HCP-C

MODULE 5

Mental Health Supports

OVERVIEW

This module focuses on organizational self-assessment and troubleshooting tools that can assist leadership, clinical and front-line staff in designing and implementing mental health and wellness focused programming, as well as in planning for and navigating challenges that commonly arise in this programming within the youth homelessness context. This work is based on the following assumptions:

1. **Youth experiencing homelessness are more likely than other youth their age to be experiencing serious and complex mental health challenges** (Hodgson, Shelton, van den Bree, & Los, 2013; Merscham et al., 2009)
2. **Despite this significant need, youth experiencing homelessness are also less likely to access mental health services**. This is due to difficulties navigating the health care system, few clinic sites, lack of coordination among providers, lack of identification and formal diagnoses, as well as challenges resulting from long wait lists and active substance use, among other barriers (Edidin, Ganim, Hunter, & Karnik, 2012; Gaetz, O'Grady, Kidd, & Schwan, 2016). Because of this gap between need and access to services, it is most often youth housing and homelessness support organizations and their front-line staff, such as case managers and shelter staff, who must navigate how best to meet the mental health needs of and coordinate care for youth.
3. **Challenges with service access become even more complex as youth navigate transitions from homelessness services (i.e., shelter, transitional housing) into independent or less supported/unsupported housing arrangements**. Dominant approaches to intervention with youth experiencing homelessness are mainly crisis responses, often in the form of general drop-in and emergency shelter services, where predominantly reactive approaches are focused on meeting basic needs and providing education, employment, and skills training. Traditionally these crisis-oriented services consider housing as an end goal, while youth often continue to experience or experience an increase in mental health symptoms as they transition into more stable and independent housing arrangements (Kidd, 2013). To this end, tertiary supports, including a strong focus on mental health, are critical in stabilizing the trajectories of youth out of homelessness and preventing the recurrence of homelessness.
4. **Culturally appropriate service delivery systems that are based on Indigenous views of health are often holistic in nature, such that they incorporate mental, physical, spiritual, and emotional aspects of wellbeing** (Health Canada, 2015). Interventions aimed to address the mental health needs of Indigenous youth experiencing homelessness should consider the role of historical trauma in their presenting difficulties. Interventions can be adapted to incorporate cultural engagement and traditional healing within Western evidence-based practices. Specific resources and supports can also be utilized to provide youth with the opportunity to engage with their cultural identity,

This module contains guiding documents to help collaborative ventures, organizations, and practitioners alike attend to key elements in the development of tertiary mental health supports across both individual and group service contexts. This approach aims to further stabilize young people who have attained a relative level of stability in meeting their housing and basic needs, and who may be beginning to transition from "survival mode" to navigating the compounded and distinct mental, physical, and social health challenges that can arise in the transition from homelessness.

This module is composed of considerations and guiding activities to be used in the planning, design and implementation of tertiary mental health supports for young people transitioning from homelessness.

Worksheet 1: Organizational Mental Health Needs Assessment aims to provide a thorough overview of common wellness and mental health needs that collaborations, organizations, and staff are likely to navigate with their clientele. The worksheet is designed to a) provide a definition of each common need and examples for how these can be met; and b) prompt consideration of what resources the collaboration/organization has in order to meet these needs as they arise.

Worksheet 2: Trauma-Informed Care for Working in Youth Homelessness offers an overview of key principles in trauma-informed care with links to resources relevant to the establishment of trauma-informed care programs and organizations in the youth homelessness context.

Worksheet 3: Build Your Own Wellness Group Assessment offers framing questions for the planning and design of a wellness-based mental health group in the youth homelessness context based on the development of the HOP-C Wellness and Mindfulness Group.

Worksheet 4: Trouble Shooting Examples for Mental Health Group Work Activity suggests common scenarios that could be experienced in mental health-based group service provision in the youth homelessness context. Framing questions are provided to provoke reflection on response to challenging scenarios.

Worksheet 5: Considerations for Individual Therapy Summary Sheet offers a summary of learnings from service delivery of individual therapy to young people exiting homelessness in the HOP-C program.

