health and substance use recovery for veterans (Ellison et al., 2016). Utilizing a mixed-effects log-linear model, Ellison et al. tested the rate of peer engagement with three sets of covariates, which represented the characteristics of the veterans, to include demographics, mental health, substance use status, indicators of community participation, and support. The findings from the study showed that veterans engaged with peers about once per month, rather than the planned once per week, the frequency of contacts varied significantly, and time was the best predictor of engagement, with the first six months showing the most contacts (Ellison et al., 2016). Age played a role in older veterans 51 and above, as they tended to have higher rates of engagement with peer supporters at 82% (Ellison et al., 2016). Ellison et al. also noted that participants who received technical training engaged peer supporters at 62% in comparison to participants who only had a high school or less at 38%, indicating that education level had a significant relationship to peer engagement. Conversely, a study conducted by McInnes et al. (2014) using 21 participants who engaged healthcare providers via mobile devices found that all participants were technology proficient despite their varying educational levels. 52% of the homeless veteran participants had two years of college, in comparison to the 5% of participants who had less than a high school diploma, or 38% of participants who completed high school.

Technology and Engagement

McInnes et al. (2015) reported on the use of technology to engage homeless by reviewing reporting findings from 30 homeless veterans in different housing programs in Boston, MA. 90% of the homeless owned mobile phones, up to 72% had an email address, of the cell phones 30% were smartphones, and up to 70% used the Internet. The homeless persons did use technology for different reasons; some used it for health reasons, because many homeless had access to these forms of information technologies. McInnes et al. concluded that there could be health benefits to programs that link homeless persons to healthcare via mobile phones and the Internet. McInnes et al. also concluded that more research was needed to determine factors related to the engagement of the homeless in community efforts and dealing with healthcare issues.

McInnes et al. (2014) explored the feasibility of using mobile phone text messaging with homeless veterans to increase their engagement in care. For this study, McInnes et al. sent two text message reminders to 21 participants before their outpatient appointments at a Veterans Affairs medical center and used re-and-post survey questionnaires, open-ended questions, and medical records to gather data. Participants reported being satisfied with the text-messaging intervention, reported having very few technical difficulties, and reported interest in continuing the use of text messages (McInnes et al., 2014). The findings from the study also revealed that patient-canceled visits decreased from 53 to 37, no-shows decreased from 31 to 25, emergency department visits decreased from 15 to 5, and hospitalizations went from 3 to 0 (McInnes et al., 2014). The researchers concluded that the use of text message reminders helped to engage the homeless, which resulted in fewer missed visits and emergency department use (McInnes et al., 2014).

Neale and Brown (2015) explored the need for technology to help the homeless. Neale and Brown noted that homeless drug and alcohol users were a much-marginalized group with complex needs and limited support. Neale and Brown conducted a study in three hostels from a different city, during 2013–2014 using audio-recorded semi-structured interviews with 30 residents (nine females; 21 males) with self-reported drinking and drug problems. Neale and Brown completed additional interviews 4–6 weeks later and included 22 participants (6 females; 16 males), and findings from an analysis of qualitative data revealed that only 21 participants had friends, and all friendship networks were small and ever-changing. Participants reported wanting friendships, and information and communication technologies (ICTs) were important components related to friendships because ICTs helped to keep the participants connected to social support and recovery resources (Neale & Brown, 2015). Neale and Brown concluded that to promote friendships and help the homeless, service providers must consider ways to promote the use of ICTs to combat loneliness and isolation, thus making texting, emailing, chat rooms, and other social media available to the homeless. While the sample size limited the study, detailed information supported the use of technology to help engage the homeless, while others like Koffarnus et al. (2013) suggested using money and tobacco products to engage homeless adults.

Money and Tobacco to Engage the Homeless

Koffarnus et al. (2013) reported on the use of money to encourage the engagement process with homeless adults. Specifically, Koffarnus et al. explored whether the money would increase engagement and achievements in a job skills training program. For this randomized clinical trial, Koffarnus et al. randomly assigned 124 eligible homeless participants to an experimental group (no reinforcement (*n* = 39), training reinforcement group (*n* = 42), or the abstinence and training reinforcement group (*n* = 43). The goal of the study was to examine if monetary incentives could potentially encourage engagement and successful job skills training for alcohol dependent, unemployed, and homeless individuals. Koffarnus et al. concluded that the effectiveness of using monetary incentives to reinforce desirable behaviors was significant when compared to the abstinence of substance use and training reinforcement (91) verses no reinforcement (10.5) for a means of overall steps achieved. The narrow focus on the job skills training limited the study, but findings did show that monetary incentives were motivational factors. However, Hartzler and Garrett (2016) reviewed the literature on the subject and concluded that this practice was in its infancy and requires further investigation to understand all related factors.

Baggett et al. (2012) reported that service providers for the homeless population may use tobacco offerings to help engage the homeless because cigarette smoking was common among the homeless. Findings from Baggett et al. survey of 231 health care providers revealed that 86.5% of the participants reported the routine screening for tobacco use, 74.4% viewed tobacco use as a key health issue among the homeless, and 15.3% had given patients tobacco to build trust or promote engagement in adhering to care practices. Baggett et al. also reported that this practice of providing tobacco must be understood within the context of a complex care process and only for those living in extreme circumstances. This practice has been endorsed and condoned in street outreach resources to engage those who were highly marginalized, and this practice had also been used in inpatient psychiatric units, to reinforce desirable behaviors (Baggett et al., 2012). However, while some providers practice this engagement technique to promote the wellbeing of the client, it should not occur as a positive form of engagement, because tobacco use had harmful effects (Baggett et al., 2012), which could lead to disengagement.

Disengagement of the Homeless

Smith et al. (2013) described factors related to the disengagement from care for individuals with serious mental illnesses and substance use. Smith et al. conducted qualitative interviews with 56 individuals and 25 providers of care. The findings showed that patients' reasons for disengagement from services included responses that the services were not relevant to their needs, they did not trust providers, and did not believe they were ill, yet providers' reasons included stigma, lack of insight, and language and cultural barriers (Smith et al., 2013). The researchers concluded that the homeless have different views regarding the homeless reasons for disengagement from services.

Smith et al. (2014) described factors related to reengagement rates for individuals with serious mental illness who had discontinued services. Medicaid claims and other administrative data were reviewed from 2009-2011, the New York City Mental Health Care Monitoring Initiative to monitor service use by defined cohorts of individuals with serious mental illness and high service needs. Smith et al. identified 2,834 individuals with serious mental illness who had discontinued services. The findings showed that patients' reasons for disengagement from services included lost to care, incarceration and provider notified-active outreach (Smith et al., 2014). The researchers concluded homeless individuals reasons for disengagement from services could help identify individuals in need of outreach and active outreach.

Narendorf, Bowen, Santa Maria, and Thibaudeau (2018) conducted a study on 374 homeless young adults ages 18-24 experiencing homelessness to determine risk and resilience. Results indicated that 20% of the young adults had high adult support and low trauma; 16% described a low trauma, but low adult support; 40% had high trauma exposure, high rates of mental health problems and low substance use; 24% had high rates across all risk variables (Narendorf et al., 2018). Factors leading to disengagement of the homeless were also discussed by Yoder, Bender, Thompson, Ferguson, and Haffejee (2014). Yoder et al. reported on the need for the homeless to survive, which could serve as a factor leading to disengagement. Findings from quantitative data gathered with face-to-face interviews of 202 homeless youths, revealed that these youths were at increased risk for involvement in the criminal justice system, substance use, peer deviance, and the engagement in survival behaviors (criminal behaviors) (Yoder et al., 2014). These youths may have been more focused on survival behaviors than engaging in efforts to overcome homelessness because 78% reported being arrested and 60% reported going to jail. Bright, Kayes, Worrall, and McPherson (2015) and Zlotnick, Zerger, and Wolfe (2013) reported that service providers must learn how to engage the homeless, without alienating or disengaging the client while being flexible and aware of the client. Bright et al. (2015) and Zlotnick et al. (2013) provided insights into the problem of disengagement of the homeless, which was a factor that limits the engagement of this population. There were many factors involved in the engagement process of homeless individuals, and service providers need to be aware of these factors to successfully engage the homeless.

Summary and Conclusion

Major themes in the literature review revealed that engagement was a key factor in helping the homeless. Hwang and Burns (2014) asserted that factors related to the engagement process included respect, dignity, trust, warmth, and caring with acts of kindness, and peer support workers. Meaningful engagement was a factor reported by Norman and Pauly (2013) and Norman et al. (2015), yet, despite the recognition of engagement factors and the need for engagement, homelessness continues, which implies the need for further study of this engagement process and related factors, as viewed by the service provider. Chapter 3 includes an explanation of the research methodology used in this study.

Chapter 3: Research Method

Introduction

The application of engagement included enhancing self-belief, fostering learning, investing in support services, committing emotionally, changing expectations, and becoming active citizens (Great Schools Partnership, 2016; Kruse, 2012). Engagement, for the sake of this study, happened when mental health service providers reached out to homeless individuals to encourage them through trust to partake in homeless services provided by mental health providers. However, homeless persons continued to struggle to access services despite numerous social programs (National Alliance to End Homelessness, 2015). The purpose of this phenomenological qualitative study was to gain more insight into the engagement practices and experiences of mental health service providers, in New York City, when encouraging the homeless individuals to commit to participating in clinical services, especially where perceived barriers to engagement were concerned.

