

Design and Development of an Integrated Nursing Care Framework for Homeless Youth Experiencing Substance Use Disorders in Community-Based Shelters

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ABSTRACT

This study, entitled “Design and Development of an Integrated Nursing Care Framework for Homeless Youth Experiencing Substance Use Disorders in Community-Based Shelters,” aimed to develop a nursing-oriented framework responsive to the complex healthcare needs of homeless youth aged 16 to 25 years in selected community-based shelters in Kitchener, Ontario, Canada. This study used a developmental mixed-methods research design with an exploratory sequential approach. The qualitative phase involved 12 purposively selected participants, while the quantitative phase included 112 respondents from an accessible population of 128 homeless youth. Data were gathered using a researcher-developed questionnaire assessing healthcare needs and the extent of nursing care delivery, together with semi-structured interviews exploring healthcare experiences, service gaps, barriers, and facilitators. Findings revealed an overall High Need for healthcare ($M = 3.25$, $SD = 0.44$), with Mental Health Needs ($M = 3.42$) and Substance Use Management Needs ($M = 3.38$) receiving the highest ratings. Nursing care was generally delivered to a High Extent ($M = 2.82$, $SD = 0.52$), with Comprehensive Assessment ranking highest and Substance Use Management and Harm Reduction ranking lowest. A significant moderate negative relationship was found between nursing care delivery and healthcare needs ($\rho = -0.46$, $p < .001$). Healthcare needs significantly differed according to duration of homelessness, primary substance used, duration of substance use, and previous treatment or rehabilitation history, but not according to age, sex, or gender identity. Qualitative findings identified four major experiences: inconsistent healthcare access, the need for respectful and nonjudgmental care, interconnected health concerns, and gaps in continuity of care. Barriers included fragmented services, limited accessibility, stigma and mistrust, and complex co-occurring needs, while facilitators included therapeutic nursing relationships, accessible shelter-based support, coordinated care, and individualized approaches. Integration of the findings resulted in a seven-component Integrated Nursing Care Framework encompassing Comprehensive and Continuous Assessment; Mental Health and Psychosocial Support; Substance Use Management and Harm Reduction; Health Promotion and Self-Management Support; Healthcare Access, Referral, and Care Coordination; Person-Centered and Trauma-Informed Therapeutic Engagement; and Interprofessional Collaboration and Continuity of Care. Anchored in the Roy Adaptation Model, the framework provides a structured basis for holistic, trauma-informed, recovery-oriented, coordinated, and continuous nursing care for homeless youth experiencing substance use disorders.

Keywords: Homeless Youth, Substance Use Disorders, Integrated Nursing Care, Community-Based Shelters, Harm Reduction, Mental Health, Roy Adaptation Model, Mixed Methods

INTRODUCTION

Homelessness is a major global public health and development concern that undermines human dignity, health equity, and sustainability. Despite international efforts to reduce poverty and improve health, millions experience housing insecurity, with young people among the most vulnerable. Persistent poverty, inequality,

and unequal access to health and social services impede sustainable development (United Nations Department of Economic and Social Affairs [UN DESA], 2024). Homelessness therefore requires more than housing assistance; it demands coordinated, integrated interventions addressing physical health, mental health, social exclusion, and broader determinants of well-being.

This study supports Sustainable Development Goal 1 on poverty, Goal 3 on health and well-being, Goal 10 on reducing inequalities, and Goal 11 on inclusive communities (UN DESA, 2024). Homelessness is both a consequence and driver of poverty because unstable housing disrupts education, employment, relationships, and healthcare access. Continuous services for homeless youth with substance use disorders can reduce preventable illness, strengthen social protection, and advance equitable access to care.

In Canada, youth homelessness remains a significant public health and social concern. Unlike adult homelessness, it occurs during identity formation, increasing independence, and transitions into education or employment. Housing instability can interrupt these processes and expose youth to violence, exploitation, victimization, and chronic illness. Canadian evidence indicates that responses must be preventive, coordinated, and developmentally appropriate (Gaetz et al., 2024). Shelter-based research also shows that housing insecurity, personal presentation, hygiene, and access to mental health resources affect psychological well-being (Wadge et al., 2024).

Youth homelessness is further complicated by co-occurring mental health problems, trauma, and substance use disorders. National findings show substantial overlap between mental health and substance use concerns, especially during chronic homelessness (Housing, Infrastructure and Communities Canada, 2024). Substance use may contribute to homelessness while also helping youth cope with trauma, discrimination, unsafe environments, and exclusion (Goodyear et al., 2024). These interactions create needs that isolated or short-term services cannot adequately address. Effective care must integrate physical health, psychological well-being, addiction treatment, harm reduction, safety, social support, and recovery.

Community-based shelters provide temporary accommodation, meals, crisis intervention, and referrals, yet healthcare is often fragmented. Services may focus on immediate symptoms, medication, stabilization, or external referral without coordinated follow-up. Consequently, youth may repeatedly move among shelters, emergency departments, detoxification facilities, treatment programs, and street environments without sustained recovery. Long waits, poor provider communication, limited availability, stigma, and mistrust can discourage engagement and interrupt care.

The researcher's experience as a registered nurse in a Canadian youth shelter confirms these concerns. Homeless youth aged 16 to 25 commonly present with chronic homelessness, substance use, mental health conditions, trauma, family estrangement, unemployment, and limited healthcare access. Although nurses address urgent concerns, the absence of a structured framework restricts the integration of assessment, mental health support, substance use management, harm reduction, health promotion, case coordination, referral, and continuity. This mismatch between complex needs and available nursing structures is evident.

Nurses are positioned to address this gap through holistic, person-centered, trauma-informed, and recovery-oriented practice. Their functions encompass assessment, therapeutic engagement, health education, advocacy, harm reduction, psychosocial support, interprofessional collaboration, and continuity across services. Youth-engaged harm-reduction research further highlights the importance of centering lived experience and creating safer, nonjudgmental opportunities for participation (Goodyear et al., 2025). Nevertheless, existing approaches often emphasize housing programs, social work interventions, or general multidisciplinary care, with limited attention to nursing-specific coordination within shelters. Therefore, this study aims to develop an integrated nursing care framework for homeless youth experiencing substance use disorders in community-based shelters. It will assess healthcare needs and lived challenges, identify service gaps, integrate evidence with practice-based findings, and recommend coordinated shelter-based nursing care that strengthens accessibility, continuity, safety, and recovery outcomes.

CONCEPTUAL FRAMEWORK

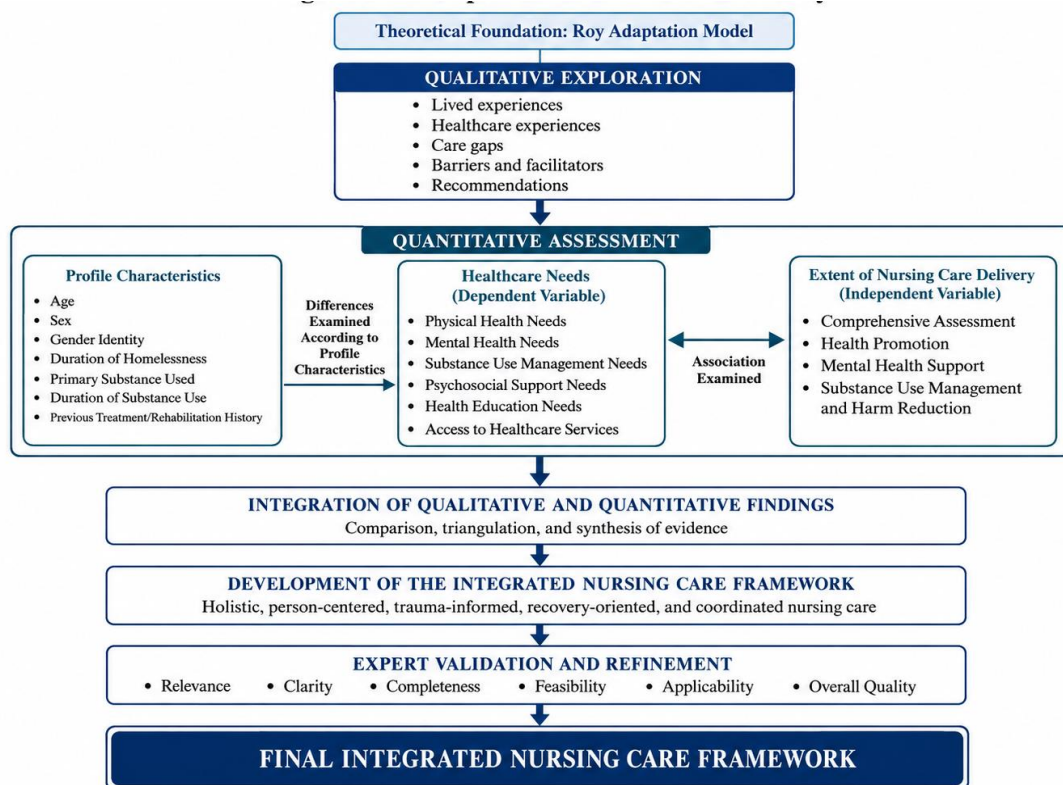


Figure 1: Self-developed Conceptual Framework

The conceptual framework of the study illustrates the relationships among the major variables and the process through which the Integrated Nursing Care Framework for Homeless Youth Experiencing Substance Use Disorders in Community-Based Shelters was developed. It is grounded in the Roy Adaptation Model and the study's developmental exploratory sequential mixed-methods design. The Roy Adaptation Model views the individual as an adaptive system who continuously interacts with a changing environment and responds to internal and external stimuli through coping processes. Nursing interventions aim to promote positive adaptation by assessing behaviors, identifying relevant stimuli, and addressing health-related responses (Hosseini et al., 2022).