Worksheet 6: Mental Health Professionals and Evidence-Based Approaches provides examples of the mental health service provision structure within HOP-C and offers links to websites and toolkits in order to access more information on possibilities for these components, as well as a description of how HOP-C's mental health services were delivered.

Worksheet 7: Walking in Balance is a worksheet that can help service providers learn to engage with Indigenous approaches to wellbeing that include engaging with emotional, physical, mental, and spiritual needs. It can also be used to help providers reflect on aspects of their own wellbeing, including what actions they can take to achieve a balanced life.

WORKSHEET 1
Organizational Health and Wellness Needs Assessment

Step 1: Review the common wellness and mental health needs of clients listed below. Highlight those that are most relevant to your collaboration/organization/practice.

Step 2: For your highlighted needs, reflect on what resources your collaboration/organization/practice has in order to meet them.

Brainstorm and plan how these needs might be met in your context reflecting on how these needs can be met through one or more of the following:

- Existing Internal Capacity
- Hiring and/or Building Internal Capacity
- Partnership Creation
- External Referral

Common Wellness Needs

Self-Care

Strategies for taking an active role in protecting one's own well-being and happiness, in particular during periods of stress.

Examples:

- Art, exercise, and relaxation opportunities within the organization delivered in a group or offered to clients on an individual basis
- Wellness group inclusive of modules re: accumulating positive experiences, the basics of self-care
- Discussions of self-care actively incorporated into case management goal setting and planning

Healthy Relationships/Interpersonal Effectiveness

Strategies for building and maintaining positive and healthy relationships.

Examples:

- Models for conflict resolution within the organization
- Wellness group inclusive of modules including DBT interpersonal effectiveness strategies (GIVE skills; DEAR MAN skills; FAST skills)
- Psycho-education provided on healthy relationships and how to maintain them

Emotional Awareness and Regulation

Ability to recognise and make sense of your own and others' emotions. Ability to effectively manage and respond to emotional experience in both a spontaneous and socially acceptable way.

Example:

- CBT or DBT-based skills group
- Individual therapy focused on emotional awareness and coping
- Emotional regulation plan made with case manager (e.g., "When I am sad, I can...")

Managing Anger – Conflict Resolution

Ability to understand the message behind anger and express it in a healthy way without losing control. Ways for two or more parties to find a peaceful solution to a disagreement among them.

Example:

- CBT-based individual or group therapy focused on managing anger and building alternative strategies
- Emotional regulation plan made with case manager (e.g., "When I am angry, I can...")
- Models for conflict resolution within the organization

Managing Crisis – Distress Tolerance

In times of intense emotional intensity, strategies to get to a more manageable emotional place for crisis survival.

Example:

- DBT-based modules or skills group focused on crisis management skills (TIPP; Coping Ahead; Pros and Cons of acting on crisis urges)
- Individual therapy
- Individual crisis plans with clients and staff
- Organization-wide emergency safety plans and procedures
- Staff adequately supported in supporting clients in crisis (e.g., training, supervision, debriefing procedures)

Building Self-Esteem

Increasing overall sense of self-worth or personal value.

Examples:

- Group modules or workshops focused on self-esteem building
- Individual conversations highlighting strategies for increasing self-esteem/self-worth
- A strengths-based approach to case management/client care

Reducing Self-Stigma

Self-stigma refers to the internalization or absorption of negative attitudes towards a group (i.e. mental health consumers, homelessness). It also is linked with a greater tendency to catastrophize and with a reduced sense of personal control.

Examples:

- Group modules or workshops focused on self-stigma
- Building awareness and offering education on this phenomenon
- Individual therapy attending to the impact of self-stigma

Mindfulness and Relaxation Skills

Therapeutic techniques to focus one's awareness on the present moment, while calmly acknowledging and accepting one's feelings, thoughts, and bodily sensations.

Examples:

- Ongoing skills-based group focused building mindfulness practice (can also be a portion of a more general group)
- Individual teaching of mindfulness and relaxation skills
- Availability of mindfulness-based resources (e.g, audio clips, a list of online mindfulness resources and apps) readily available
- Individual plans incorporating mindfulness and relaxation strategies

Goal Setting

Involves the development of an action plan designed to motivate and guide a person toward a goal.