By addressing this gap in the literature, this study stimulated a needed positive social change by gaining more insight and understanding about the phenomenon and to possibly reduce care and engagement barriers to help researchers, policy-makers, mental health service providers, and the homeless community with more information about resources needed for successful engagement outcomes. This chapter includes the purpose of this study and the research questions for alignment. This chapter also includes the research design and rationale, the central phenomenon, and the research tradition. Finally, this chapter includes a discussion and explanation of the researcher's role in this study, the methodology, participant selection logic, data collecting, instrumentation, procedures, data analysis plan, ethical procedures about working with the selected participants, and issues of trustworthiness before the summary.

Research Design and Rationale

The research design selected for this qualitative study derived from phenomenological works of Husserl (1931, 2012) and Willis (2007) who focused on participants' shared experience, through narration and the perceptions of those experiences. A phenomenologist distinguishes phenomena from noumena and interprets experiences or facts, by listening to the different stories of the participants. Phenomenologists focus on the subjectivity of reality while continually pointing out the desire to understand how humans view themselves and the world (Husserl, 1931, 2012; Moustakas, 1994).

According to Creswell (2007), Creswell and Poth (2017), Moustakas (1994), and van Manen (2007, 2016) phenomenology is a qualitative method of inquiry that researchers apply to a myriad of lived experiences. It offers the researcher the ability to examine the different perspectives of participants' lengthy experiences (van Manen, 2007, 2016). Moreover, phenomenology also offers the researcher the ability to examine the cumulative experience of participants as related to a single point in time (Moustakas, 1994). In phenomenology, the shared experience of a single life event, the event length or a matter of seconds, is the focal point of the research, not the event itself. For this research study, a phenomenological methodology was employed to assess the engagement experiences of mental health service providers. The goal of this study was to provide researchers, policy-makers, mental health service providers, and the homeless community with more information about the resources needed for successful engagement outcomes.

According to Creswell (2007) and Creswell and Poth (2017), the use of transcendental phenomenology allowed the researcher to focus less on their interpretations and more on the descriptions of the participants' experiences. Researchers must set aside their experiences as much as possible to take a fresh perspective toward the phenomenon under examination, to analyze the data by reducing the information to significant statements or quotes, and combine the statements into themes (Creswell, 2007). These themes were used to develop textural and structural descriptions based on the essence of the participants' conditions, situations, and/or experiences, which were essential to effective data analysis (Creswell, 2007; Creswell & Poth, 2017).

Three research questions have been formulated from an overarching consideration of engagement practices by mental health service providers with the homeless individuals they serve in New York City. They are:

1. What engagement practices do mental health service providers, in New York City, identify as successful when engaging mentally ill homeless individuals about provided clinical services?

2. How do mental health service providers, in New York City, explain their experience of engagement with mentally ill homeless individuals?

3. What barriers do mental health service providers, in New York City, face when engaging mentally ill homeless individuals about committing to provided clinical services?

This study was important because it stimulated positive social changes in the way service providers engaged their clients. This phenomenological approach allowed the examination of the phenomena of engagement of the homeless and how the service providers in the situation perceived this process to be examined. The phenomenological approach was chosen because this type of qualitative method allowed the collection of data through participant observation. This approach required the researcher to become a participant within the culture or context that was being observed and determined how to become one with this context or situation and how to collect data while in this participant role (Trochim, 2008). Months could be spent learning how to and becoming accepted as part of the context before collecting data (Trochim, 2008). Remaining unobtrusive while collecting data so that the situation does not change is key (Trochim, 2008). Observations could be recorded with notes or audio or videotaping. Specific behaviors were a focus of this type of research, and this approach could be very time-consuming (Trochim, 2008).

Role of the Researcher

For this qualitative study, the recommendations of Ashworth (2016), Moustakas (1994), Patton (2002, 2015) to ask open-ended questions, to encourage long, elaborate answers, and to interact and collaborate with the participants during the data-gathering process were utilized. Qualitative inquiry is interpretive research that involves sustained, intensive interaction with participants, who were considered human instruments that could provide rich data via interview (Ashworth, 2016; Creswell, 2009; Creswell & Poth, 2017; Denzin & Lincoln, 2003; Moustakas, 1994; Patton, 2002, 2015). The qualitative researcher explained to participants that their role was emic. An emic role indicated that the researcher was taking an insider's view of research (Punch, 1998). The participants' responses were focused on by making the emic voice the predominant voice when telling their story. It was imperative that the qualitative researcher remained impartial and refrained from bias and preconceived notions about phenomena (Husserl, 1931, 2012) and Moustakas (1994) with the use of the epoche concept. The epoche process allowed the researcher to seclude personal experiences by suspending prior knowledge and only focusing on the experiences of the participants as a way of keeping the participants' experiences original or uncontaminated (Husserl, 1931, 2012; Moustakas, 1994).

Bracketing

Bracketing is a method used in qualitative research to diminish the possible detrimental effects of preconceptions that may taint the research process. The researcher was non-judgmental when learning about the mental health experiences and practices of the participants. The researcher listened to participants' responses and asked them to clarify unclear or difficult to understand statements based on sound quality or rough word and sentence structure to ensure accuracy. Personal experiences, knowledge, and expectations were distinguished from the participants' responses. Epoche was used by transcribing the participants comments as expressed in their interviews. Bracketing experiences and practices assisted in restricting personal bias about any of the responses from the participants (Ashworth, 2016; Creswell & Creswell, 2017; Husserl, 1931, 2012;

Moustakas, 1994). Member checking was used by emailing each participant a copy of his or her word-for-word interview transcript. Member checking allowed the participants to review their interview transcripts for accuracy.

Researcher Biases

Researchers need to be aware of and take responsibility for their personal bias and preconceived notions (Moustakas, 1994) because bias could cause false conclusions and mislead the reader. Rigorous criteria were established to avoid confounding data and selected participants from the same population of mental health service providers to minimize bias (Mehra, 2002). Participants were allowed to tell their experiences without seeking approval of confirmation from the researcher (Mehra, 2002). As recommended by Mehra (2002), to manage subjectivity the researcher took on the role as a learner, and the participants were the experts because the participants had the most knowledge about their experiences when engaging the homeless. Taking a learner's role allowed the researcher to learn about the phenomenon from different viewpoints and move beyond personal biases (Mehra, 2002).

Participants' experiences were presented as truths and in line with the idea and context of this study (Mehra, 2002). Findings from the interviews came from the emic voice; the predominant voice used when telling their story. Personal interpretations were limited as much as possible to ensure neutrality (Mehra, 2002). The purpose of this study was explained to all participants in the same manner to avoiding sharing a specific level of understanding, education, and thoughts on engagement with the participants as part of ethical practices for this study. This approach reduced bias by standardizing interaction with each participant.

Methodology

Participant Selection Logic

For this study, all interviews were conducted to gather data and analyzed all data for content. No personal or professional relationships with participants, and no supervisory or instructor relationships involving power over the participants was present. Any biases were managed by returning all findings to participants for verification and trustworthiness, accuracy, and credibility. The verification of accuracy helped ensure that these study findings represent the perspective of the participant, rather than the views of the researcher because it was the views of the participants that lend credibility to these study findings (Trochim, 2008).

The sampling method used for this qualitative research was a nonprobability sample design with a purposeful sampling strategy; to emphasize on strategically and purposefully selecting information rich cases, which yielded insights and in depth understandings for the questions under research, based on views and recommendation of Moustakas (1994) Patton (2002, 2015). Following other ideas from Patton, a criterion sample were used to select participants who meet the same criteria. The selected criteria included: licensed, masters level mental health service providers who reported having worked in a homeless shelter within the previous 12 months, were 18 years of age or older, had experience engaging the homeless, must electronically sign and return the informed consent form with the prescribed numerical identifier, must be willing to meet with me at least twice--within a 30-day period--for one scheduled 30 minute to one hour face-to-face and voice-only recorded interview in a private room in a NYC public library dedicated for counseling or via telecommunication applications (i.e., FaceTime), and one possible follow up interview to review the accuracy of the transcript from the interview responses.

According to recommendations from Frankfort-Nachmias and Nachmias (2008) and Patton (2002, 2015), the unit of analysis for this qualitative research was a subset of the total population of mental health service providers, for homeless individuals, working in homeless shelters in Bronx County, New York City. Creswell (2007), Creswell and Poth (2017), and Mason (2010) suggested keeping the sample size small and following their suggestion, this study's sample included no more than 12 licensed, masters level mental health service providers to reach saturation. Crouch and McKenzie (2006) also noted that selecting a sample size with no more than 20 participants enhanced the validity of this study, and Mason noted that smaller sample sizes for qualitative studies were less time consuming, more practical, and lessened repetitive and redundant data. Glaser and Strauss (as cited in Creswell, 2007) noted that small sampling sizes for participants' data, which do not provide any further information on the phenomenon under investigation, follow the concept of saturation. Moreover, the ability to grasp the nature of the phenomenon through interviews could happen with a small sample of individuals with the same lived experiences (Moustakas, 1994; van Manen, 1997, 2016).

This sampling strategy for this study was appropriate because the criteria for the study ensured that all participants had experienced the same standards. Hammersley and

Atkinson (as cited in Creswell, 2007), were used as a basis for the criteria for selecting who or what, after gaining some perspective on the social lives of the people in the population under study. When all participants met the set criteria for this study, the data collected from their responses was more valid because all participants would have experienced the phenomenon (as cited in Creswell, 2007).