In the context of the present study, homeless youth experiencing substance use disorders are exposed to multiple and interacting stressors associated with homelessness, substance use, trauma, mental health concerns, limited social support, and barriers to healthcare access. These conditions may affect their physical, psychological, and social adaptation and create complex healthcare needs requiring comprehensive, person-centered, trauma-informed, recovery-oriented, and coordinated nursing care. The Roy Adaptation Model therefore provided the theoretical foundation for understanding the healthcare needs of homeless youth and for identifying nursing responses that may support their health and adaptation. The proposal similarly identifies homelessness, addiction, trauma, mental health concerns, and limited support systems as significant stressors affecting adaptation among the target population.

The conceptual framework has four major components: the profile characteristics of homeless youth, healthcare needs, the extent of nursing care delivery, and the development of the Integrated Nursing Care Framework. These components represent the study's major quantitative variables and developmental output and are complemented by qualitative findings from participants' lived experiences. The original conceptual framework likewise identifies profile characteristics, healthcare needs, nursing care delivery, and framework development as its major components.

The first component comprises the profile characteristics of homeless youth, including age, sex, gender identity, duration of homelessness, primary substance used, duration of substance use, and previous treatment or rehabilitation history. These characteristics provide important context about the respondents and serve as grouping variables to determine whether healthcare needs differ significantly across selected participant characteristics.

The second component represents the healthcare needs of homeless youth experiencing substance use disorders, which serve as the dependent variable of the quantitative component of the study. Healthcare needs are examined across six domains: Physical Health Needs, Mental Health Needs, Substance Use Management Needs, Psychosocial Support Needs, Health Education Needs, and Access to Healthcare Services. These domains recognize that homeless youth may experience interconnected physical, psychological, substance use-related, social, educational, and healthcare-access concerns that require an integrated rather than fragmented approach to care. These six domains correspond to the healthcare-needs questionnaire administered in the study.

The third component represents the extent of nursing care delivery, which serves as the independent variable of the quantitative component of the study. Consistent with the instrument used in the study, nursing care delivery is examined across four domains: Comprehensive Assessment, Health Promotion, Mental Health Support, and Substance Use Management and Harm Reduction. Comprehensive Assessment includes assessments of physical health, mental health, substance use concerns, nutritional status, and immediate healthcare needs. Health Promotion includes nursing activities related to healthy lifestyle practices, nutrition, disease prevention, healthcare-seeking behaviors, and self-care. Mental Health Support includes emotional support, identifying psychological distress, encouraging engagement in mental health services, and crisis intervention. Substance Use Management and Harm Reduction encompasses substance-use education, harm-reduction strategies, addiction-treatment support, recovery support, and respect for individual choices while encouraging healthier behaviors.

The conceptual framework proposes an association between the extent of nursing care delivery and the healthcare needs of homeless youth experiencing substance use disorders. Specifically, the study examined whether variations in the extent of nursing care received were significantly related to the healthcare needs respondents reported. Because the study used a nonexperimental design, the researchers interpreted this relationship as an association rather than a causal effect. The study also examined whether healthcare needs significantly differed when respondents were grouped according to their profile characteristics. These relationships correspond to the inferential questions and hypotheses established in the study.

Consistent with the exploratory sequential mixed-methods design, the study began with the qualitative phase. The researchers conducted semi-structured interviews with homeless youth to explore their lived experiences of healthcare and nursing services, major healthcare concerns, perceived gaps in healthcare delivery, and recommendations for improving nursing care in community-based shelters. The qualitative phase provided an in-depth understanding of the experiences and contextual factors shaping the target population's healthcare needs.

The quantitative phase then assessed respondents' profile characteristics, healthcare needs, and the extent of nursing care delivery. It also examined the significant relationship between nursing care delivery and healthcare needs and determined whether healthcare needs significantly differed according to selected profile characteristics. This sequence corrected the proposal-stage conceptual framework, which had previously described the quantitative phase as occurring before the qualitative phase.

After completing and analyzing both phases, the qualitative and quantitative findings were integrated through comparison, triangulation, and synthesis. Areas of convergence, complementarity, and divergence between the qualitative themes and quantitative findings were examined to obtain a more comprehensive understanding of the healthcare needs, nursing care experiences, service gaps, barriers, facilitators, and priorities for nursing intervention among homeless youth experiencing substance use disorders. The integrated findings served as the empirical foundation for developing the proposed Integrated Nursing Care

Framework. The proposal likewise identifies integration and synthesis of the two forms of evidence as the basis for framework development.

The fourth component represents the development of the Integrated Nursing Care Framework. The framework was derived from integrated qualitative and quantitative findings and informed by the Roy Adaptation Model, reviewed literature, and the contextual realities of community-based shelter care. It was designed to organize the identified healthcare needs, nursing-care priorities, and appropriate nursing responses into a coherent structure that promotes holistic, person-centered, trauma-informed, recovery-oriented, and coordinated care for homeless youth experiencing substance use disorders.

After development, the preliminary Integrated Nursing Care Framework underwent expert validation. Five expert validators evaluated the proposed framework for relevance, clarity, completeness, feasibility, applicability, and overall quality. The researchers considered their ratings, comments, and recommendations when refining the framework before finalization. The validation checklist in the research instrument assesses relevance, clarity, completeness, feasibility, applicability, and overall quality, scientific soundness, and readiness for implementation.

Overall, the conceptual framework shows how the lived experiences of homeless youth, their profile characteristics, identified healthcare needs, and the extent of nursing care received were systematically examined and integrated to provide the empirical basis for developing the Integrated Nursing Care Framework. Rather than assuming that nursing care directly causes changes in healthcare needs, the framework recognizes the relationship between nursing care delivery and healthcare needs and uses the combined qualitative and quantitative evidence to identify nursing-care priorities appropriate to community-based shelter settings.

Statement of the Problem

This study aims to design and develop an integrated nursing care framework for homeless youth experiencing substance use disorders in community-based shelters. Specifically, it seeks to answer the following questions:

1. What are the demographic characteristics of homeless youth in terms of:

1.1 Age

1.2 Sex

1.3 Gender identity

1.4 Duration of homelessness

1.5 Primary substance(s) used

1.6 Duration of substance use

1.7 Previous treatment or rehabilitation history

2. What are the healthcare needs of homeless youth experiencing substance use disorders in terms of:

2.1 Physical health needs

2.2 Mental health needs

2.3 Substance use treatment needs

2.4 Psychosocial support needs

2.5 Health education needs

2.6 Access to healthcare services

3. What is the extent of nursing care received by homeless youth experiencing substance use disorders in community-based shelters in terms of:

3.1 Comprehensive Assessment;

3.2 Health promotion;

3.3 Mental Health Support; and

3.4 Substance Use Management and Harm Reduction?

4. Is there a significant relationship between the extent of nursing care delivery and the healthcare needs of homeless youth experiencing substance use disorders?
5. Is there a significant difference in the healthcare needs of homeless youth experiencing substance use disorders when grouped according to their demographic characteristics?
6. What are the lived experiences of homeless youth regarding nursing care and healthcare services received within community-based shelters?
7. What barriers and facilitators influence the delivery of integrated nursing care for homeless youth experiencing substance use disorders?
8. Based on the quantitative and qualitative findings, what integrated nursing care framework can be developed for homeless youth experiencing substance use disorders in community-based shelters?

Significance of the Study

The findings of this study are expected to contribute to nursing education, practice, research, and community health by providing an evidence-based integrated nursing care framework for homeless youth experiencing substance use disorders in community-based shelters. Specifically, the study may benefit the following:

Students. The study may enhance nursing students' understanding of the complex health and psychosocial needs of homeless youth experiencing substance use disorders. It may also increase their awareness of trauma-informed, recovery-oriented, and community-based nursing care, thereby strengthening their knowledge and competencies in caring for vulnerable populations.

Nurse Educators. The proposed nursing care framework may serve as a valuable educational resource for integrating concepts related to homelessness, substance use disorders, harm reduction, community health nursing, and integrated care into nursing curricula. The findings may also support the development of learning activities and clinical experiences that prepare future nurses to address the needs of socially marginalized populations.

Nursing Professionals. The study may provide practicing nurses with an evidence-informed framework to guide comprehensive assessment, care planning, care coordination, health promotion, harm reduction, and continuity of care for homeless youth experiencing substance use disorders. The framework may strengthen person-centered and trauma-informed nursing practice while promoting interdisciplinary collaboration in community-based settings.

Community-Based Health Workers. The findings may assist community-based health workers, outreach personnel, case managers, and shelter staff in understanding the healthcare needs of homeless youth and improving coordination with nursing and other healthcare professionals. The proposed framework may

facilitate more integrated and collaborative service delivery that supports the physical, psychological, and social well-being of homeless youth.

Nursing Administrators. The study may provide nursing administrators and healthcare managers with evidence that can inform the development of policies, clinical protocols, and service delivery models for community-based shelters. The proposed framework may support strategic planning, resource allocation, workforce development, and quality improvement initiatives aimed at delivering coordinated and holistic care for homeless youth experiencing substance use disorders.

Future Researchers. The study may serve as a foundation for future investigations on integrated nursing care, homelessness, substance use disorders, community health, and vulnerable populations. Future researchers may utilize, validate, modify, or expand the proposed nursing care framework in different populations, healthcare settings, or geographical contexts, thereby contributing to the continued advancement of nursing knowledge and evidence-based practice.