Examples:

- Informal and formal individual conversations about goal setting
- Group module(s) or workshops focused on how to make SMART goals
- Availability of handouts, graphics, fillable sheets, apps for clients

Budgeting

Creating and troubleshooting plans to spend money.

Examples:

- Informal and formal individual conversations about budgeting
- Group module(s) or workshops focused on budgeting skills (interactive, dynamic activities)
- Availability of handouts, graphics, fillable sheets, apps for clients

Time Management

The ability to use one's time effectively or productively, especially balancing employment, education, self-care, and social obligations.

Examples:

- Informal and formal individual conversations about time management
- Group module(s) or workshops focused on time management
- Availability of handouts, graphics, fillable sheets, apps for clients

Common Wellness Needs

Note: the terms below refer to clinical diagnoses that clients report or may be found in client documents and/or in speaking with their mental health practitioners.

Complex Post-Traumatic Stress

Diagnoses related to the psychological impacts of (repeated) trauma including but not limited to prolonged feelings of terror, worthlessness, helplessness, and disruptions to one's identity and sense of self.

Examples:

- Individual or group trauma-focused therapy
- Psychiatric management
- Building safety and safety planning within the organization through trauma-informed practices and policies
- Ongoing staff education, awareness and support

Substance Use Disorders

When a person's use of alcohol or another substance (i.e. drugs) leads to health issues or problems at work, school, or home.

Examples:

- Individual or group substance use focused treatment
- Clear policies on substance use within the organization
- Support for staff and clients in implementing substance use policies; exploring flexibility and consistency.
- Safety and harm reduction plans developed with clients and staff
- Medical management and care
- Inpatient, Day Treatment Rehabilitation

Borderline Personality Disorder

Marked by an ongoing pattern of varying moods, self-image, and behaviour. These symptoms often result in impulsive actions and problems in relationships. May experience intense episodes of anger, depression, and anxiety that can last from a few hours to days.

Examples:

- Individual or Group-Based Dialectical Behaviour Therapy Treatment
- Staff education and awareness on how best to work with clients experiencing trauma, BPD, and other challenges to emotional regulation and interpersonal relationship
- Ensuring adequate staff support and supervision
- Emergency and safety planning (Client, Staff, Organization)

Depression

Causes feelings of sadness and/or a loss of interest in activities once enjoyed. It can lead to a variety of emotional and physical problems and can decrease a person's ability to function across settings.

Examples:

- Individual or Group-Based psychotherapeutic treatment
- Outpatient, Day Treatment, Inpatient Medical/Psychiatric Care
- Wellness groups focused on self-care, emotional regulation, and daily activity
- Case management oriented to daily goal setting and activity based behavioural activation strategies
- Ensuring adequate staff support and supervision
- Emergency and safety planning (Client, Staff, Organization)

Social Anxiety

Involves a fear or anxiety about being humiliated or scrutinized in social situations. This fear causes significant distress or impairment in day-to-day functioning.

Examples:

- Individual or Group-Based psychotherapeutic treatment
- Outpatient, Day Treatment, Inpatient Medical/Psychiatric Care
- Case management-based planning and goal setting focused on gradual exposure
- Ensuring adequate staff support and supervision

Psychosis

Used to describe conditions that affect the mind, in which people have trouble distinguishing between what is real and what is not. When this occurs, it is called a psychotic episode. A first episode of psychosis is often very frightening, confusing and distressing.

Examples:

- Inpatient, Day Treatment, Outpatient Medical/Psychiatric Care
- Access to assessment and treatment
- Ensuring adequate staff education, support and supervision
- Emergency and safety planning (Client, Staff, Organization)

Autism Spectrum Disorder

A developmental disorder that affects communication and behaviour. Traits include difficulty with communication and interaction with other people and restricted interests and repetitive behaviours that hurt the person's ability to function in school, work, and other areas of life.

Examples:

- Organization and staff awareness and education
- Access to occupational, behavioural, psychological supports specific to ASD
- Client case management planning attending to differences in client functioning. Requiring flexibility and consistency from staff and organization.
- Ensuring adequate staff education, support and supervision

Intellectual Disability

A group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviours such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18.