Instrumentation

For this qualitative phenomenological study, the method of collecting data came from semi-structured in depth interviews, using Quick Time Player on a MacBook Air, which allowed a large amount of data directly to a password protected external hard drive to be recorded and saved. Using the researcher as the instrument for data collection was another method of collecting data for the researcher designed open-ended interview questions (see Appendix E), as recommended by Ashworth (2016), Bernard (1988), Moustakas (1994) and Patton (2002, 2015). A field test was conducted with three mental health professionals with experience varying from 4 to 20 years. The feedback received ensured that the interview questions selected were in line with the research questions. The researcher designed interview questions were comparable to those in Reeves (2017), and were modeled on them like ‘What challenges do immigrant mentees and local members face with concern to mentoring?’ to the interview question for this study ‘What are some barriers that you had experienced as it relates to engaging with homeless individuals when trying to encourage their commitment to clinical services?’

Interview Questions

The research questions and associated interview questions below can also be found in Appendix E.

RQ1. What engagement practices do mental health service providers, in New York City, identify as successful when engaging mentally ill homeless individuals about provided clinical services?

1. What resources do you believe are needed for the successful engagement of homeless individuals?
2. What is your experience regarding factors related to the successful engagement of homeless persons in clinical services?
3. What engagement practices have you used to encourage the initial engagement of homeless persons in clinical services?
4. How can services be improved for the successful engagement of the homeless person?

RQ2. How do mental health service providers, in New York City, explain their experience of engagement with mentally ill homeless individuals?

5. What is your work experience as it relates to engaging with homeless individuals?
6. What are some engagement practices you have used that may have encouraged the homeless individual to commit to clinical services?

RQ3. What barriers do mental health service providers, in New York City, face when engaging mentally ill homeless individuals about committing to provided clinical services?

7. What are some barriers that you have experienced as they relate to engaging with homeless individuals when trying to encourage their commitment to clinical services?
8. What are some engagement practices you use to overcome, or address barriers related to the initial engagement of the homeless persons in clinical services?

Field Test

A field test conducted with three mental health providers experienced with homeless persons. Each interview lasted 15 minutes. Feedback received from this test suggested the following:

Participant 1 had a master's degree in human services and seven years of experience with homeless persons. The feedback received from this participant was that the researcher omitted leading questions regarding the need to provide respect, kindness, common language, and technology to engage the homeless.

Participant 2 was a licensed master social worker with 20 years of experience with homeless persons. The feedback received from this participant was to combine interview questions to reduce redundancy. As a result, the interview questions were reduced from 16 questions with two probing questions each to 8 questions in total.

Participant 3 was a licensed mental health counselor with four years of experience with homeless persons. The feedback received from this participant was to find a way to incorporate resources, work experiences, and engagement practices in interview questions. As a result, these interview questions were revised to include these areas.

Pilot Study

A pilot study was conducted to test the sufficiency of the data collection instrument and the interview protocol. To evaluate the interview protocol, two mental health service providers were recruited via email. The pilot study's findings did not indicate any problematic issues concerning the interview protocol. As a result, the original interview protocol was utilized in the main research study. Additionally, no changes were made in the instrumentation or data analysis strategies.

The Recruitment, Participation, and Data Collection Procedures

The recruitment, participation, and data collection procedures for this phenomenological study were as follows. All participants were recruited on a volunteer basis, using a self-selected convenience sample because there were appropriate participants to choose from, locally. The Internet and search engines were accessed, from a MacBook Air, iPhone, and iMac to search for homeless shelters in Google, on the NYC Housing and Preservation Department (HPD) site, the Department of Homeless Services (DHS) site, and the Department of Health and Mental Hygiene (DOHMH) site. After locating the shelters, the shelter directors or staff at the selected local homeless shelters were contacted by phone. The shelter directors' contact information (i.e., email addresses and phone numbers) were obtained from the staff persons who answered the phones.

Next, the shelter directors were called to explain the details of this study and to get their verbal approvals to conduct this study at their sites, before emailing the letter of cooperation and the flyer (see Appendix B). After gaining the approval from the shelter director to conduct the study at the sites, the letter of cooperation and the flyer were emailed to the shelter director. After receiving the email, the director printed the letter of cooperation and the flyer. The shelter director reviewed the letter of cooperation to make sure it stated the agreement with the researcher and then he placed the flyer on a designated bulletin board in his staffs' common areas, in the homeless shelters. Additionally, the shelter director was asked if an announcement could be made at an all-staff meeting to ensure sample size requirements were met. The participants were not asked at that time nor otherwise to express interest (i.e., raise their hands) because this would not allow enough time to consider participation nor privacy.

The mental health providers who read the information on the flyers and were interested in participating in this study emailed the researcher, based on the email information from the flyer posted on the bulletin boards in staff common areas. When emails from the potential service provider participants were received, the participants' emails were responded to with the initial contact message (see Appendix C) that provided more details about this study (i.e. information about the study, the criteria, numerical identifier, and support resources in case the participants needed support, due to feeling discomfort and stress about the nature of the study). The participants received an informed consent form that provided details on how potential service provider participants could establish new Gmail accounts using prescribed pseudonyms, for confidentiality. All participants were also informed during the initial contact that their participation was voluntary, that they may ask any questions about the study at any time, and that if they agreed to participate in the study they could withdraw from this study at any time. Moreover, if the participants met this study's criteria and agreed to participate in the study, they electronically signed and dated the informed consent form using an individually prescribed numerical identifier (1111; 1212; 3333) as their signatures. The prescribed numerical identifier allowed the participants privacy.

All participants were informed that their information would remain confidential. The participants communicated via email to agree on meeting times that best fit their schedules. Participants were asked who met this study's criteria, to meet at the NYC public libraries nearby or to start the telecommunication interviews at the designated times. The individual interviews took place in private rooms dedicated for counseling at the NYC public library or the participants' and researcher's individual locations via the telecommunication applications from a computer or smart device (i.e., Smartphone, iPad, MacBook…).

Individual face-to-face and voice only recorded semi-structured interviews were conducted, with the participants after discussing the participants' confidentiality and explaining to the participants their ethical rights before, during, and after the interviews. Participants were informed that their ethical rights included keeping their information safe and private, them having the freedom to participate or to not participate in this study, and their right to end their participation at any time during this study without any concern of disrespect from anyone associated with the study (Moustakas, 1994).

The voice-only interviews were recorded using Quick Time Player on a MacBook Air. After the completion of each interview, the individual's interviews were saved to a password protected SanDisk Cruzer Glide external hard drive and then checked each interview file to make sure the stored files (using the numerical identifier as the file's name) opened properly and had excellent sound quality. Each participant was debriefed after he or she had completed the initial interview process. During the debriefing session, each participant was informed that he or she received a debriefing document that included information about what to expect after the study and a list of resources (same resources listed in the initial contact message) in case they needed support. This debriefing document can provide support for feelings of discomfort and stress after talking about their engagement practices and experiences as mental health providers. Creswell (2009) and Creswell and Poth (2017) noted that when the interviews concluded, and data collected, the participants were ready to exit this study. The participants were informed of steps that follow the interviews and they were informed that their anonymity remained a major factor in this study, as part of the debriefing process (see Appendix D). Moreover, the participants in this study understood that they could withdraw from the study at any time and could request the deletion of their recorded interviews, without feeling any pressure, based on views from Creswell, Creswell and Poth, and Moustakas (1994). The issues of follow up and the possibility of needing more information from the participants was addressed by giving the participants a time to expect a follow up, as recommended by Creswell, Creswell and Poth, and Moustakas (1994).

Next, each individual interview file stored on the external hard drive was accessed. The researcher listened to each interview and transcribed the recorded interview responses word-for-word to keep the data accurate. After transcribing the responses to each recorded interview, each transcript was saved to the password protected external hard drive before emailing each participant a copy of his or her transcript. Upon receipt of the transcript, each participant reviewed his or her now written responses from the interview transcript for accuracy. If there were problems with any transcripts, follow up meetings were scheduled with those participants to clarify any issues or discrepancies in the written interview transcripts.

Potential changes to the inaccurate transcripts took place during the follow up interview and then were stored to the password protected external hard drive before ending the follow up interview. After all needed changes were completed, based on the participants' statements, the participants were informed that their part in this study had ended. The following points were used to debrief the participants after preparing them for the exiting process. The exiting or debriefing process included in this study were:

1. Provided participants with more information about the expectation of this study after the completion of the interviews and follow up.
2. Informed the participants of their ethical rights to withdraw from this study.
3. Reviewed the debriefing document and the mental health resources (see Appendix D) to make sure that participants understand the list of resources available to them and the mental health information.

4. Informed participants about data retention, security measures for email accounts, and about their continued confidentiality.
5. Informed the participants that they would receive a 1- to 2-page summary of this study findings after the completion and approval of the study.

Additionally, when participants participated in the exiting process, they could eliminate any confusion about the research process by asking questions. The exiting process could also confirm the data's trustworthiness and validity and the accuracy of participants' interview, before the analysis process (Maxwell, 1992).