Overall, this study is expected to contribute to the advancement of community and public health nursing by promoting evidence-based, person-centered, and integrated care for homeless youth experiencing substance use disorders. Furthermore, the proposed framework may help healthcare organizations and policymakers strengthen nursing practice, improve health outcomes, and reduce health inequities among one of the most vulnerable populations in the community.

Scope and Delimitations

This study focused on the design and development of an Integrated Nursing Care Framework for homeless youth experiencing substance use disorders in selected community-based shelters in Kitchener, Ontario, Canada. Specifically, it examined the healthcare needs, lived experiences, and perceived gaps in nursing and healthcare service delivery among homeless youth aged 16 to 25 years who were residing in or receiving services from the participating community-based shelters. The study also examined the relationship between the extent of nursing care delivery and the healthcare needs of homeless youth and determined whether healthcare needs differed according to selected demographic characteristics.

The study was delimited to homeless youth aged 16 to 25 years who met the established eligibility criteria and were accessing services from the participating community-based shelters. Homeless youth who were not accessing shelter services, individuals residing in long-term supportive housing, psychiatric institutions, correctional facilities, inpatient addiction treatment centers, or other residential care facilities, and persons outside the prescribed age range were excluded from the study.

METHODOLOGY

The study employed a developmental mixed-methods design using an exploratory sequential approach to develop and validate an Integrated Nursing Care Framework for homeless youth experiencing substance use disorders in community-based shelters. This design was appropriate because it combined the depth of qualitative inquiry with the measurement capacity of quantitative research, thereby generating experiential and numerical evidence about healthcare needs, nursing care, and service gaps (Wasti et al., 2022). The first phase used semi-structured interviews with 12 purposively selected homeless youth aged 16 to 25 who had direct experience of homelessness, substance use disorders, and shelter-based healthcare. Recruitment continued until data saturation, consistent with qualitative research's emphasis on informational richness rather than statistical representation (Hennink & Kaiser, 2022). Interviews explored physical and mental health concerns, substance use needs, access to care, helpful nursing services, perceived barriers, and recommendations for improving shelter-based care. Themes from this phase informed the content and interpretation of the subsequent quantitative assessment. In the second phase, the team conducted total enumeration of 128 eligible and accessible youth in participating shelters. Of these, 112 completed usable questionnaires, producing an 87.5% completion rate. The quantitative component described participant characteristics, measured healthcare needs and the extent of nursing care received, examined relationships

between these variables, and tested differences in healthcare needs across selected demographic and clinical characteristics. Participants who were medically unstable, severely intoxicated, experiencing an acute psychiatric crisis, or unable to provide voluntary informed consent were excluded to protect their safety and decisional capacity.

The research was conducted in selected community-based youth shelters in Kitchener, Ontario, where health, addiction, mental health, housing, and social services intersect. This locale offered an appropriate context for examining fragmented care and identifying opportunities for stronger nursing coordination, although transferability to other settings depends on their populations, resources, and service structures.

Data were collected through complementary self-developed instruments anchored in the Roy Adaptation Model, research questions, conceptual framework, and related literature. The Healthcare Needs Questionnaire contained 36 items covering physical health, mental health, substance use management, psychosocial support, health education, and healthcare access. The Nursing Care Delivery Questionnaire included 20 items addressing comprehensive assessment, health promotion, mental health support, and substance use management and harm reduction. Both used four-point Likert scales. A five-question semi-structured interview guide captured participants' experiences, while a 30-item checklist enabled experts to evaluate the proposed framework for relevance, clarity, completeness, feasibility, applicability, scientific soundness, and implementation readiness. Five experts in nursing, community health, mental health, addiction care, public health, and shelter services reviewed the instruments.

Item-level content validity indices ranged from 0.80 to 1.00, while scale-level indices ranged from 0.94 to 0.96, yielding an overall S-CVI/Ave of 0.95 and demonstrating excellent content validity (Yusoff, 2019; Said et al., 2022). Pilot testing with 30 comparable participants excluded from the final sample established internal consistency. Cronbach's alpha was 0.94 for the Healthcare Needs Questionnaire and 0.93 for the Nursing Care Delivery Questionnaire, with all domain coefficients exceeding the accepted 0.70 threshold (Taber, 2018). Finally, the team integrated qualitative and quantitative results through comparison, triangulation, and synthesis to identify convergence, complementarity, and divergence (Grand-Guillaume-Perrenoud et al., 2023). These integrated findings guided framework development, after which five expert validators assessed and refined its components. Thus, the four-stage process—qualitative exploration, quantitative assessment, evidence integration and framework development, and expert validation—ensured that the final framework was empirically grounded, contextually responsive, methodologically rigorous, and potentially useful for improving coordinated nursing care among homeless youth with substance use disorders. It also strengthened the framework's practical relevance by incorporating participants' lived experiences, measurable service patterns, established theoretical guidance, and multidisciplinary professional judgment throughout development and refinement stages.

RESULTS, ANALYSIS, AND DISCUSSION

This section presents and analyzes the data gathered in the study. The findings are organized according to the research questions and include the respondents' profile characteristics, healthcare needs, extent of nursing care delivery, significant relationships and differences among the study variables, qualitative themes from the participants' lived experiences, and the integrated findings used in developing and validating the proposed Integrated Nursing Care Framework.

Profile Characteristics of the Respondents

This section presents the profile characteristics of the 112 respondents according to age, sex, gender identity, duration of homelessness, primary substance used, duration of substance use, and previous treatment or rehabilitation history. These characteristics correspond to the variables identified in the study and included in the respondent-profile section of the research instrument. Regarding sex, 62 respondents (55.36%) were male, 46 (41.07%) were female, and four (3.57%) preferred to self-describe. In terms of gender identity, 58 respondents (51.79%) identified as men, 43 (38.39%) as women, eight (7.14%) as non-binary or gender-diverse, and three (2.68%) reported another self-described identity. The inclusion of gender-diverse

respondents is important because recent Canadian research indicates that gender identity shapes the mental health, safety, substance-use experiences, and service needs of youth experiencing homelessness (Goodyear et al., 2024; Wadge et al., 2024). Regarding the duration of homelessness, the largest proportion had experienced homelessness for one to three years, comprising 41 respondents (36.61%). This was followed by 29 respondents (25.89%) who had experienced homelessness for six to 12 months, 24 (21.43%) for less than six months, and 18 (16.07%) for more than three years. Thus, more than half of the respondents had experienced homelessness for at least one year, demonstrating the prolonged housing instability affecting a considerable proportion of the study population. This pattern is consistent with Canadian evidence showing that chronic homelessness is commonly associated with multiple health concerns, including co-occurring mental health and substance-use problems (Housing, Infrastructure and Communities Canada, 2024). In terms of the primary substance used, cannabis was most frequently reported by 31 respondents (27.68%), followed by opioids among 25 (22.32%) and alcohol among 24 (21.43%). Methamphetamine was reported by 14 respondents (12.50%), cocaine by 12 (10.71%), and other substances by six (5.36%). The presence of cannabis, alcohol, opioids, and stimulants reflects the diversity of substances reported among street-involved youth in Canada and emphasizes the need for substance-specific and polysubstance-responsive interventions rather than a uniform treatment approach (Health Canada, 2024). Regarding the duration of substance use, 48 respondents (42.86%) reported using substances for more than three years, while 47 (41.96%) reported substance use lasting one to three years.

The remaining 17 respondents (15.18%) had used substances for less than one year. Consequently, 84.82% had used substances for at least one year, indicating that substance use was an established concern rather than an isolated or recent behavior for most respondents. Recent research suggests that substance use among homeless youth may be connected to coping with trauma, discrimination, unstable housing, social exclusion, and the need to obtain temporary safety or belonging (Goodyear et al., 2024). Finally, 67 respondents (59.82%) had previously received treatment or rehabilitation, whereas 45 (40.18%) had no treatment or rehabilitation history. Although most respondents had previously accessed treatment, this finding should not be interpreted as evidence of treatment completion or sustained recovery. Youth may continue to encounter barriers such as stigma, restrictive program requirements, limited-service availability, distrust of providers, and insufficient youth-centered harm-reduction services (Beck et al., 2024). Overall, the findings demonstrate considerable diversity in respondents' sex, gender identities, homelessness experiences, substance-use patterns, and treatment histories. These differences support the development of individualized, gender-responsive, trauma-informed, harm-reduction-oriented, and integrated nursing interventions within community-based shelters.

Healthcare Needs of the Respondents

This section presents respondents' healthcare needs in terms of Physical Health Needs, Mental Health Needs, Substance Use Management Needs, Psychosocial Support Needs, Health Education Needs, and Access to Healthcare Services. The 36-item Healthcare Needs Questionnaire contains six items for each of these six domains.

Table 2: Healthcare Needs of the Respondents

Healthcare Needs Domain	Weighted Mean	Standard Deviation	Interpretation	Rank
Physical Health Needs	3.12	0.53	High Need	5
Mental Health Needs	3.42	0.49	Very High Need	1
Substance Use Management Needs	3.38	0.51	Very High Need	2
Psychosocial Support Needs	3.31	0.50	Very High Need	3
Health Education Needs	2.98	0.57	High Need	6
Access to Healthcare Services	3.26	0.54	Very High Need	4
Overall	3.25	0.44	High Need	—

Legend: 3.26–4.00 = Very High Need; 2.51–3.25 = High Need; 1.76–2.50 = Low Need; 1.00–1.75 = Very Low Need.