Examples:

- Organization and staff awareness and education
- Access to occupational, behavioural, psychological supports specific to intellectual disabilities
- Client case management planning attending to differences in client functioning. Requiring flexibility and consistency from staff and organization.
- Ensuring adequate staff education, support and supervision

Traumatic Brain Injury

A form of acquired brain injury when a sudden trauma causes physical damage to the brain. Symptoms can be mild, moderate, or severe. Symptoms include headache, confusion, light headedness, dizziness, blurred vision or tired eyes, ringing in the ears, bad taste in the mouth, fatigue or lethargy, a change in sleep patterns, behavioural or mood changes, and trouble with memory, concentration, attention, or thinking.

Examples:

- Organization and staff awareness and education
- Access to occupational, behavioural, psychological supports specific to traumatic brain injury
- Client case management planning attending to differences in client functioning. Requiring flexibility and consistency from staff and organization.
- Ensuring adequate staff education, support and supervision

WORKSHEET #2

Trauma-Informed Care

Guiding principles of the service provision of mental health to youth experiencing homelessness include:

1. *Services MUST BE trauma-informed:*
   - The potential impact of previous traumatic experiences on past and current behaviour must be understood by all organizations and staff at a broad level.
   - Indigenous youth may not only be impacted by individual past experiences of trauma, but intergenerational influences that impact their mental health, as well as the mental health of their family and community. Understanding the historical context of the trauma experienced among Indigenous communities is necessary to provide individual trauma-informed care.
   - Mental health care must be provided by clinicians with experience, training and ongoing support in the delivery of trauma-informed care.
   - Organizations must seek to limit the re-traumatization of young people in their care. The experiences of homelessness and for many service usage itself, can be unavoidably re-traumatizing. Organizations should work to limit these effects through staff training, ongoing staff support, and organizational practices that reduce exposure to re-traumatizing events and circumstances.
2. *Trust*
   - Youth voice and input on programming design and implementation builds trust within the community and improves services (see Module 6 - Peer Support for more details).
   - Youth must be given the opportunity to build trust in relationships to individual staff, a program, or an organization as a whole. Opportunities for low-stakes exposure to programming, clinical staff, and the physical environment assist in building trust and engaging youth.
   - Meet and greets, introductory videos, phone calls, and text messages are a means of building relationships over time.
   - Endorsement of new programs/service providers by already trusted service providers is often key to successful care transition and engagement.
3. *Accessible and Flexible*
   - Services must be flexible enough to accommodate youth as they navigate periods of unavoidable and necessary transition in their lives.
   - Youth benefit from and are responsive to both choice in determining what they want and need from service providers, as well as clear boundaries with services and service providers.
   - Service provision in non-clinical environments, support in transportation to and from appointments/sessions, out of the box communication between sessions, and short wait times can increase youth engagement in mental health services.

Trauma-informed care 101

- Trauma: Refers to experiences that cause **intense physical** and **psychological** stress reactions. Experiences can refer to **one event,** a **series** of events, or a **set of circumstances** that is experienced by an individual as physically or emotionally harmful and have **lasting adverse effects** on the individual's physical, social, emotional or spiritual well-being (Pearlman & Saakvitne, 1995).
- Many youth who experience homelessness have been exposed to **Adverse Childhood Events** (or ACEs) such as childhood abuse and neglect that have long-lasting effects on physical and mental health, relationships, and overall wellness.

Trauma and the Developing Brain

Trauma causes the brain to adapt in ways that contributed to survival
(i.e. constant fight/flight/freeze)

These adaptations can look like behaviour problems in "normal" contexts

When triggered, the "reptilian" brain dominates the "thinking" brain

The normal developmental process is interrupted, and young people may exhibit internalizing or externalizing symptoms and behaviours that interfere with their daily functioning and are barriers to them reaching their life goals.

What behaviours might we see?

- ☑ Physical symptoms
- ☑ Poor emotional control
- ☑ Blowing up/lashing out
- ☑ Confrontational/control battles
- ☑ Overly protective of personal space/ belongings
- ☑ Over- or underreacting to loud noises or sudden movements
- ☑ Difficulty with transitions
- ☑ Emotional response doesn't match situations
- ☑ Depression/withdrawal
- ☑ Anxiety/worry about safety of self and others
- ☑ Poor or changed school/work performance/attendance
- ☑ Avoidance behaviours
- ☑ Difficulty focusing, with attention, memory, thinking
- ☑ Increase in impulsive, risk-taking behaviours
- ☑ Repetitive thoughts or comments about death or dying
- ☑ Non-age appropriate behaviour

What might be triggers for these behaviours?