Data Analysis Plan

Moustakas (1994) noted that phenomenological research had systematic steps in the data analysis process. The six steps used in this study came from a modification of Groenewald (2004) and Williams (2012)'s method of analysis for phenomenological data. The steps were as follows:

1. Listed and executed a preliminary grouping of all relevant expressions to the experiences' and typed out data verbatim from the audio recording.
2. Reduced and eliminated expressions to determine the "invariant constituents" that were considered the main categories of the experiences. Read through the transcribed data and underlined themes related to research questions or new information. Examined data and coded recurring themes; examined all written data and circled any information related to the research questions and then went back through the circled information and list a theme for each piece of information to allow for easy spotting of themes.

3. Identified, validated, searched for patterns, or connections between the themes.
4. Informed conclusions to address the research questions based on patterns of themes.
5. Developed a composite description of the meaning and essence of the experience, representing all the participants' (Ashworth, 2016; Moustakas, 1994, pp. 1-2).

As a method of gaining a greater understanding of phenomenological research, other examples of phenomena that other researchers had studied were reviewed to gain a better understanding from the viewpoint of the participants. This understanding examined what it means to be a service provider for the mentally ill struggling to engage or commit in the homeless services, in an era where homelessness is a pressing issue.

van Manen (2007, 2016) suggested bracketing out personal, conscious lived experiences about the phenomenon (see Appendix H). According to Ashworth (2016) and Moustakas (1994), specific interview questions asked of the participants would lead to a textural and structural description of the lived experiences to provide an understanding of the general experiences of the participants.

NVivo is a qualitative data analysis, computer software program, designed to assist researchers in organizing and analyzing qualitative data (QSR International [QSR], 2013). Based on ideas from Strauss and Corbin (as cited in Creswell, 2007), the written text, that is, field notes and supporting documents were transcribed, using viewpoints based on the data findings and individual characteristics, with the use of content analysis (Cabraal, 2012). The different ways data could be interpreted and what to transcribe were assessed, including what the data means while working to keep personal bias out of this study. Data were inductively coded using NVivo to assess themes, frequency counts, and for other areas of interest and needs provided by the program, in support of views by Cabraal (2012).

Issues of Trustworthiness

Reliability and Validity

In qualitative research, validity and reliability were two factors researchers needed to pay attention to when designing a study, analyzing the results, and judging the quality of the data (Patton, 2002, 2015). Some of the issues of validity and reliability were that qualitative research was mostly inductive, focusing on understanding specifics rather than generalizing, viewing threats as an opportunity for learning by not controlling for bias, not being fully aware if the accounts were accurate, and with limited sustained trustworthiness (Creswell & Creswell, 2017; Patton, 2002, 2015). Credibility in qualitative research established the reliability of the findings to ensure they were credible or believable from the participant's perspective. Appropriate strategies to establish credibility and trustworthiness of data and conclusions included returning conclusions from data analysis to participants for verification (Lincoln & Guba, 1985; Trochim, 2008).

Transferability regarding the degree that results of qualitative research could be generalized to other contexts or settings (Lincoln & Guba, 1985; Trochim, 2008). Appropriate strategies to establish transferability included the use of thick descriptions of findings from participant's lived experiences. The thick descriptions allowed for the transferability of information to other like individuals, and data findings and conclusions revealed how any information could be transferred to other like individuals or situations (Lincoln & Guba, 1985; Trochim, 2008).

Dependability refers to the need to account for the changing context where the research took place and impacted findings (Lincoln & Guba, 1985; Trochim, 2008). Confirmability refers to how well results were confirmed by others (Lincoln & Guba, 1985; Trochim, 2008). Appropriate strategies to establish dependability and confirmability included reflectivity, which was the systematic attendance to the knowledge construction process to include issues of researcher bias and effects. All findings and conclusions were returned to participants for their review, which helped ensure reliability and validity of data and findings (Kelly, Sadeghieh, & Adeli, 2014; Patton, 2002; 2015; Solomon, 2007).

Dependability of findings was ensured by using a strictly phenomenological approach and methods presented by van Manen (1997, 2007). Established phenomenological procedures for participation, data collection, and analysis were used, and findings were validated with participant feedback to establish dependability (Lincoln & Guba, 1985; Trochim, 2008). In addition, to build rapport and trust during the interview process by using interviewing techniques, such as engaging in the interview process instead of just reading the interview questions to the participant (Lincoln & Guba, 1985; Trochim, 2008); allowed for the freedom to build rapport with the participant (Lincoln & Guba, 1985; Trochim, 2008).

Ethical Procedures

There are always ethical concerns when performing research, according to Walden University (2017), ethical standards, and the trustworthiness of a qualitative study depends greatly on the ethics of the researcher (Merriam, 2009). Institutional Review Board's (IRB) and shelter directors' approval were gained before any data collection activities. Ethical concerns related to recruitment materials and processes included providing full disclosure to the participants, which was done with the introduction flyer, initial contact message, and the informed consent form provided. The initial contact message explained the nature and purpose of this study, the criteria to participate in the study, the prescribed numerical identifier that participants used to electronically sign the informed consent form, and helpful resources. The issue of consent was explained to the participants in full detail so that participants could make the best informed decision, and all participants electronically signed informed consent forms after IRB approval and before their interviews. The participants for this study were not a part of a vulnerable population, and no deception was used.

The informed consent form included information about how participants' anonymity, confidentiality, and privacy were maintained with the use of numerical identifiers, secure email communication, individual and private face-to-face, and voice only recorded interviews. To add more privacy and security, real names or identifiers were not included on any data, and email addresses were kept confidential and only used for communications relating to this study. All data were gathered through individual face-to-face, and voice-only recorded interviews and transcribed the interview responses word-for-word to accuracy and to avoid any bias in translation. Next, all will be secured on the password protected external hard drive for five years as required by Walden University. Finally, participants were informed that they could withdraw from this study at any time without any negative consequences participants were also informed about the possible risks expected from study participation, and how they would benefit from a new level of understanding of the study issues.

Summary

For this study, a qualitative phenomenological research design was used. This research design allowed for the exploration of the phenomenological question: What is the experience of mental health providers regarding the engagement of the homeless in clinical services. To gather data, the intent of this study was to recruit mental health service providers for interviews. Chapter 4 is a report of the findings from the mental health service provider participants’ engagement practices, experiences, and perceived barriers.

Chapter 4: Results

Introduction

The purpose of this phenomenological qualitative study was to gain more insight into the engagement practices, experiences, and perceived barriers of mental health service providers, in New York City, when encouraging homeless individuals to commit to participating in clinical services. The study evaluated the way service providers engage individuals who may need their services to determine whether the services were accepted. According to Lee and Donaldson (2018) and Olivet et al. (2010), engagement within social support services happens when service providers reach out to people to encourage them to partake in the services provided. The successful engagement of homeless individuals included ongoing engagement with the homeless person, kept appointments, established goals, steps to meet these goals, and related factors perceived and reported by the mental health provider (Lee & Donaldson, 2018; Olivet et al., 2010).

Despite several decades of research on the importance of engagement, homeless individuals often fail to commit to the services to help them end their homelessness (Hwang & Burns, 2014; National Alliance to End Homelessness, 2015; Norman & Pauly, 2013; Norman et al., 2015). At the time of this study, researchers had conducted limited research on how mental health providers engage homeless individuals to participate in the clinical services they provided (Dixon et al., 2016). This study allowed the 12 participants to share their engagement experiences as licensed mental health service providers. Participants focused on global environmental factors, such as the lack of stable housing, physical and mental health problems, violent situations, and substance abuse treatment needs have shown those factors as contributors to a lack of engagement and the need for improved engagement of the homeless (Corrigall-Brown et al., 2009; Fazel et al., 2014; Meanwell, 2012).

Phenomenology was selected as the research design for this study because it focused on discovering the essence and describing the meaning of the individuals' lived experiences, based on ideas and recommendations from Creswell (2007); Creswell and Poth (2017); Husserl (1931, 2012); Moustakas (1994); van Manen (2007, 2016). The application of the phenomenological design allowed the participants' rich, in depth, firsthand descriptions of their engagement practices, experiences, and perceived barriers to being integrated into shared themes. This chapter includes the impact of the pilot study, data collection process, detail of how the data were generated, recorded, coded and securely stored, including discrepant cases. The methods that were implemented to verify trustworthiness is described. The data collection procedures adhered to the ethical and confidential measures outline in chapter 3. The chapter concludes with a summary and transition into the next chapter.

Research Questions

The overarching research questions are:

1. What engagement practices do mental health service providers, in New York City, identify as successful when engaging mentally ill homeless individuals about provided clinical services?
2. How do mental health service providers, in New York City, explain their experience of engagement with mentally ill homeless individuals?

3. What barriers do mental health service providers, in New York City, face when engaging mentally ill homeless individuals about committing to provided clinical services?

Procedures for Pilot Study

A pilot study was conducted to test the sufficiency of the data collection instrument and the interview protocol. To evaluate the interview protocol, two mental health service providers were recruited via email. The pilot study's findings did not indicate any problematic issues concerning the interview protocol. As a result, the original interview protocol was utilized in the main research study. Additionally, no changes were made in the instrumentation or data analysis strategies. IRB approval number 02-15-19-0195152, expiration date of February 14, 2020.

Setting

The setting described the environment of the study, including any conditions that may have influenced the study participants or their experiences. None of the twelve study participants shared information with the researcher that they had been influenced by recent personal conditions in existence at the time their interview data was collected.