Table 2 presents the respondents' healthcare needs across the six assessed domains. Mental Health Needs obtained the highest weighted mean of 3.42 (SD = 0.49) and was interpreted as a Very High Need. This result indicates that mental health assessment, crisis intervention, counselling, psychological support, and referral services should be prioritized within community-based shelters. The finding is consistent with recent Canadian evidence demonstrating a substantial overlap among homelessness, psychological distress, mental health disorders, and substance use concerns (Housing, Infrastructure and Communities Canada, 2024). Research involving Canadian homeless youth similarly shows that mental well-being is affected by housing instability, personal safety, access to resources, social relationships, and gender-related experiences (Wadge et al., 2024). Substance Use Management Needs ranked second, with a weighted mean of 3.38 (SD = 0.51), interpreted as a Very High Need. This finding emphasizes the respondents' need for accessible addiction assessment, withdrawal management, overdose prevention, harm-reduction education, treatment referral, relapse prevention, and recovery support. Pan-Canadian findings show that street-involved youth report using various substances, including cannabis, alcohol, opioids, and stimulants, indicating that service providers must be prepared to address diverse and potentially overlapping substance-use patterns (Health Canada, 2024). Moreover, youth may avoid or disengage from services when programs are stigmatizing, abstinence-focused, inaccessible, or insufficiently responsive to their developmental and social circumstances (Beck et al., 2024). Psychosocial Support Needs ranked third, with a weighted mean of 3.31 (SD = 0.50), also interpreted as a Very High Need. The result suggests that respondents require emotional support, therapeutic relationships, family or natural-support interventions, social connection, case management, employment assistance, and reintegration services. Substance use among homeless youth may be associated with attempts to cope with trauma, discrimination, family conflict, social exclusion, and unsafe living environments (Goodyear et al., 2024). Consequently, psychosocial interventions should be trauma-informed, identity-affirming, youth-centered, and sensitive to the different experiences of gender-diverse youth. Access to Healthcare Services ranked fourth, with a weighted mean of 3.26 (SD = 0.54), interpreted as a Very High Need. This result indicates continuing difficulties in obtaining timely, acceptable, and continuous healthcare. People experiencing homelessness commonly encounter fragmented services, transportation problems, stigma, competing survival priorities, and difficulties navigating healthcare systems (Garcia et al., 2024). Youth-specific evidence also shows that rigid requirements, distrust of providers, limited confidentiality, and inadequate harm-reduction options can restrict service engagement (Beck et al., 2024). Shelter-based nursing services may therefore improve access through outreach, care navigation, referral coordination, follow-up, and collaboration with mental health and addiction providers. Physical Health Needs obtained a weighted mean of 3.12 (SD = 0.53), while Health Education Needs received the lowest weighted mean of 2.98 (SD = 0.57). Both were interpreted as High Need. Although ranked lower, these domains remain important because homelessness increases exposure to illness, injury, poor nutrition, environmental hazards, interrupted medication use, and inadequate preventive care (Garcia et al., 2024). Health education can strengthen knowledge concerning medication safety, infection prevention, overdose response, nutrition, sexual health, self-care, and appropriate healthcare utilization. Overall, respondents obtained a weighted mean of 3.25 (SD = 0.44), interpreted as High Need and positioned at the upper boundary of that category. Four domains were rated as very high and two as high, demonstrating that the respondents' needs were multidimensional rather than limited to substance use alone. These findings support an integrated nursing care framework combining physical healthcare, mental health support, substance-use management, psychosocial intervention, health education, harm reduction, and coordinated healthcare access.

Extent of Nursing Care Delivery

This section presents the extent of nursing care received by the respondents in terms of Comprehensive Assessment, Health Promotion, Mental Health Support, and Substance Use Management and Harm Reduction. The finalized Extent of Nursing Care Delivery Questionnaire consists of 20 items, with five items measuring each of the four domains.

Table 3: Extent of Nursing Care Delivery Received by the Respondents

Nursing Care Domain	Weighted Mean	SD	Interpretation	Rank
Comprehensive Assessment	3.02	0.55	High Extent	1
Health Promotion	2.91	0.58	High Extent	2
Mental Health Support	2.74	0.61	High Extent	3
Substance Use Management and Harm Reduction	2.62	0.64	High Extent	4
Overall	2.82	0.52	High Extent	—

Legend: 3.26–4.00 = Very High Extent; 2.51–3.25 = High Extent; 1.76–2.50 = Low Extent; 1.00–1.75 = Very Low Extent.

Table 3 presents the extent of nursing care delivery received by respondents across the four assessed domains. Comprehensive Assessment obtained the highest weighted mean of 3.02 (SD = 0.55) and was interpreted as being delivered to a High Extent. This result indicates that nurses generally performed assessments addressing respondents' physical health, mental health, substance use, nutritional condition, medication requirements, and immediate healthcare concerns. Comprehensive assessment is essential among people experiencing homelessness because their health problems frequently involve interconnected physical, psychological, substance-related, and social factors that cannot be adequately identified through symptom-specific assessment alone. Recent evidence therefore emphasizes the importance of accessible, integrated, and coordinated approaches that respond to the complex, multifaceted needs of people experiencing homelessness (Meda et al., 2025). Health Promotion ranked second, obtaining a weighted mean of 2.91 (SD = 0.58), which was also interpreted as a High Extent. This finding suggests that respondents generally received nursing interventions involving health education, disease prevention, nutrition, hygiene, self-care, medication safety, and appropriate healthcare-seeking practices. Health-promotion interventions are particularly important because homelessness can restrict access to reliable health information and reduce opportunities to practice preventive health behaviors. A recent scoping review found that health promotion among people experiencing homelessness requires accessible information, trusting relationships, service flexibility, outreach, and interventions adapted to individuals' immediate living circumstances (Simkhada et al., 2025). Nurses should therefore provide practical and individualized education that reflects the realities of shelter residence, housing instability, and limited access to resources. Mental Health Support ranked third, with a weighted mean of 2.74 (SD = 0.61), interpreted as a High Extent. Although this indicates that respondents generally received emotional support, mental health screening, crisis assistance, and referrals, its lower mean compared with Comprehensive Assessment and Health Promotion may indicate opportunities to strengthen shelter-based mental health services. This is particularly important because Canadian evidence demonstrates a substantial intersection among homelessness, psychological distress, mental health conditions, and substance use (Housing, Infrastructure and Communities Canada, 2024). The mental health experiences of homeless youth are also shaped by housing insecurity, personal safety, hygiene, social relationships, gender identity, and the availability of appropriate services (Wadge et al., 2024). These findings support the integration of trauma-informed mental health screening, therapeutic communication, suicide-risk assessment, crisis intervention, and coordinated referral into routine shelter nursing practice. Substance Use Management and Harm Reduction obtained the lowest weighted mean of 2.62 (SD = 0.64), although it remained within the High Extent category. Its relatively larger standard deviation suggests greater variation in respondents' experiences of these services. This domain may therefore represent the most important area for improvement. Youth frequently encounter barriers to harm-reduction care, including stigma, abstinence-oriented requirements, limited service availability, inadequate confidentiality, distrust of providers, and services that are insufficiently responsive to youth-specific needs (Beck et al., 2024). Youth-

focused mobile harm-reduction programs show the value of flexible, low-barrier services that combine overdose prevention, safer-use education, naloxone access, addiction treatment, and connections to healthcare and social support (Yeo et al., 2024). Shelter nurses should consequently strengthen overdose-risk assessment, naloxone education and distribution, safer-use counseling, withdrawal monitoring, treatment navigation, and recovery-oriented support. Overall, nursing care delivery obtained a weighted mean of 2.82 (SD = 0.52), indicating a High Extent. However, none of the four domains reached the Very High Extent category. The findings therefore indicate that nursing services were generally available but could still be strengthened, particularly in mental health support and substance use management and harm reduction. An integrated nursing care framework may help standardize comprehensive assessment, health promotion, trauma-informed mental healthcare, harm reduction, care coordination, referral, and follow-up across community-based shelter services.

Relationship Between the Extent of Nursing Care Delivery and Healthcare Needs

This section presents the relationship between the extent of nursing care delivery and respondents' healthcare needs. Spearman's rank-order correlation coefficient (Spearman's rho) was used to determine the direction and strength of the association between the two variables at the 0.05 level of significance, consistent with the statistical procedure specified in the methodology.

Table 4: Relationship Between the Extent of Nursing Care Delivery and Healthcare Needs of the Respondents

Variables	Spearman's rho (ρ)	p-value	Interpretation	Decision on H_{01}
Extent of Nursing Care Delivery and Healthcare Needs	-0.46	< .001	Moderate Negative Significant Relationship	Reject H_{01}

Level of significance: $\alpha = 0.05$.