- Unpredictable situations or sudden changes. E.g., new room; new routine
- Transitions. E.g., moving; change of worker; leaving shelter
- Conflicts, disagreements or confrontation. E.g., perceived face changes, or yelling
- Sights, sounds, smells, or other senses that remind of the trauma
- Feelings of vulnerability, powerlessness, or loss of control
- Experiences of rejection. E.g., break-up, trouble for breaking the rules
- Sometimes praise, positive attention and intimacy

A note on trauma and substance abuse:

- Youth who had experienced physical or sexual abuse/assault were 3x more likely to report past or current substance abuse than those without a history of trauma (Kilpatrick, Saunders, & Smith, 2003)
- In surveys of adolescents receiving treatment for substance abuse, more than 70% of patients had a history of trauma exposure (Funk, McDermeit, Godley, & Adams, 2003).
- Trauma is a risk factor for substance abuse
- Substance abuse is a risk factor for trauma

Trauma-Informed Care is an approach that **acknowledges** the existence and significance **trauma** (past and present) plays in the health and recovery of our clients. The approach includes **ensuring safety of both client and provider**; using supportive practices and environments to **engage** client (s); being client focused through **collaboration and choice**; and **acknowledging the strength and resilience** of the individual.

Keys to Trauma-Informed Care:

- realizing how often trauma occurs.
- recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce.
- responding by putting this knowledge into practice.

> *"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet."*
>
> *Rachel Naomi Remen, Kitchen Table Wisdom 1996*

A major challenge of youth homelessness service provision is the staff burn out and turnover. Trauma-informed care models must attend to this as a foundational aspect of implementation.

Compassion fatigue is the cumulative physical, emotional and psychological effect of exposure to traumatic stories or events when working in a helping capacity, combined with the strain and stress of everyday life (Cocker & Joss, 2016).

Burnout is about being 'worn out' and can affect any profession. The impacts of burnout emerge gradually over time and are easily identified to direct links and stressors within the working and personal life.

Integral to trauma-informed care is the implementation of organizational practices that attend to and reduce staff burn-out and compassion fatigue. A trauma-informed care model must include safety (both emotional and physical) for staff, as well as ongoing discussion, supervision and support in navigating challenges.

Further Reading

Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings:
https://www.homelesshub.ca/resource/shelter-storm-trauma-informed-care-homelessness-services-settings-free-access

Trauma-Informed Care for Street-Involved Youth:
https://www.homelesshub.ca/sites/default/files/attachments/Ch1-4-MentalHealthBook.pdf

An introduction to Dr. Sandra Bloom's Sanctuary Model for Trauma-Informed Care Implementation:
http://sanctuaryweb.com/

The TICOMETER is a tool that measures degree to which an organization is engaged in trauma-informed practices. It evaluates needs and progress in implementing trauma-informed care and ensuring its sustainability:
https://c4innovates.com/training-technical-assistance/trauma-informed-care/ticometer

Preventing Burnout Among Service Providers
https://www.homelesshub.ca/resource/31-preventing-burnout-among-service-providers

WORKSHEET #3

Building Your Wellness and Mental Health Group

Background

Main Goals of Group:

1.
2.
3.

Leader/Co-Leaders:

- Professional Background and Training Appropriate Fit for Population and Group Needs? (Y/N)

Setting:

- ☐ Accessible?
- ☐ Transportation support in place?
- ☐ Safety Considerations?
- ☐ Clinical vs. Non-Clinical Setting Options?

# of Sessions:

Length of Sessions:

Closed or Open Group:

- If closed, attendance requirement?

Structure of Sessions:

- Check-In
- Group Guidelines
- Main Learning
- Wrap Up
- Documentation Time

Engagement Plan

Recruitment/Advertising

Initial Plan:
Who?
How?
When?

Ongoing:
Who?
How?
When?