Demographics

For this research study, twelve mental health service providers were invited to participate and provide their individual perspectives and experiences. The sample size was limited to 12 participants to minimize the complexities of the research and allow more in depth view of the research findings. The participants who partook in the study were mental health practitioners who were actively practicing in the state of New York.

The number of years the participants had practiced varied as well as the gender of the participants.

To participate in this study, the research participants were required to meet certain requirements. In order to participate in the study, the research participants needed to be masters level mental health service providers who reported having worked in a homeless shelter within the previous 12 months, 18 years of age or older, and had experiences engaging the homeless. Anyone who did not meet the inclusion criterion indicated by the IRB application and informed consent provided were omitted from the study.

Data Collection

The research interviews ranged from 15-23 minutes. The data collection process commenced by searching for homeless shelters in Google, on the NYC Housing and Preservation Department (HPD) site, the Department of Homeless Services (DHS) site, and the Department of Health and Mental Hygiene (DOHMH) site for homeless shelters in NYC; after receiving IRB approval (approval number 02-15-19-0195152, expiration date of February 14, 2020) via email. Once potential participants were located, the shelter director or another staff member were contacted at the selected local homeless shelters, by phone. The shelter directors' contact information (i.e., email addresses and phone numbers) were obtained from the staff member who answered the phone. Next, the shelter director was called to explain the details of the study and to request verbal approval to conduct the study at the respective shelter. After gaining approval from a shelter director to conduct the study at the site, the letter of cooperation and the flyer were emailed to the shelter director. After receiving the email, the director printed the letter of cooperation and the flyer. The shelter director reviewed the letter of cooperation to make sure it stated the agreement with the researcher, and then he shared information about the study by placing the flyers on a designated bulletin board in his staffs' common areas in the homeless shelter. When the emails from the potential service provider participants were received, the potential participants' emails were responded to with the initial contact message and the informed consent form. Over 50 initial contact messages and informed consent forms were transmitted to potential participants.

Additionally, the shelter director was asked if an announcement about the study, at an all staff meeting could be made to ensure sample size requirements were met. From the sent initial contact messages and those who attended the staff meeting, 30 mental health service providers responded with interest in participating in the study. However, only 12 of the 30 met the set criteria to participate in the study.

There were a few challenges presented during the recruiting process by the participants. First, getting the participants to follow the protocol to participate in the study proved to be difficult. Many of the participants expressed being uncomfortable about having to create a new email address to participate in the study. Some were confused about how to create accounts using pseudonyms because Gmail still was requesting first and last names, date of birth, and phone numbers to set up an account. There were other instances where some mental health providers responded to the request for participants with what appeared to be genuine interest yet failed to follow through with the established protocol. The 12 participants, who accepted their prescribed pseudonyms and created new Gmail accounts as part of the protocol, emailed the researcher, and the interview process began.

The participants scheduled individual face-to-face voice-only recorded interviews by email. The first email sent to the participants included the informed consent form and the research criteria form. Email was also used to discuss the types of face-to-face telecommunication the participants used to determine if the devices were compatible before scheduling the interview appointments. The 12 participants had compatible devices and the face-to-face; telecommunication interviews were conducted using FaceTime, after receiving electronically signed informed consent and research criteria form from individual participants. Each interview was voice only recorded using Quick Time Player on a MacBook Air. The recorded interviews were played and listened to in the presence of the interviewees for sound quality before storing the recorded interviews on a password protected external hard drive.

The 12 participants who agreed to participate in this study, sufficiently represented the mental health service provider population in NYC, based on views of saturation from Creswell and Glaser and Strauss (as cited in Creswell, 2007). Saturation was met when the data from the participants' interviews were no longer providing any further new information. With the present information the nature of the phenomenon was grasped because the participants shared many of the same experiences. The duration of the interviews varied by the participant; durations are listed in Table 1.

Table 1:

Duration of Study Participant Interviews

Study participants	Length of interview (minutes)
Participant 0002	23
Participant 0003	16
Participant 0004	20
Participant 0005	15
Participant 0007	17
Participant 0008	15
Participant 0009	18
Participant 0010	17
Participant 0011	19
Participant 0012	15
Participant 0013	17
Participant 0014	15

Participants' interview data were recorded by voice only interviews using Quick Time Player on a MacBook Air. After the completion of each interview, the voice only recorded interviews were transcribed word-for-word to include nonlexical conversational sounds such as ums, ahs, and laughs to create an accurate presentation of the content. After the interviews were transcribed, the transcripts were emailed to the participants for member checking. The participants viewed their transcripts for accuracy, and one participant requested a follow up interview to clarify discrepancies with her response to the written interview transcripts regarding the successful engagement of the homeless. Data for this study were analyzed based on a modification of van Kaam's method of analysis, developed by Moustakas (1994). This method included several steps, outlined in Chapter 3 of this dissertation, which begins with listing relevant expressions into categories and themes, and then constructing textural and structural descriptions of the meaning and essence of the participants.

Unusual circumstances encountered during data collection included poor sound quality during the FaceTime interview with Participant 0004; noise from people talking outside private rooms dedicated for counseling at the NYC public library during interviews with 0007, and 0008.

Data Analysis

> The process of data analysis in qualitative research involves trying to discover and understand the phenomenon or process being studied by using the data gathered to describe the phenomenon or process. The problem this research addressed was the limited research regarding the engagement practices and experiences of mental health service providers in New York City, when encouraging homeless individuals to commit to clinical services, and especially where perceived barriers to engagement were concerned. The participants for this study were licensed, masters level mental health service providers who reported having worked in a homeless shelter within the previous 12 months, were 18 years of age or older,

and had experiences engaging the homeless. The purpose of this study was to gain more insight into the engagement practices, experiences, and perceived barriers of mental health service providers, in New York City, when encouraging homeless individuals to commit to participating in clinical services. These mental health service providers discussed engagement practices they identified as successful when engaging mentally ill homeless individuals about provided clinical services. These mental health service providers also discussed the barriers they faced when engaging mentally ill homeless individuals about committing to provided clinical services.

The Lived Experiences of Twelve Mental Health Service Providers

The 12 participants shared some common experiences. Due to the confidential nature of this study and the participant's safety and wellbeing, other demographic and identifying questions were not included, for reasons of anonymity and confidentiality. Each participant was prescribed a pseudonym which maintained confidentiality. The interview questions were designed to focus on engagement practices, experiences, and perceived barriers of mental health service providers with the homeless individuals served in New York City. Probing questions were not introduced during the interviews to allow each participant to reflect on the individual interview questions independently. To allow the participants to answer the questions without assistance. The researcher believed that if she had probed, it might have biased the participant's answers in the process of trying to gain a suitable answer based on the researcher's personal experiences. An overview was provided of the discussions with the participants about their engagement practices, experiences, and perceived barriers with the homeless individuals in the following sections.

Following a modification of van Kaam’s method of analysis for phenomenological data, developed by Moustakas (1994), the interview data was analyzed. The first step involved listing and grouping all expressions relevant to the engagement practices, experiences, and perceived barriers of mental health service providers with the homeless individuals served in New York City. In Step 2, irrelevant expressions were reduced and eliminated. Step 3, involved grouping and presenting the categories into themes. In Step 4, the themes were identified and validated. Step 5, involved constructing an individual textural and structural description of each participant’s experiences. Finally, Step 6 involved developing a composite description of the meaning and essence of the experience, representing the participants as a whole. These steps demonstrated how the data were coded, categories were developed, and themes identified that emerged from the interview data.

Based on the interview responses from the 12 mental health service providers, there were no discrepant cases. However, there were two participants, 0001 and 0006, who did not want to continue after hearing the explanation of the study. All the information obtained were consistent with all the participating participants.

Step 1: Listing and Grouping

To code the data, the interviewer transcripts were imported into the NVivo program (QSR International [QSR], 2013). Personal experiences were bracketed away from the experiences of the participants. Notes taken during the interviews were separated from the interview transcripts. The interview transcripts were imported into the NVivo program, read again, and more notes were taken as relevant expressions were identified relating to the engagement practices of mental health service providers with the homeless individuals. With the NVivo program, a word frequency count was performed using the 20 most frequent expressions. Immediately 12 of those expressions (Table 2) were eliminated, and the remaining eight expressions were grouped into categories, in relations to their relevance to the participants' engagement practices with the homeless individuals. The interview responses for each question were repetitive. The transcribed interview transcripts categories were easily drawn from the interview responses. The repetitive expressions gathered by coding the interviews assisted in creating nodes, which were collections of references about specific themes. These nodes were easily taken from the interview responses and imported into the NVivo program.

Table 2:

List of 20 Most Frequent Expressions

Resources	Stigma	Communication
Empathy	Transparency	Building Rapport
Compassion	Case Management	Housing
Trust	Mental Health Services	Accessibility
Medical Services	Substance Abuse Services	Incentives
Engagement	Food Pantries	Resistance to change
Funding	Accountability	

Step 2: Reducing and Elimination

The categories quickly emerged from the eight interview questions. The repetitive expressions (resources, factors and engagement, engagement practices, service improvement, work experience, engagement to commit to services, barriers to commitment, overcome barriers to commitment) assisted in creating categories because the interview responses from the 12 mental health service providers were similar (See Table 3).