Table 4 presents the relationship between the extent of nursing care delivery and the healthcare needs of the respondents. The analysis yielded a Spearman's rho coefficient of -0.46, with a p-value of less than .001. Based on commonly applied guidelines for interpreting correlation coefficients, the absolute coefficient of .46 indicates a moderate relationship between the variables (Schober et al., 2018). The negative direction of the coefficient means that higher scores for the extent of nursing care delivery were associated with lower healthcare-needs scores. Conversely, respondents who reported receiving nursing care to a lower extent tended to report higher levels of unmet healthcare needs. Because the obtained p-value was lower than the predetermined .05 level of significance, the null hypothesis stating that there was no significant relationship between the extent of nursing care delivery and respondents' healthcare needs was rejected. Therefore, the findings indicate a statistically significant negative relationship between the extent of nursing care delivery and the healthcare needs of homeless youth experiencing substance use disorders in community-based shelters. The finding suggests that respondents who reported more extensive nursing services—such as comprehensive assessment, health promotion, mental health support, substance-use management, and harm-reduction care—also tended to report fewer unmet healthcare needs. This pattern highlights the potential importance of accessible, comprehensive, and integrated nursing services within community-based shelters. However, the moderate coefficient also indicates that nursing care delivery does not account for all differences in respondents' healthcare-needs scores. Other factors, including the severity of substance use, co-occurring mental health conditions, duration of homelessness, availability of specialized services, social support, and structural barriers to healthcare, may also influence the level of need experienced by respondents. The result must nevertheless be interpreted as an association rather than evidence of causation. A statistically significant correlation does not establish that greater nursing care directly caused respondents' healthcare needs to decrease. Confounding variables, reverse relationships, measurement limitations, and other unexamined factors may influence correlational findings (D'Amico et al., 2025). Accordingly, longitudinal or experimental studies would be needed to determine whether improvements in nursing care

delivery produce subsequent reductions in unmet healthcare needs. Within the limits of the present study, the findings provide empirical support for strengthening coordinated, trauma-informed, recovery-oriented, and harm-reduction nursing services for homeless youth in community-based shelters.

Differences in Healthcare Needs According to the Profile Characteristics of the Respondents

This section presents the differences in the healthcare needs of the respondents when grouped according to age, sex, gender identity, duration of homelessness, primary substance used, duration of substance use, and previous treatment or rehabilitation history. The Kruskal–Wallis H test was used for profile variables with three or more groups, while the Mann–Whitney U test was used for previous treatment or rehabilitation history, which consisted of two groups. Statistical significance was evaluated at the 0.05 level.

Table 5: Differences in Healthcare Needs According to the Profile Characteristics of the Respondents

Profile Characteristic	Statistical Test	Test Statistic	p-value	Decision on H_{02}	Result
Age	Kruskal–Wallis H	5.87	.118	Do not reject H_{02}	Not Significant
Sex	Kruskal–Wallis H	1.96	.375	Do not reject H_{02}	Not Significant
Gender Identity	Kruskal–Wallis H	2.88	.410	Do not reject H_{02}	Not Significant
Duration of Homelessness	Kruskal–Wallis H	10.62	.014	Reject H_{02}	Significant
Primary Substance Used	Kruskal–Wallis H	12.34	.030	Reject H_{02}	Significant
Duration of Substance Use	Kruskal–Wallis H	8.21	.016	Reject H_{02}	Significant
Previous Treatment/Rehabilitation History	Mann–Whitney U	1,147.00	.032	Reject H_{02}	Significant

Level of significance: $\alpha = 0.05$.

Table 5 shows that healthcare-needs scores did not differ significantly according to age, $H = 5.87$, $p = .118$; sex, $H = 1.96$, $p = .375$; or gender identity, $H = 2.88$, $p = .410$. Because their respective p-values exceeded the .05 significance level, the null hypothesis was not rejected for these characteristics. These nonsignificant results should be understood as indicating that the present sample did not provide sufficient evidence of group differences. They should not be interpreted as proof that age, sex, or gender identity has no relevance to healthcare experiences. Conversely, healthcare needs differed significantly by duration of homelessness, $H = 10.62$, $p = .014$. Adjusted post hoc pairwise comparisons indicated that respondents experiencing homelessness for more than three years had significantly higher healthcare-needs scores than those experiencing homelessness for less than six months, adjusted $p = .021$. The remaining comparisons were not statistically significant. This finding is consistent with Canadian evidence showing that people experiencing chronic homelessness report a greater burden of concurrent mental health and substance-use problems than those who are not chronically homeless (Housing, Infrastructure and Communities Canada, 2024). Healthcare needs also differed significantly by primary substance used, $H = 12.34$, $p = .030$. Adjusted pairwise comparisons showed that respondents who primarily used opioids had higher healthcare-needs scores than those who primarily used cannabis, adjusted $p = .041$. No other pairwise comparisons were significant. Recent evidence indicates that people experiencing homelessness who use opioids encounter substantial overdose risks and unmet treatment needs, thereby requiring accessible treatment, harm-reduction services, naloxone, and continuing healthcare support (Assaf et al., 2025). A significant difference was also identified according to the duration of substance use, $H = 8.21$, $p = .016$. Respondents reporting substance use for more than three years had significantly higher healthcare-needs scores than those reporting substance use for less than one year, adjusted $p = .018$. Other pairwise comparisons were not significant. Prolonged substance use may coincide with cumulative health complications, co-occurring mental health problems, unstable housing, and increased barriers to treatment. National Canadian data similarly demonstrate the close intersection of chronic homelessness, substance use, and mental health concerns (Housing, Infrastructure and Communities Canada, 2024). Previous treatment or rehabilitation history also

produced a significant difference, $U = 1,147.00$, $p = .032$. Respondents without previous treatment or rehabilitation had a higher mean rank for healthcare-needs scores than respondents who had received treatment. Thus, the null hypothesis was rejected for treatment history. This result may indicate greater unmet service needs among respondents who have never entered formal treatment. Recent evidence has documented persistently low treatment engagement and considerable unmet treatment demand among people experiencing homelessness who use substances (Assaf et al., 2025). Overall, healthcare needs did not differ significantly according to age, sex, or gender identity but differed according to homelessness duration, primary substance used, substance-use duration, and previous treatment or rehabilitation history. Accordingly, H_{02} was rejected for the latter four characteristics and was not rejected for age, sex, and gender identity. Because these findings are based on group comparisons, they indicate statistical differences but do not establish that the profile characteristics caused the observed differences in healthcare needs.

Lived Experiences Regarding Nursing Care and Healthcare Services

This section presents the qualitative findings concerning the lived experiences of homeless youth regarding the nursing care and healthcare services they received within community-based shelters. The qualitative data were obtained through semi-structured interviews with 12 participants. The interview guide explored participants' experiences in accessing healthcare, their major health needs, nursing services they found helpful, perceived gaps in healthcare delivery, and recommendations for improving nursing care in shelters.

Table 6: Summary of Themes and Subthemes on the Lived Experiences of Homeless Youth Regarding Nursing Care and Healthcare Services

Theme	Subthemes
1. Navigating Inconsistent Access to Healthcare	Availability of immediate healthcare support; Delays and difficulties in accessing external services
2. Seeking Respectful and Nonjudgmental Care	Feeling heard and respected by healthcare providers; Importance of trust and psychological safety
3. Managing Interconnected Health Concerns	Coexisting physical and mental health needs; Substance use concerns requiring continuing support
4. Experiencing Gaps in Continuity of Care	Fragmented referrals and follow-up; Need for consistent and coordinated healthcare support

The thematic analysis identified four major themes reflecting the participants' experiences with nursing care and healthcare services within community-based shelters: navigating inconsistent access to healthcare, seeking respectful and nonjudgmental care, managing interconnected health concerns, and experiencing gaps in continuity of care.

Theme 1: Navigating Inconsistent Access to Healthcare. The first theme reflected participants' experiences in obtaining healthcare while residing in or receiving services from community-based shelters. Participants described the availability of some immediate healthcare assistance within the shelter environment, particularly for basic health concerns and initial assessment. At the same time, experiences with accessing services beyond the shelter were characterized by varying levels of availability and timeliness. Two subthemes emerged under this theme: availability of immediate healthcare support and delays and difficulties in accessing external services.

Theme 2: Seeking Respectful and Nonjudgmental Care. The second theme centered on the manner in which participants experienced interactions with nurses and other healthcare providers. Participants placed importance on being listened to, treated respectfully, and approached without judgment regarding their homelessness or substance use. Their accounts indicated that supportive interactions contributed to greater comfort in communicating health concerns and accepting care. The two subthemes identified were feeling heard and respected by healthcare providers and importance of trust and psychological safety.

Theme 3: Managing Interconnected Health Concerns. The third theme captured the multiple and overlapping health concerns experienced by the participants. Their accounts reflected the coexistence of

physical health problems, mental and emotional concerns, and substance use-related needs. Mental health and substance use concerns were frequently described as occurring alongside other health and psychosocial difficulties rather than as isolated conditions. The subthemes under this theme were coexisting physical and mental health needs and substance use concerns requiring continuing support.

Theme 4: Experiencing Gaps in Continuity of Care. The fourth theme reflected participants' experiences with the continuity and coordination of healthcare services. Participants described circumstances in which referrals, follow-up care, or access to specialized services were not always continuous. The findings also reflected the importance of maintaining connections between shelter-based services and external healthcare providers. Two subthemes were identified: fragmented referrals and follow-up and need for consistent and coordinated healthcare support.

Overall, the qualitative findings reflected varied experiences of healthcare access and nursing care among the participants. The themes captured their experiences of accessing available services, interacting with healthcare providers, managing multiple health concerns, and navigating continuity of care within and beyond community-based shelter settings.

Barriers and Facilitators to the Delivery of Integrated Nursing Care

This section presents the barriers and facilitators associated with the delivery of integrated nursing care for homeless youth experiencing substance use disorders in community-based shelters. The findings were organized into themes representing conditions that hindered the delivery and continuity of nursing care and those that supported access, engagement, coordination, and continuity of services.