Topics Menu

For detailed examples and options, see: Developing a Trauma-Informed Mental Health Group Intervention for Youth Transitioning Out of Homelessness)

Top 10 Topics

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

The HOP-C South Wellness and Mental Health Group was created with the intention of providing youth transitioning from homelessness with non-intimidating, strengths-based, wellness and mental health support. This open group ran for 46 consecutive weeks in an arts-centric non-clinical organization. The two facilitators, a PhD level psychologist and a MA level Mindfulness Therapist, both came from trauma-informed and trauma-focused training backgrounds. The presence of two facilitators was an essential component of programming in order to be able to meet individual and group needs when particular challenges arose. The group was also attended by the HOP-C Peer Mentors who were participants in the group and were mentored in opportunities for co-facilitation.

Topics and rationale for inclusion can be found in **Developing a Trauma-Informed Mental Health Group Intervention for Youth Transitioning Out of Homelessness**

HOP-C North

The HOP-C North Mental Health support was provided by a MA level social worker with extensive experience working with Indigenous youth. Initially, she attended many non-mental health related groups as a means to build rapport and trust with the youth. The social worker provided both individual and group counselling to the youth. Individual sessions were conducted on an as-needed basis, allowing the youth to decide when and to what extent they accessed to support. Over time, the youth developed trust in the facilitator and began to seek interventions for specific mental health issues. She was flexible with her schedule which meant meeting youth at times and in locations that were accessible to them. Her understanding of Indigenous teachings was also an important component of the interventions she provided. For example, she utilized exposure tasks that were land-based, mindfulness exercises using smudging and drumming, and psychoeducation around cognitive behavioural strategies that incorporated the seven grandfather teachings.

WORKSHEET #4

Mental Health Group Trouble Shooting

Instructions: With all members of the clinical team, review at least three of these common scenarios and make a plan for how your team can plan ahead for these tricky situations: (Some of these situations may be more or less relevant to your particular context.)

1. A participant arrives to group heavily intoxicated, disrupting the flow and engagement of group.
2. A participant arrives to group very distressed, alluding to suicidal ideation, while checking in at the beginning of group.
3. A participant arrives to group heavily dysregulated, speaking quickly and constantly. They have difficulty pausing their speech for facilitators and other participants to speak. You notice that other participants are beginning to be frustrated and annoyed and the participant is not noticing this.
4. A participant in group has trouble following the content, you notice that they are becoming quietly frustrated as the group goes on.
5. A participant arrives too afraid to enter the group room alone and asks for their non-participating/ non-registered friend to sit in with them for the session.
6. There is a loss in the community, participants arrive to group upset and grieving this loss.
7. A participant arrives in group and informs you that they have lost their housing and do not have a place to stay tonight and don't know what they are going to do.
8. Two participants in the group have a conflict with each other outside of the group. When they arrive to your group one of the participants refuses to sit in the room with the other as they feel bullied and worried about interacting with the other participant.
9. The facilitators arrive to group and there is only one participant present, you notice that facilitators/ staff outnumber participants 4:1.
10. Unexpectedly, your group room is in use by another group or unable to be accessed. Your participants and facilitators are present.

For each, please consider:

- Define the main challenge of the situation
- Who's needs do you need to be aware of in this situation? (often multiple stakeholders)
- What are all the options for responding to this challenge?
- What are the pros and cons of each? Any rules or policies that must be considered?
- Who should be consulted when this arises?
- Who will implement the response and how?
- Considerations for documentation and follow-up?

HOP-C Example

A young woman, Alexa, with severe social anxiety arrives to group and requests that her sister be able to sit in on the HOP-C group this week. The group, while open to HOP-C participants, is closed to non-HOP-C participants to protect confidentiality. The young woman has struggled to get to programming and her appearance at group today is a significant step in service engagement for her.

1. *Define the main challenge of the situation*

   Wanting to support Alexa's step towards service engagement and wanting to set her up for success in the group. Concerns over breaking the rules/making exceptions around group confidentiality and the impact on maintaining rules in the future. Concerns over how other participants will feel about a non-HOP-C participant to sit in on group (i.e. more vulnerable, less comfortable). Potential for scarcity of resources (i.e. tokens for transportation, food, art supplies) and how that will be navigated with a non-HOP-C participant who we do not have the resource budget for.