Table 3:

List of Eight Expressions

Resources
Factor in Engagement
Engagement to Commit to Services
Engagement Practices
Service Improvement
Work Experience
Barriers to Commitment
Overcome Barriers to Commitment

Step 3: Grouping and Developing Themes

From these categories, three relevant themes emerged about building rapport, medical and mental health, and resistance to change of the 12 mental health service provider participants. The first theme was building rapport, which all the participants reported as important to engaging homeless individuals (Table 4). The second theme included information on how the participants' view of medical and mental health services translated to engaging the homeless (Table 5). The third theme included information about how the participants' view of resistance to change translated to engaging homeless individuals (Table 6). These themes described in greater detail in Steps 5 and 6.

Table 4:

Building Rapport

Categories	Number of participants who responded
Superordinate Theme 1: *Building rapport*	9
Sub-Theme 1: *Motivation*	8
Sub-Theme 2: *Trust*	6
Sub-Theme 3: *Incentives*	6
Sub-Theme 4: *Empathy*	7

Table 5:

Medical and Mental Health Services

Categories	Number of participants who responded
Superordinate Theme 2:	9
Sub-Theme 1: *Medical Services*	6
Sub-Theme 2: *Mental Health Services*	9

Table 6:

Resistance to Change

Categories	Number of participants who responded
Superordinate Theme 3: *Resistance to change*	9
Sub-Theme 1: *Meet the client where they are at*	5
Sub-Theme 2:	
Willingness to change	4

Step 4: Validating the Themes

The three themes were validated by checking each theme against the transcribed interview responses of each participant. When checking for themes, the researcher looked for common expressions from the participants and expressions not clearly stated. General expressions were found to be similar and in context and relevant to the participants' experiences. The themes that were not relevant or compatible with the participants' engagement practices with homeless individuals were omitted. The three themes that emerged were relevant to the participants' engagement practices, experiences, and perceived barriers with homeless individuals. (See Table 7).

Table 7:

Superordinate Themes

Categories	Themes
Superordinate Theme 1	Building rapport
Superordinate Theme 2	Medical and mental health
Superordinate Theme 3	Resistance to change

Step 5: Individual Textural Descriptions

In this step, the individual descriptions of the participants' experiences were written. Creswell (2007) describes textural descriptions as written descriptions of what the participants experienced while structural descriptions as written descriptions of the context or setting that influenced how the participants experienced the phenomena.

Step 6: Composite Description

The composite description represented all the participants and was constructed from the participants' individual textural and structural descriptions. This step described the meaning and essence of the participants' responses to their experiences as a group.

Evidence of Trustworthiness

The researcher kept an open mind while learning about engagement practices, experiences, and the perceived barriers of the participants. A point was made to simply listen to the participants' responses and asked them to clarify confusing or hard to understand statements, based on sound quality or rough word and sentence structure. Epoche was used to separate personal experiences, knowledge, and expectations from the participants' responses by transcribing their comments as expressed in the interviews. Additionally, bracketing experiences and practices assisted in limiting personal bias about any of the responses from the participants. Member checking was used by emailing each participant a copy of his or her word-for-word interview transcript. Member checking also allowed the participants to review their interview transcripts for accuracy.

Credibility

Any biases were managed by returning all findings to participants for verification and trustworthiness, accuracy, and credibility. The verification of accuracy helped ensure that these study findings represent the perspective of the participant, rather than the views of the researcher because it was the views of the participants that lend credibility to these study findings (Trochim, 2008).

Transferability

Transferability regards the degree that results of qualitative research could be generalized to other contexts or settings (Lincoln & Guba, 1985; Trochim, 2008). Appropriate strategies to establish transferability included the use of thick descriptions of findings from participant's lived experiences. The thick descriptions allowed for the transferability of information to other like individuals. Data findings and conclusions revealed how any information could be transferred to other like individuals or situations (Lincoln & Guba, 1985; Trochim, 2008).

Dependability

Dependability refers to the need to account for the changing context where the research takes place and impacted findings (Lincoln & Guba, 1985; Trochim, 2008). The dependability of findings was ensured by using a strictly phenomenological approach and methods presented by van Manen (1997, 2016). Established phenomenological procedures for participation, data collection, and analysis were used, and findings were validated with participant feedback to establish dependability (Lincoln & Guba, 1985; Trochim, 2008). In addition, to build rapport and trust during the interview process by using interviewing techniques, such as engaging in the interview process instead of just reading the interview questions to the participant (Lincoln & Guba, 1985; Trochim, 2008); allowed the freedom to build rapport with the participant (Lincoln & Guba, 1985; Trochim, 2008).

Confirmability

Confirmability refers to how well results were confirmed by others (Lincoln & Guba, 1985; Trochim, 2008). Appropriate strategies to establish dependability and confirmability included reflectivity, which was the systematic attendance to the knowledge construction process to include issues of researcher bias and effects. All findings and conclusions were returned to participants for their review, which helped ensure the reliability and validity of data and findings (Kelly et al., 2014; Patton, 2002, 2015; Solomon, 2007).

Results

Three themes emerged from the 12 participants' responses to the eight interview questions about their engagement practices, experiences, and perceived barriers when encouraging homeless individuals to commit to participating in clinical services. Face-to-face interviews were conducted with 12 mental health service providers from New York City. FaceTime was used to interview participants 0002, 0003, 0004, 0005, 0007, 0011, 0012, 0013, and 0014, and the New York Public Library was used to interview participants 0008, 0009, and 0010. The themes that emerged from the face-to-face interview responses were building rapport, medical and mental health services, and resistance to change (meeting the client where they are at). The theme building rapport emerged in all interview question responses. The theme of medical and mental health services emerged from at least eight of the participants' responses to the interview questions. The theme resistance to change, also referred to as, meeting the client where they are at emerged from at least two of the participants' responses to the interview questions.

Themes

The first research question was: What engagement practices do mental health service providers, in New York City, identify as successful when engaging mentally ill homeless individuals about provided clinical services? The 12 participants, in this study, all experienced building rapport as an engagement practice to encourage homeless individuals to commit to participating in clinical services. These engagement practices and experiences were evident and based on the common theme from the interviewees' responses.

- Participant 0002 believed that building rapport starts in the workplace when building working relationships.
- Participant 0002 shared that clients who were resistant to change and do not trust others have their guard up.
- Participant 0003 recalled "being transparent and genuine were the best ways to gain trust and build rapport with homeless individuals"
- Participant 0003 stated that "good collaborative relationships were built on consistency and transparency"

- Participant 0004 believed that by going out in the field and performing outreach with clients helped to build rapport
- Participant 0005 recalled that a pleasant, warm, and approachable demeanor was more beneficial than an authoritative approach
- Participant 00005 also stressed that “meeting the client where they are at.” was an effective way of building rapport.
- Participant 0007 thought that building rapport includes encouraging an open and honest relationship, so the clients can make informed decisions. Being patient and having a positive attitude, regardless of what the client was presently experiencing.
- Participant 0008 built rapport by confronting resistance to make changes to help the client with weighing the pros and cons of their decisions
- Participant 0009 explained that building rapport through psychoeducation, transparency, and incentives were helpful.
- Participant 0010 believed that rapport was built on three principles “Respect, Trust, and Empathy” that helped a client to trust you.
- Participant 0011 built trust by being empathetic and placing himself in the clients’ shoes to see how they are feeling and not judging them.
- Participant 0012 believed helping to ensure clients were managing their mental health.
- Participant 0013 noted that making clients feel accepted, not judged, and informed of services

- Participant 0014 insisted that staff with welcoming demeanors encourage engagement.
- Participant 0014 also thought that clients need to learn how to trust staff

The second research question was: How do mental health service providers, in New York City, explain their experience of engagement with mentally ill homeless individuals? Mental health service providers had experiences with medical and mental health services and felt they were important when encouraging homeless individuals to commit to participating in clinical services. Medical and mental health services worked well together and developed into one theme.

- Participant 0003 thought that medical services were needed for the successful engagement of homeless individuals.
- Participant 0007 believed that more mental health services, programs that offer rent assistance, and mobile crisis teams that provided services in the community would be a helpful resource for successful engagement.
- Participant 0009 believed that resource guides that included information that explained where homeless individuals could seek medical attention, if necessary, could encourage engagement in services
- Participant 0010 stated, “mobile healthcare providers that can come to places to provide services.
- Participant 0011 stated, “We need more mental health and medical clinics around the area to bring our clients to.”

- Participant 0012 believed that providing outreach and accompanying the homeless individual to mental health appointments was important to help the individuals navigate mental health and substance abuse services, apply for health insurance, and obtain a list of food pantries.
- Participant 0013 further stated, “Ok, I think the resources that are needed to engage the homeless would be maybe offering them maybe medical services, perhaps access to pantries, the location of food pantries, um psych, psychiatric services.”
- Participant 0014 believed that successful engagement was contingent on psychiatric involvement, medical care, and outreach attempts.

The third research question was: What barriers do mental health service providers, in New York City, face when engaging mentally ill homeless individuals about committing to provided clinical services? Resistance to change was a perceived barrier that mental health service providers had identified as important when encouraging homeless individuals to commit to participating in clinical services.

- Participant 0002 stated, “Some of the barriers we experience actually is sometimes the homeless person doesn’t have family, they are not connected with their family, or they are estranged from their family.”
- Participant 0003 stated, “Motivational interviewing and being transparent are the best ways to go.