Table 7: Barriers and Facilitators to the Delivery of Integrated Nursing Care

Category	Theme	Subthemes
Barriers	Fragmented and Discontinuous Services	Gaps in referral and follow-up; Difficulty navigating multiple service systems
	Limited Accessibility of Needed Services	Delays in accessing specialized care; Transportation and communication difficulties
	Stigma, Mistrust, and Reluctance to Seek Care	Fear of judgment related to homelessness and substance use; Difficulty establishing trust with providers
	Complexity of Multiple and Co-occurring Needs	Simultaneous physical, mental health, substance use, and psychosocial concerns; Difficulty addressing multiple priorities
Facilitators	Respectful and Nonjudgmental Nursing Relationships	Feeling listened to and respected; Development of trust and psychological safety
	Accessible Shelter-Based Support	Immediate access to basic nursing assistance; Availability of support within the shelter
	Coordinated and Collaborative Care	Communication among healthcare and shelter personnel; Effective referral and linkage to external services
	Individualized and Supportive Approaches to Care	Responsiveness to individual needs; Support for substance use management and harm reduction

The qualitative findings identified both barriers and facilitators relevant to the delivery of integrated nursing care within community-based shelter settings. The barriers reflected difficulties related to continuity, accessibility, trust, and the complexity of participants' healthcare needs, while the facilitators represented conditions that supported engagement with nursing and healthcare services.

Fragmented and Discontinuous Services. One barrier identified was the fragmentation of healthcare services across different providers and service settings. Difficulties were observed in maintaining continuity when care required referrals outside the shelter or involvement of multiple healthcare and social service providers. The subthemes under this barrier were gaps in referral and follow-up and difficulty navigating multiple service systems.

Limited Accessibility of Needed Services. Another barrier involved limitations in accessing healthcare services beyond those immediately available within the shelter. This included difficulties obtaining specialized healthcare services and practical challenges associated with accessing external providers. Two subthemes were identified: delays in accessing specialized care and transportation and communication difficulties.

Stigma, Mistrust, and Reluctance to Seek Care. Participants' experiences also reflected interpersonal barriers affecting engagement with healthcare services. Concerns about being judged because of homelessness or substance use were associated with hesitancy in communicating health concerns or seeking assistance. The two subthemes under this barrier were fear of judgment related to homelessness and substance use and difficulty establishing trust with healthcare providers.

Complexity of Multiple and Co-occurring Needs. The delivery of integrated nursing care was also challenged by the presence of multiple, interconnected healthcare and psychosocial concerns. Physical health problems, mental health concerns, substance use needs, housing instability, and other psychosocial difficulties often required attention at the same time. This theme consisted of simultaneous physical, mental health, substance use, and psychosocial concerns and difficulty addressing multiple priorities.

In contrast, several conditions facilitated the delivery of nursing care and participants' engagement with available healthcare services.

Respectful and Nonjudgmental Nursing Relationships. A major facilitator involved positive interpersonal relationships between homeless youth and healthcare providers. Respectful communication, active listening, and nonjudgmental interactions supported greater comfort in expressing healthcare concerns and accepting assistance. The subthemes were feeling listened to and respected and development of trust and psychological safety.

Accessible Shelter-Based Support. The availability of healthcare assistance within the shelter served as another facilitator. Shelter-based support provided opportunities for participants to obtain basic health assistance and seek guidance without always having to navigate external healthcare settings. The subthemes identified were immediate access to basic nursing assistance and availability of support within the shelter.

Coordinated and Collaborative Care. Coordination among shelter personnel, nurses, healthcare providers, mental health professionals, addiction services, and other community resources facilitated access to a broader range of services. The two subthemes were communication among healthcare and shelter personnel and effective referral and linkage to external services.

Individualized and Supportive Approaches to Care. Nursing care that responded to the individual circumstances and needs of homeless youth also served as a facilitator. Such approaches acknowledged variations in health concerns, readiness to engage in care, substance use experiences, and personal circumstances. The subthemes under this theme were responsiveness to individual needs and support for substance use management and harm reduction.

Overall, the findings identified four principal barriers—fragmented and discontinuous services, limited accessibility of needed services, stigma and mistrust, and complexity of multiple and co-occurring needs—and four principal facilitators—respectful and nonjudgmental nursing relationships, accessible shelter-based support, coordinated and collaborative care, and individualized and supportive approaches to care.

Development of the Integrated Nursing Care Framework

Purpose of the Framework. The Integrated Nursing Care Framework was developed to guide nurses in delivering coordinated, person-centered, trauma-informed, harm-reduction, and recovery-oriented care to youth experiencing homelessness and substance use disorders in community-based shelters. It supports early identification of multidimensional risks, timely nursing intervention, access to appropriate health and social services, and continuity across shelter, healthcare, addiction-treatment, and community settings. The framework does not replace specialized medical, psychiatric, addiction, housing, or social services; rather, it defines the nurse's role in assessment, therapeutic engagement, education, medication-related care within scope of practice, referral, advocacy, and coordination.

Evidence Sources and Stakeholder Participation. Development drew on four complementary evidence sources. First, the literature review identified recurring recommendations on integrated healthcare, harm reduction, trauma-informed practice, service accessibility, and interprofessional coordination. Second, the quantitative needs assessment of 112 respondents established the relative importance of physical health, mental health, substance-use management, psychosocial support, health education, and healthcare access. Third, semi-structured interviews with 12 participating youth clarified how they experienced care, including fragmented referrals, mistrust, stigma, inconsistent access, and the importance of respectful, nonjudgmental relationships. Fourth, five experts representing nursing, community health, mental health, addiction care, public health, and shelter services reviewed and refined the preliminary framework. This integration of literature, measured needs, lived experience, and multidisciplinary judgment strengthened the framework's clinical relevance and contextual responsiveness (Grand-Guillaume-Perrenoud et al., 2023; Meda et al., 2025).

Role of Youth Lived Experience. The study incorporated the target population's perspectives directly rather than inferring them solely from providers. Participating youth described their priorities, barriers, experiences of nursing care, and recommendations for improving shelter-based services. Their accounts informed the emphasis on psychological safety, choice, individualized care, accessible shelter-based support, referral follow-through, and sustained engagement. This approach is consistent with evidence that youth-centered service development should recognize lived experience, identity, readiness for change, and the structural conditions shaping substance use and homelessness (Goodyear et al., 2024).

Table 8: Integration of Quantitative and Qualitative Findings as Basis for the Integrated Nursing Care Framework

Area of Integration	Quantitative Findings	Qualitative Findings	Framework Component
Comprehensive health needs	Healthcare needs were generally high, with very high needs identified in several domains	Participants described overlapping physical, mental health, substance use, and psychosocial concerns	Comprehensive and Continuous Assessment
Mental health	Mental Health Needs emerged as the highest healthcare-needs domain	Participants described mental and emotional concerns occurring together with homelessness and substance use	Mental Health and Psychosocial Support
Substance use	Substance Use Management Needs were among the highest healthcare	Participants identified continuing substance use	Substance Use and Management

	needs, while Substance Use Management and Harm Reduction ranked lowest among the nursing-care domains	concerns and the need for individualized support	Harm Reduction
Healthcare access	Access to Healthcare Services was identified as a very high need	Participants described delays and difficulties accessing services outside the shelter	Healthcare Access, Referral, and Care Coordination
Continuity of care	The overall extent of nursing care was high, although variation was observed among nursing-care domains	Participants described fragmented referrals and gaps in follow-up	Interprofessional Collaboration and Continuity of Care
Therapeutic engagement	—	Respectful, nonjudgmental relationships, active listening, and trust were identified as facilitators of care	Person-Centered and Trauma-Informed Therapeutic Engagement
Complex needs	Healthcare needs differed according to selected homelessness, substance use, and treatment characteristics	Participants described the difficulty of addressing multiple health and psychosocial needs simultaneously	Individualized Care Planning
Collaborative services	—	Coordination among shelter personnel, nurses, mental health professionals, addiction services, and external providers was identified as a facilitator	Interprofessional Collaboration and Continuity of Care

The integrated evidence resulted in seven interrelated domains: Comprehensive and Continuous Assessment; Mental Health and Psychosocial Support; Substance Use Management and Harm Reduction; Health Promotion, Motivational Intervention, and Self-Management Support; Healthcare Access, Referral, and Care Coordination; Person-Centered and Trauma-Informed Therapeutic Engagement; and Interprofessional Collaboration and Continuity of Care. These domains form a continuous pathway of assessment, individualized planning, integrated intervention, referral and coordination, follow-up, and reassessment.

Comprehensive and Continuous Assessment. This domain provides the framework's clinical foundation. It includes assessment of substances used, frequency, route, duration, last use, polysubstance use, previous treatment, readiness for change, current intoxication, withdrawal symptoms, overdose history and risk, and access to naloxone. It also includes mental-health and suicide-risk screening; physical-health assessment; medication reconciliation; and assessment of nutrition, sexual health, trauma, safety, housing, social support, and barriers to healthcare. Assessment is repeated when the youth's health, substance use, housing, treatment engagement, or social circumstances change.

Mental Health and Psychosocial Support. This domain addresses depression, anxiety, trauma-related symptoms, psychological distress, self-harm, suicide risk, social isolation, family disruption, and other psychosocial concerns. Nursing actions include validated screening when appropriate, supportive listening, crisis recognition and response, safety planning, emotional support, and timely referral to specialized mental-health or psychosocial services. Care should recognize that mental-health symptoms, substance use, trauma, and homelessness may interact and should not be managed as isolated concerns.