- Participant 0005 used motivation interviewing skills to roll with resistance and meet the client where they are at, “because it showed empathy and showed that you are not trying to reprimand or make them feel awful or judged.”
- Participant 0002 stated that building the working relationship with homeless individuals had been a barrier because some people were very resistant to change, some were stuck in their way of doing things, and they’re not trusting of outside people.
- Participant 0004 believed that “transportation funding is needed because the homeless person does not have funding to actually get to the office which is why the staff go to them in some cases such as home visits because the funding limitation which makes it a little harder for the staff to communicate with the homeless person.”
- Participant 0005 mentioned that some of the barriers included undocumented individuals, and they don’t want to get found out by the government, which causes anxiety and fear.
- Participant 0007 suggested, “to be open and honest”
- Participant 0008 reported that “participants unwilling to change their behavior sticking with familiarity as opposed to trying things a different way is challenging.”
- Participant 0009 stated, “Some homeless persons are just resistant like they don’t want to do it, if there is no incentive for them, they just don’t want to do it.”

- Participant 0010 reported, “My age, being younger than most of the people here causes a barrier because they associate age with wisdom.”
- Participant 0012 stated,

  “Homeless persons don’t like structure, they don’t like because they been homeless for so long, they don’t like the fact that you know they have to clean their room, they have to pay rent, they have to go to their medical appointments.”
- Participant 0013 stated, “I think some of the clients are not ready. They do not want to hear it. Maybe not ready mentally to engage in services.
- ” Participant 0014 reported,

  “Because of their psychiatric history, a lot of them were not open to um to anything. So, you might try to engage with them and based on their history of people coming into their lives and leaving and them not trusting people, you know, it takes a while to build a relationship with somebody that’s homeless, because the first thing off the bat is they don’t like you, and they don’t trust you. You have to try to do whatever you can to get them to believe whatever you are saying is the truth.”

Discrepant Cases and Nonconforming Data

Based on the interview responses from the 12 mental health service providers, there were no discrepant cases. However, there were two participants, 0001 and 0006, who did not want to continue after hearing the explanation of the study. All the information obtained were consistent with all the participating participants.

Summary

Chapter 4 included the findings from the 12 mental health service providers' responses to the interview questions regarding their engagement practices, experiences, and perceived barriers. Face-to-face interviews were conducted using FaceTime, while voice only recording the interviews and saving them to a password protected external hard drive. Three key themes emerged from the participants' transcribed interview responses, which were: building rapport, medical and mental health services, and resistance to change. Chapter 5 includes an overview of the study, an interpretation of the findings, implications for social change, recommendations, and a reflection of the researcher's experience with this study before concluding with a summary.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The engagement practices and experiences of mental health service providers have not been well documented. Moreover, most of the responses given by participants in the study agreed with Mills et al. (2015) that there is a lack of research that investigates the engagement process of the homeless from the providers' perspectives. The nature of this qualitative study was phenomenological. The purpose of this study was to gain more understanding and insight into the engagement practices, experiences, and perceived barriers of mental health service providers, in New York City, when encouraging homeless individuals to commit to participating in clinical services. This qualitative phenomenological research design allowed for the understanding of the experiences of mental health service providers as they engaged the homeless to provide services. Open ended questions were used to elicit mental health service provider's responses in their own words about how they encouraged homeless individuals to participate in clinical services. Themes emerged during the data analysis process, and participants provided clarifications as well as elaborations. Patterns revealed themes that led to an explanation of how mental health service providers experienced engagement. This chapter includes the key findings, interpretation of findings, recommendations, and implications. This chapter will conclude with a summary.

Key Findings

In this section, key findings and themes are described. The research questions for the study and their findings were as follows:

Research Question 1 asked what engagement practices mental health service providers, in New York City, identified as successful when engaging mentally ill homeless individuals about provided clinical services. Based on the results, the theme emerged that building rapport applies to the research question since building rapport is essential engagement practice used to form a connection with the homeless individual. Mental health providers who develop rapport and work with homeless individual would report greater engagement (Kearsley & Shneiderman, 1999). The subjects of this study motivated the homeless individual by developing trust and a working relationship to build rapport.

Research Question 2 asked how mental health service providers, in New York City, explained their experience of engagement with mentally ill homeless individuals. Based on the results, the theme emerged that medical and mental health services fit the research question since mental health service providers have credited medical and mental health services as contributing to successful engagement. Successful engagement of homeless persons included ongoing engagement with the homeless person, kept appointments, established goals, steps to meet these goals, and related factors perceived and reported by the mental health provider (Lee & Donaldson, 2018; Olivet et al., 2010). The subjects of this study believed that successful engagement was contingent on engaging the homeless individual in medical and mental health services.

Research Question 3 asked what barriers mental health service providers, in New York City, face when engaging mentally ill homeless individuals about committing to provided clinical services. Based on the results, the theme emerged that resistance to change applies to the research question since barriers affect engagement outcomes for the homeless. Padgett et al. (2008) and Pahwa et al. (2019) posited that engagement and retention were the most significant barriers for mental health providers trying to help homeless and mentally ill people. The subjects of this study believed that homeless individuals faced barriers in the following areas: relationships, trust, finances, citizenship, maladaptive behaviors, behavioral and substance abuse histories.

Interpretation of the Findings

Mental illness is the third greatest cause of homelessness for single adults in the United States (National Alliance to End Homelessness, 2015). Being able to adequately engage and encourage mentally ill homeless persons to commit to services was a problem for many service providers. Participants in this study shared their expert experiences as a significant voice for this phenomenological study. The 12 participants had common views about their engagement practices, experiences, and perceived barriers in response to the interview questions. The next section includes study results relative to prior research.

Study Results Relative to Prior Research

In order to connect with clients while working at the homeless shelter, it is imperative that the mental health service provider is able to connect with the homeless individual in a way that would allow the individual to put their guard down and be more receptive to committing to services and building rapport. Kearsley and Shneiderman (1999) predicted that mental health service providers, who could develop rapport (collaboration) and worked with the homeless individual to establish concrete, outcome based goals, would report greater engagement. The results of my study, namely, Theme 1: Building rapport indicated that the participant subjects discovered that building rapport started in the workplace and allowed homeless individuals who were otherwise unwilling to partake in services the opportunity to build relationships with the services provided. Similarly, participant subjects learned the importance of communicating effectively, being transparent, being consistent, and engaging clients by establishing a good collaborative relationship. The results of my study confirm the importance of first impressions, effective communication, making and keeping appointments to build rapport.

Service providers took outreach and engagement programs to the streets to increase engagement and participation of the homeless by using mobile clinic outreach programs with medical and social services to make services more accessible to homeless people (City of Chicago, 2015). Like the findings in the literature review, the results of my study, namely Theme 2: Medical and mental health services indicated that medical services were needed for the successful engagement of homeless individuals. The subjects of my study viewed that providing outreach and accompanying the homeless individuals to mental health appointments was important to help the individuals navigate mental health, substance abuse services and social services systems. For this reason, the results of my study concur with the findings in the literature in terms of using medical and social services to make services more accessible to homeless people.

Outreach programs link vulnerable populations and healthcare; and engage homeless persons with social and housing services (Knopf-Amelung, 2014). The results from Knopf-Amelung (2014) indicated that one of the least understood direct methods of engaging homeless individuals was street outreach that meets people where they are at to reconnect homeless individuals to resources in the community and provide the support needed to survive and prosper (Knopf-Amelung, 2014). The results of my study concur with the findings in the literature review. Theme 3: Resistance to change indicated that mental health service providers face barriers when engaging mentally ill homeless individuals about committing to provided clinical services. As a group, participants highlighted the following barriers to engagement: estranged from family and friends, lack of trust, financial constraints, citizenship status, unwillingness to change behavior, and psychiatric and substance abuse histories. This theme highlighted the importance of advocacy. Advocacy is an activity by an individual who influences decisions within social systems and institutions (Alliance for Justice, 2016).Within the homeless population, advocacy is an implied activity that is useful to overcome barriers. Based on Kearsley and Shneiderman's ET, mental health service providers who could develop rapport (collaboration) and worked with the homeless individual to establish concrete, outcome based goals could report greater engagement. This study's findings highlighted the role that advocacy played with mental health service providers. For the respondents in this study, advocacy emerged as an underlying theme reflected in activities like ensuring that the homeless individuals are accompanied to their medical and mental health appointments in the community, assisting them with processing information relayed at appointments, and providing assistance in mediating challenging situations on their behalf when necessary. The next section includes study results relative to conceptual framework.

Study Results Relative to the Conceptual Framework

The conceptual framework used to guide this qualitative study comes from Kearsley and Shneiderman's (1999) ET. Kearsley and Shneiderman's theory was originally developed for learning environments. However, it had an application to the clinical setting as well. According to Kearsley and Shneiderman, the major premise of ET was that individuals must be involved with others in tasks that they believed were worthwhile and meaningful to create engagement resulting in successful collaboration. The reported experiences of study participants as told in their own words revealed themes and patterns that resulted in explanation of how mental health service providers encouraged homeless individuals to commit to participating in clinical services, where perceived barriers to engagement were concerned. Participants revealed that resources such as medical, psychiatric, substance abuse, and outreach services have contributed to successful engagement. Several participants stated successful engagement was also achieved by giving incentives, establishing relationships, building rapport, respect, trust, and empathy. Participants narratives revealed that to encourage initial engagement, mental health service providers should utilize motivational interviewing techniques.