Substance Use Management and Harm Reduction. This domain uses individualized, nonjudgmental, and recovery-oriented care. It incorporates monitoring for withdrawal and overdose risk; overdose-response and naloxone education; safer-use and infection-prevention education; individualized risk-reduction planning;

relapse-prevention support; and referral to withdrawal-management, addiction-treatment, and opioid agonist treatment services when clinically indicated. Immediate abstinence is not required as a condition for nursing support, and engagement is maintained across different stages of readiness.

Health Promotion, Motivational Intervention, and Self-Management Support. This domain combines developmentally appropriate health education with motivational intervention and collaborative goal setting. Nurses assess readiness for change, use motivational interviewing or comparable evidence-informed communication approaches, and support achievable goals related to physical health, mental wellness, substance-related risk, medication use, treatment participation, preventive care, and self-management. Medication-related care includes reconciliation, education, adherence support, monitoring for adverse effects within nursing scope, safe storage planning, and coordination with prescribers and pharmacists.

Healthcare Access, Referral, and Care Coordination. This domain translates identified needs into completed service connections. It includes referral to primary care, addiction treatment, withdrawal-management services, mental-health care, dental and sexual-health services, housing programs, and other community resources. Nurses assist with appointment scheduling, transportation or communication barriers, service navigation, information exchange with consent, referral tracking, and confirmation that the youth reached the intended service. Referral is therefore treated as a monitored care process rather than a single administrative action.

Person-Centered and Trauma-Informed Therapeutic Engagement. This cross-cutting domain emphasizes safety, trust, choice, collaboration, empowerment, cultural responsiveness, and avoidance of retraumatization. Nursing plans are developed with the youth and reflect expressed priorities, preferences, identity, readiness, strengths, and goals. Respectful, non-stigmatizing communication is maintained even when a young person declines a referral or is not ready to pursue formal treatment, thereby preserving opportunities for harm reduction, education, crisis support, and later engagement.

Interprofessional Collaboration and Continuity of Care. This domain links shelter nurses with physicians, nurse practitioners, pharmacists, mental-health professionals, addiction specialists, social workers, shelter personnel, housing providers, and community organizations. It includes shared care planning with appropriate consent, medication continuity, planned transitions, follow-up after referral or discharge, communication across settings, and reassessment after changes in placement or treatment. No single discipline is expected to address all identified needs independently.

Integrated Care Pathway. Together, the seven domains form a continuous nursing pathway: comprehensive assessment, individualized care planning, integrated nursing intervention, referral and coordination, follow-up, and reassessment. Person-centered, trauma-informed, harm-reduction, and recovery-oriented principles operate throughout the pathway, while interprofessional collaboration connects shelter-based care with external services. Guided by Roy's Adaptation Model, the framework recognizes that physiological, psychological, social, and environmental conditions change over time and require continuing assessment and adaptation.

Expert Content Review and Pilot Testing. Five expert validators assessed the preliminary framework using a 30-item checklist covering relevance, clarity, completeness, feasibility, applicability, scientific soundness, and implementation readiness. Their multidisciplinary feedback was used to refine the domains and proposed nursing actions. However, the framework has not yet undergone field implementation or pilot testing in routine shelter practice. It should therefore be described as expert-reviewed and evidence-informed, not as proven feasible or effective. A subsequent pilot should evaluate workflow fit, staff preparation, resource requirements, fidelity, safety, and youth acceptability before broader implementation.

Proposed Implementation Outcomes. Future pilot and implementation studies should measure service engagement, completion of nursing assessments, referral completion, entry into addiction or mental-health treatment, treatment retention, uptake of harm-reduction education and naloxone, medication continuity, follow-up completion, continuity across settings, adverse events, and patient-reported acceptability. These

outcomes should be interpreted together with implementation indicators such as staff adherence, interprofessional participation, barriers, resource use, and adaptations required by individual shelters.

Ethical and Safeguarding Provisions. Because the intended population includes youth aged 16 to 25 years, the framework incorporates safeguards for minors and other vulnerable individuals. Care and future framework evaluation must use voluntary, age- and capacity-appropriate informed consent or assent procedures, including parental or guardian permission when required by applicable law and the approving research ethics board. Confidentiality should be protected through private assessments, secure and limited records access, minimum-necessary information sharing, and clear explanation of confidentiality limits involving imminent harm, abuse, exploitation, or other safeguarding concerns. Participation in research or framework evaluation must not affect access to shelter or services. Nurses should use person-first, non-stigmatizing language and receive preparation in trauma-informed care, cultural safety, harm reduction, suicide and overdose response, safeguarding, confidentiality, and professional boundaries.

Development of the Integrated Nursing Care Framework

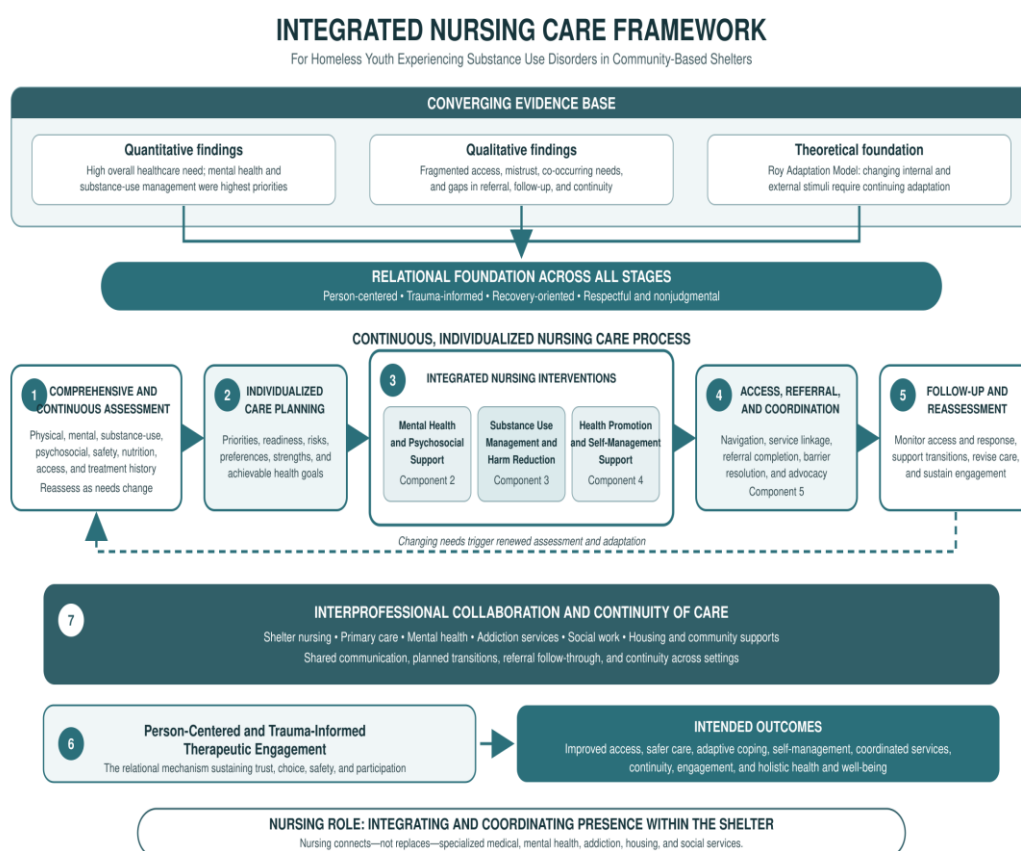


Figure 2: Integrated Nursing Care Network

The Integrated Nursing Care Framework integrates the study's literature base, quantitative needs assessment, qualitative accounts from participating youth, Roy's Adaptation Model, and multidisciplinary expert review. It responds to the finding that healthcare needs are multidimensional and that fragmented access, mistrust, co-occurring concerns, and discontinuity can prevent youth from obtaining appropriate care.

The seven domains operationalize substance-use assessment, withdrawal and overdose risk, mental-health screening, physical-health assessment, harm-reduction education, motivational intervention, referral to addiction treatment, medication-related care, psychosocial support, and continuity of care. Youth priorities and lived experiences provide the relational foundation, while interprofessional collaboration supports referral completion and continuity across shelter, healthcare, addiction-treatment, housing, and community settings.

The framework positions nurses as integrating and coordinating practitioners, not substitutes for specialized services. Although multidisciplinary experts reviewed its content, pilot implementation and outcome evaluation are needed to assess feasibility, acceptability, and effectiveness. Accordingly, the framework is presented as an evidence-informed and expert-reviewed nursing model whose proposed benefits remain to be tested in practice.

CONCLUSION

This study concluded that homeless youth experiencing substance use disorders have multidimensional and interconnected healthcare needs that cannot be adequately addressed through fragmented or crisis-oriented services alone. Among the 112 respondents, healthcare needs were generally high, with mental health, substance-use management, psychosocial support, and healthcare access emerging as the most pressing areas. Although nursing care was delivered to a high extent, comprehensive assessment and health promotion were more prominent than mental health support, substance-use management, and harm reduction. This imbalance shows the need to strengthen nursing interventions in the areas respondents identified as most critical.

The significant moderate negative relationship between nursing care delivery and healthcare needs indicated that greater nursing-care delivery was associated with lower levels of reported healthcare need. Although this relationship does not establish causation, it highlights the potential contribution of accessible and comprehensive nursing services to addressing unmet needs. Healthcare needs also varied according to the duration of homelessness, primary substance used, duration of substance use, and previous treatment or rehabilitation history. Youth experiencing prolonged homelessness or substance use, those primarily using opioids, and those without previous treatment demonstrated greater healthcare needs. Conversely, no significant differences were identified according to age, sex, or gender identity, indicating that essential nursing services should remain broadly accessible while being individualized according to homelessness, substance-use, and treatment experiences.

The qualitative findings clarified how people experienced these needs. Participants described inconsistent healthcare access, fragmented referrals, limited continuity, mistrust, stigma, and difficulty navigating multiple service systems. They also emphasized the importance of respectful, nonjudgmental, accessible, and individualized nursing care. They also identified therapeutic relationships, shelter-based support, coordinated referrals, and collaboration among service providers as important facilitators of engagement. These findings show that the effectiveness of nursing interventions depends not only on service availability but also on how care is delivered and coordinated.

Integrating the quantitative and qualitative findings resulted in the development of the Integrated Nursing Care Framework. Its seven components—Comprehensive and Continuous Assessment; Mental Health and Psychosocial Support; Substance Use Management and Harm Reduction; Health Promotion and Self-Management Support; Healthcare Access, Referral, and Care Coordination; Person-Centered and Trauma-Informed Therapeutic Engagement; and Interprofessional Collaboration and Continuity of Care—provide a structured nursing response to the population's complex needs. Guided by Roy's Adaptation Model, the framework recognizes homeless youth as adaptive individuals whose health responses are influenced by interacting physical, psychological, social, environmental, and substance-related conditions.

Overall, the study establishes nursing as an integrating and coordinating presence within community-based shelters. Nurses do not replace specialized medical, mental health, addiction, housing, or social services; rather, they connect these services through assessment, therapeutic engagement, referral, advocacy, follow-up, and continuity. The proposed framework therefore offers a person-centered, trauma-informed, harm-reduction, and recovery-oriented foundation for organizing shelter-based nursing care. Its implementation by adapting it to local resources, supporting it with interprofessional partnerships, and evaluating feasibility, acceptability, and effectiveness before broader application. Through this framework, community-based shelters may move beyond temporary crisis response toward coordinated and continuous care that promotes

health, recovery, dignity, and social reintegration among homeless youth experiencing substance use disorders.

RECOMMENDATIONS

Community-based shelters should pilot the Integrated Nursing Care Framework and adapt its components to their available personnel, resources, and referral networks. Priority should be given to strengthening mental health support, substance-use management, and harm-reduction services, as these represented the respondents' most substantial needs and the comparatively weaker areas of nursing care. Shelter nurses should conduct comprehensive, ongoing assessments; develop individualized care plans; provide trauma-informed, nonjudgmental care; and monitor whether referrals are completed.

Shelter administrators should establish formal partnerships with primary care providers, mental health professionals, addiction-treatment programs, hospitals, social workers, housing agencies, and community organizations. Shelter administrators should develop clear referral protocols, information-sharing procedures, follow-up mechanisms, staff training, and adequate nursing coverage should be developed to improve continuity. Policymakers and funding agencies should support accessible shelter-based healthcare, harm-reduction resources, and integrated health and social services. Future researchers should validate the framework with experts and youth representatives, pilot-test it in different shelters, and evaluate its feasibility, acceptability, effectiveness, and long-term influence on healthcare access and recovery outcomes.

The study was limited by its inclusion of 112 respondents from selected community-based shelter settings, which restricts the generalizability of the findings to other youth, shelters, and geographic locations. Self-reported data may have introduced recall and social-desirability biases. The correlational, cross-sectional findings establish associations but cannot demonstrate causality or change over time. Furthermore, although the framework was grounded in mixed-methods findings and Roy's Adaptation Model, its effectiveness has not yet been established through full-scale implementation or longitudinal evaluation.

REFERENCES

1. Beck, K., Pallot, K., & Amri, M. (2024). A scoping review on barriers and facilitators to harm reduction care among youth in British Columbia, Canada. *Harm Reduction Journal*, 21, Article 189. <https://doi.org/10.1186/s12954-024-01063-1>
2. D'Amico, F., Marmiere, M., Fonti, M., Battaglia, M., & Belletti, A. (2025). Association does not mean causation, when observational data were misinterpreted as causal: The observational interpretation fallacy. *Journal of Evaluation in Clinical Practice*, 31(1), Article e14288. <https://doi.org/10.1111/jep.14288>
3. Gaetz, S., Buchnea, A., Fournier, C., Dej, E., & Schwan, K. (2024). Towards the prevention of youth homelessness. *Youth*, 4(4), 1694–1725. <https://doi.org/10.3390/youth4040108>
4. Garcia, C., Doran, K., & Kushel, M. (2024). Homelessness and health: Factors, evidence, innovations that work, and policy recommendations. *Health Affairs*, 43(2), 164–171. <https://doi.org/10.1377/hlthaff.2023.01049>
5. Goodyear, T., Jenkins, E., Oliffe, J. L., Fast, D., Kia, H., & Knight, R. (2024). 2S/LGBTQ+ youth substance use and pathways to homelessness: A photovoice study. *International Journal of Drug Policy*, 133, Article 104621. <https://doi.org/10.1016/j.drugpo.2024.104621>
6. Goodyear, T., Barborini, C., Gilmore, R., Collin-Gray, A., Jensen, M., Young, L., Hossain, A., He, E., & Other Members of the Substance Use Beyond the Binary Youth Action Committee. (2025). Harm reduction in photovoice knowledge mobilization with 2S/LGBTQ+ youth who use(d) drugs: A community showcase. *Harm Reduction Journal*, 22, Article 109. <https://doi.org/10.1186/s12954-025-01263-3>
7. Grand-Guillaume-Perrenoud, J. A., Geese, F., Uhlmann, K., Blasimann, A., Wagner, F. L., Neubauer, F. B., Huwendiek, S., Hahn, S., & Schmitt, K.-U. (2023). Mixed methods instrument validation: Evaluation procedures for practitioners developed from the validation of the Swiss

- Instrument for Evaluating Interprofessional Collaboration. *BMC Health Services Research*, 23, Article 83. <https://doi.org/10.1186/s12913-023-09040-3>
8. Health Canada. (2024). Substance use among street-involved youth in Canada: Pan-Canadian findings from the People with Lived and Living Experience Survey. Government of Canada. <https://www.canada.ca/en/health-canada/services/publications/healthy-living/substance-use-street-involved-youth-canada.html>
9. Hennink, M., & Kaiser, B. N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social Science & Medicine*, 292, Article 114523. <https://doi.org/10.1016/j.socscimed.2021.114523>
10. Housing, Infrastructure and Communities Canada. (2024). Homelessness data snapshot: Mental health, substance use, and homelessness in Canada. Government of Canada. <https://housing-infrastructure.canada.ca/homelessness-sans-abri/reports-rapports/mental-health-substance-use-sante-mentale-consom-substances-eng.html>
11. Kumar, M., Padgett, D., Louie, K., & Narendorf, S. C. (2026). Crossing the divides: Integrated services for youth at risk of homelessness. *The Lancet Regional Health—Americas*, 62, Article 101556. <https://doi.org/10.1016/j.lana.2026.101556>
12. Meda, F., Oprea, N., & Buongiorno Sottoriva, C. (2025). Improving access to healthcare services for people experiencing homelessness: Evidence from a scoping review of interventions. *Health & Justice*, 13, Article 77. <https://doi.org/10.1186/s40352-025-00384-y>
13. Polit, D. F., & Beck, C. T. (2006). The content validity index: Are you sure you know what's being reported? Critique and recommendations. *Research in Nursing & Health*, 29(5), 489–497. <https://doi.org/10.1002/nur.20147>
14. Schober, P., Boer, C., & Schwarte, L. A. (2018). Correlation coefficients: Appropriate use and interpretation. *Anesthesia & Analgesia*, 126(5), 1763–1768. <https://doi.org/10.1213/ANE.0000000000002864>
15. Simkhada, B., Singh, D., Sah, R. K., Barclay, H., Duke, M., & Brown, P. (2025). Health promotion efforts for people experiencing homelessness in England: A scoping review. *Journal of Social Distress and Homelessness*, 34(2), 296–311. <https://doi.org/10.1080/10530789.2024.2395163>
16. Taber, K. S. (2018). The use of Cronbach's alpha when developing and reporting research instruments in science education. *Research in Science Education*, 48(6), 1273–1296. <https://doi.org/10.1007/s11165-016-9602-2>
17. United Nations Department of Economic and Social Affairs. (2024). The Sustainable Development Goals report 2024. United Nations. <https://unstats.un.org/sdgs/report/2024/>
18. Wadge, S., Lethby, M., Stobbe, K., Gardner, P., & Michaelson, V. (2024). Gender matters: Exploring the mental health of youth experiencing homelessness in Canada. *International Journal on Homelessness*, 4(2), 200–221. <https://doi.org/10.5206/ijoh.2023.3.16751>
19. Wasti, S. P., Simkhada, P., van Teijlingen, E. R., Sathian, B., & Banerjee, I. (2022). The growing importance of mixed-methods research in health. *Nepal Journal of Epidemiology*, 12(1), 1175–1178. <https://doi.org/10.3126/nje.v12i1.43633>
20. Yeo, E. J., Hausman, E., Noyes, E., & Chatterjee, A. (2024). Evaluating mobile harm reduction services for youth and young adults. *Frontiers in Public Health*, 12, Article 1375323. <https://doi.org/10.3389/fpubh.2024.1375323>
21. Yusoff, M. S. B. (2019). ABC of content validation and content validity index calculation. *Education in Medicine Journal*, 11(2), 49–54. <https://doi.org/10.21315/eimj2019.11.2.6>