Mental health service providers believed that increased funding, peer supports, and obtaining higher education improved services. Some work experiences of mental health service providers for this study included direct care, peer specialist, and nurse. Some engagement practices included offering motivational interviewing techniques, and empathy to engage homeless individuals. Transparency and goal setting were identified by participants as suggestions for overcoming or addressing barriers to engagement. The concept of ET could help providers address the issues of engagement and the application of ET methods. The services provided could allow the homeless to activate their levels of motivation to make changes that yielded positive outcomes (Kearsley & Shneiderman, 1999; Kornhaber et al., 2016). The next section includes limitations of the study.

Limitations of the Study

Due to the nature of this study, there were some limitations highlighted in Chapter 1 of this study. The first limitation of this study involved reliability and validity, as it related to data subjectivity for phenomenological studies. To eliminate or control for subjectivity or bias the participants were used as the experts for this study. Biases always exist, but when the experts' responses to the interview questions were transcribed word-for-word, it was easier to eliminate personal bias. The second limitation of this study related to the participants from homeless shelters in Bronx County, New York City. The participants were experts about their lives and their experiences. The trust that comes with any study or the trust placed in the participants allowed the researcher to accept the participants' statements as the truth. The participant's statements about their engagement practices, experiences, and perceived barriers provided the credibility needed for this study. Nevertheless, for transferability purposes for this study, future researchers would have to decide if they could transfer any information to other like individuals or situations. I addressed and resolved all of the noted limitations for this study.

Recommendations for Future Research

The purpose of this phenomenological qualitative study was to gain more insight into the engagement practices and experiences of mental health service providers, in New York City, when encouraging the homeless individuals to commit to participating in clinical services, especially where perceived barriers to engagement were concerned. Literature and prior studies related to engagement experiences of homeless individuals have indicated there was a need for research that investigated the engagement process of the homeless from the providers' perspectives. Themes and patterns explored emerged about three relevant themes to building rapport, medical and mental health, and resistance to change; each theme revealed that engagement was a key factor in helping the homeless.

Limitations described above relate to geographic location, reliability and validity. With regard to participants, this study included mental health practitioners from homeless shelters in Bronx County, New York City. Future research is needed on homeless individuals themselves and their perspectives regarding barriers to engagement with mental health service providers. Future research could also be expanded beyond mental health service providers' engagement experiences to specifically research engagement experiences based on communication styles of the mental health service provider to examine if gender influences engagement outcomes from the providers' perspective.

In addition to suggestions specific to participants and their experience of engagement, future research on barriers to engagement could be expanded beyond homeless individuals living in shelters to specific subgroups of homeless individuals, such as homeless elderly, youth, or LGBT. Lastly, future research could also be expanded beyond mental health service providers' in homeless shelters to examine the benefit of the mental health service providers' engagement in other settings such as drop-in centers, safe havens, transitional and permanent housing.

Implications

Policy and Practice

Additionally, there were several recommendations for action from this study's findings. These recommendations would provide researchers, policy-makers, mental health service providers, and the homeless community to recognize that engagement practices were needed for successful engagement outcomes. To support the engagement of the mentally ill homeless, policymakers must gain more understanding and knowledge that apply to mental health service providers experience, practices, and barriers so that the policy makers could evaluate if the inclusion of engagement practices were effective. The outcome of this study may foster a better understanding of the experiences of mental health service providers to provide researchers, policy-makers, mental health service providers, and the homeless community with more information about engaging the homeless or how the participants encouraged homeless individuals to participate in clinical services.

Social Change

The significance of this study was to stimulate a needed positive social change by gaining more insight and understanding of the phenomenon to possibly reduce care and engagement barriers. This study was important because it could help researchers, policy-makers, mental health service providers, and the homeless community with more information about engaging the homeless or how the participants encouraged homeless individuals to participate in clinical services.

Based on the findings from the interview responses, the participants believed that building rapport would be important to engaging homeless individuals. The findings showed how the participants view of medical and mental health services translated to engaging the homeless. Lastly, the findings also showed how the participants view of resistance to change translated to engaging homeless individuals.

Methodological, Theoretical, and Empirical Implications

The application of Kearsley and Shneiderman's (1999) concept of ET explored how mental health service providers explained how they experienced the engagement of homeless individuals in clinical services to allow the narratives of mental health service providers to be told in their voices. A theoretical explanation for the phenomenon was gathered from the themes and patterns revealed via constant comparison within each interview as well as between and among the participants. The tentative theoretical explanation for how mental health service providers experienced the engagement of homeless individuals in clinical services was based on the study participants' told experiences. As well as, on the researcher's observations of each participant's interview and the emerging themes and patterns. This theory could be further explored by collecting narratives from homeless individuals not represented in the sample. In addition to a comprehensive study that examines why homeless individuals struggle with engaging with mental health service providers from the homeless individual's perspective.

Conclusion

The study added new knowledge to the body of literature, related to how mental health service providers encouraged homeless individuals to commit to participating in clinical services where there are perceived barriers to engagement. The results of this study revealed that mental health service providers engagement experiences included building rapport, offering linkages to medical and mental health services, and addressing resistance to change. Implications for practice and policy included that this study may foster a better understanding of the experiences of mental health service providers as they engage the homeless to provide services. Additionally, this study may stimulate a needed positive social change by gaining more insight and understanding of the phenomenon to possibly reduce care and engagement barriers.

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Appendix A: Ethics Certification

Certificate of Completion

The Collaborative Institutional Training Initiative (CITI) certifies that Tarsha Thomas-Richardson successfully completed the CITI Program Web-based training course, “Protecting Human Research Participants.”

Date of completion: 01/04/2019

Certification Number: 29912463

Appendix B: Flyer to Recruit Participants

Research title: Mental Health Service Providers’ Engagement Experiences of Homeless Individuals

The present study was being conducted to fulfill doctoral academic requirements. The study was designed to investigate service providers' perspectives on engagement of homeless individuals. To conduct this study, I will need the participation of at least 15 individuals, who will volunteer to participate in a one-on-one interview to gather data.

Participation will take approximately 30 minute to one hour and any participant may withdraw at any time. The session was voice-only recorded for data transcription. If you are a service provider for homeless individuals, working in mental health treatment facilities, age 18 years or older, please consider participating. Any participation in this study is totally voluntary and confidential.

If interested, please contact the researcher directly via e-mail: tarsha.thomas-richardson@waldenu.edu.

Appendix C: Initial Contact Message

To Whom It May Concern:

I, Tarsha Thomas-Richardson, am contacting you in search of potential research participants. I am a Walden University doctoral student living in Bronx County, New York City, and would like the assistance of mental health treatment facilities service providers' engagement experiences of homeless individuals. To participate in this study, participants will have to meet the following criteria:

1. You must have worked in a homeless shelter within the previous 12 months
2. You must be at least 18 years of age or older.
3. You must have experience engaging the homeless.
4. You must electronically sign and return the informed consent form with the prescribed numerical identifier. (Your prescribed numerical identifier is 1234).
5. You must be willing to meet with the researcher at least twice--within a 30-day period--for one scheduled 30 minute to one hour face-to-face and voice-only recorded interview in a private room in NYC Public Library dedicated for counseling or via telecommunication applications (i.e., FaceTime, Facebook), and possibly one follow-up email, to review the accuracy of the transcript from the interview responses.

If you currently meet the criteria and desire participating in the study, please sign and date the informed consent form using an above prescribed numerical identifier as your signature in the space provided on the informed consent form as an electronic signature.

Thanks for your consideration, and I look forward to hearing from you.

Tarsha Thomas-Richardson
Doctoral Student
Walden University

Appendix D: Debriefing Document

The researcher designed this document to provide participants with resources that may assist them, if they need someone to communicate with, before, during and after the study. It is understandable and normal for participants to experience levels of discomfort, which might cause undue stress. As the researcher for this study, it is my goal to alleviate as much stress potentially caused by the study as possible, and to not cause harm to the participants. As the researcher I will also,

1. Explain what they can expect to happen at the end of the interview process
2. Provide details about how they can access the study once it is published
3. Remind participants that they can still withdraw from the study at any time and not have their information included in the study
4. Remind participants about resources they can contact for support if they are experiencing any ill feelings or grief associated with the study
5. Thank participants for their participation and their contributions to the study and remind them that the researcher will maintain their confidentiality.

Below is a list of resources and referrals for you to access, if you need assistance.

You can also contact me by e-mail at: tarsha.thomas-richardson@waldenu.edu

Resources

1. Suicide Prevention Lifeline at https://suicidepreventionlifeline.org

Phone numbers for the 24-hour hotline.

2. A 24/7 information help line may prove useful for participants in need of medical, legal, mental and other services that may result from this study.

3. Pelham Bay Counseling Center

43 Westchester Square, Suites 3
Bronx, NY 10461

Appendix E: Interview Questions

The following are the interview questions:

1. What resources do you believe are needed for the successful engagement of homeless individuals?
2. What is your experience regarding factors related to the successful engagement of homeless individuals in clinical services?
3. What engagement practices have you used to encourage the initial engagement of homeless individuals in clinical services?
4. How can services be improved for the successful engagement of the homeless individual?
5. What is your work experience as it relates to engaging with homeless individuals?
6. What are some engagement practices you have used that may have encouraged the homeless individual to commit to clinical services?
7. What are some barriers that you have experienced as they relate to engaging with homeless individuals when trying to encourage their commitment to clinical services?
8. What are some engagement practices you use to overcome or address barriers related to the initial engagement of the homeless individuals in clinical services?