2. *Who's needs do you need to be aware of in this situation? (often multiple stakeholders)*

   Alexa, HOP-C Participants, Alexa's sister, HOP-C Facilitators

3. *What are all the options for responding to this challenge?*
   - Make an exception in order to support Alexa, making it clear to Alexa that this is an exception and brainstorm other ways to support her in engaging in the group. Inform the group that a guest will be joining today.
   - Say no to Alexa's sister joining the group but offer alternatives such as going over group material with Alexa separately or setting her sister up with another activity nearby but outside the group room.
   - Allow Alexa's sister to join the group, not mentioning who or why she is there as to not disrupt the other participants.
   - Change design of weekly group to allow some sessions to include outside HOP-C guests, do not invite Alexa's sister in today but encourage Alexa and sister to return to one of these future groups. Ask participants for opinions on this and advertise the opportunity to everyone.

4. *What are the pros and cons of each? Any rules or policies that must be considered?*

Option 1:

PROS:

Allows Alexa to access group for the first time and engage in a way that she feels safe.

May result in Alexa gradually being able to attend the group on her own.

Other participants are given information and an understanding of why a guest is joining the group today.

CONS:

Client confidentiality comprised due to Alexa's sister attending group.

Other group members may feel vulnerable or uncomfortable with this arrangement.

Other group members may want to bring their own support people in the future to group; may be very difficult to make an exception for this group member and not others in the future.

Alexa may never return to group if her sister not allowed to attend future groups as well.

Option 2:

PROS:

Confidentiality and guidelines of group respected and remain consistent.

Alexa has the opportunity to benefit from group material without disrupting confidentiality of group.

CONS:

Alexa may be disappointed and frustrated given the effort it took to attempt to attend group today. She may not attempt to return to group in the future.

Alexa does not get to benefit from group support and the group does not get to benefit from her participation.

Option 3:

PROS:

Alexa will feel comfortable joining the group with her sister.

Both Alexa and her sister potentially benefit from attending the group.

Group members will assume Alexa's sister is part of HOP-C and won't question her attendance, will be seen as another participant.

CONS:

Alexa may be disappointed and frustrated given the effort it took to attempt to attend group today. She may not attempt to return to group in the future.

Alexa does not get to benefit from group support and the group does not get to benefit from her participation.

Option 4:

PROS:

Alexa will feel comfortable joining the group with her sister.

Both Alexa and her sister potentially benefit from attending the group.

Group members will assume Alexa's sister is part of HOP-C and won't question her attendance, will be seen as another participant.

CONS:

Alexa may be disappointed and frustrated given the effort it took to attempt to attend group today. She may not attempt to return to group in the future.

Alexa does not get to benefit from group support and the group does not get to benefit from her participation.

5. *Who should be consulted when this arises?*

   Group co-leaders, HOP-C participants, Larger Hop-C team at a later date

6. *Who will implement the response and how?*

   Group co-leaders will primarily be in charge of implementing the response. Having two co-leaders is very helpful in these scenarios as one leader can attend to the group, while the other helps to make Alexa feel welcome and takes time to explain the situation and course of action. Validation will be especially important in this interaction.

7. *Considerations for documentation and follow-up?*

   Following up with Alexa and her supports (i.e. case manager) later in the week. Should document group attendance, decisions made, and information shared.

WORKSHEET 5

Considerations for Individual Therapy Summary Sheet

Considerations for Individual Therapy in the youth homelessness context

Common needs:

- ☐ Complex Trauma
- ☐ Depression
- ☐ Anxiety
- ☐ Addictions
- ☐ Difficulty with emotional regulation
- ☐ Difficulties with relationships
- ☐ Challenges to self-care

Qualifications necessary:

- ☐ Well-trained therapist (Master's level counsellor, social worker or psychologist, PhD level Psychologist, Psychiatrist)
- ☐ Training in trauma therapy
- ☐ Engaged in clinical consultation individually or in a group as a means of reducing burn out, vicarious trauma, and managing the impact of engagement with complex and often high acuity clients
- ☐ Sensitivity and flexibility to work with highly marginalized populations

Clinicians must attend to:

- ☐ Boundaries in working with clients who may have difficulties preserving their own and others' boundaries. In addition to actively attending to the maintenance of boundaries, a consultative framework can assist the clinician in navigating challenging situations which may test their comfort level and interfere with therapeutic progress.
- ☐ Collaborative care that aims to integrate services and supports a client may already be accessing e.g., case manager, housing worker, psychiatrist, peer worker). With permission from the client, communication with these supports can meet further needs and can help to apply therapeutic work across contexts.
- ☐ Transparency and genuineness will allow for clients to connect and build trust over time. Many young people in the homelessness context have had failed relationships with systems of care (i.e. home, school, children's aid services, homelessness shelters). It is not uncommon for youth to react poorly to overly rigid/manualized modes of interaction that feel forced or false. Genuineness may often be understood as a marker of safety.
- ☐ Suicide risk assessment and crisis planning may be common needs in this work. Training, easily accessible materials, and a crisis communication plan within teams is an important element of clinical practice.

Modalities of treatment

- **A staged approached trauma-specific therapy** For many of the young people in the homelessness context, trauma therapy work will be limited to Stage 1 Trauma Therapy: Safety and Stabilization. Stage 1 Trauma Therapy is focused on the development of a sense of personal safety, cultivating a crucial self-care routine, and learning to regulate emotions and behaviours in a healthy and efficient way. The goal is to have these necessary skills become fully integrated into current daily life. For more information, see: Herman, J. (2015) Trauma and recovery. New York, NY: BasicBooks.
- **Dialectical Behaviour Therapy** (DBT) is a cognitive behavioural treatment that was originally developed to treat chronically suicidal individuals diagnosed with borderline personality disorder (BPD) and it is now recognized as the gold standard psychological treatment for this population. In addition, research has shown that it is effective in treating a wide range of other disorders such as substance dependence, depression, post-traumatic stress disorder (PTSD), and eating disorders. The four main modules composing a DBT curriculum include: Mindfulness, Distress Tolerance, Interpersonal Effectiveness, and Emotional Regulation. Much of this skills-based approach is relevant, applicable and effective with this population. For more information, see: Linehan, M. M. (2015). DBT Skills Training Handouts and Worksheets. New York: Guilford Press.; Miller, A. L., Rathus, J. H., & Linehan, M. (2007). Dialectical behaviour therapy with suicidal adolescents. New York: Guilford Press.
- **A concurrent focus on addictions treatment** is also relevant. For more information,, see: Najavits, L. (2002). Seeking safety: A treatment manual for PTSD and substance abuse. New York: Guilford Press.

Seeking Safety is an evidence-based model that can be used in group or individual counseling. It was specifically developed to help survivors with co-occurring trauma and SUD and, crucially, in a way that does not ask them to delve into emotionally distressing trauma narratives. Thus, "safety" is a deep concept with varied layers of meaning – safety of the client as they do the work; helping clients envision what safety would look and feel like in their lives; and helping them learn specific new ways of coping.

WORKSHEET #6

Summary Sheet of Mental Health Professionals and Evidence-Based Approaches

Who can provide mental health services and what can they provide?

The following websites provide accurate and detailed information on different mental health professions and the scope of their practices:

National Alliance on Mental Illness:
https://www.nami.org/Learn-More/Treatment/Types-of-Mental-Health-Professionals

Mental Health America:
https://www.mentalhealthamerica.net/types-mental-health-professionals

Evidence-based best practices in mental health care:

CAMH Best Practice Guidelines for Mental Health Promotion Programs for Children and Youth:
https://www.porticonetwork.ca/documents/81358/128451/Best+Practice+Guidelines+for+Mental+Health+Promotion+Programs+-+Children+and+Youth/b5edba6a-4a11-4197-8668-42d89908b606

Evidence Based Best Practices Databases:

Canadian Best Practices Portal:
http://cbpp-pcpe.phac-aspc.gc.ca/

SAMHSA:
https://www.samhsa.gov/ebp-resource-center

WHO DELIVERS MENTAL HEALTH SERVICES
The HOP-C South Example

Case Managers (Child and Youth Workers):
Provided regular check-ins in the community, assistance getting to and from appointments, help accessing both HOP-C specific resources (e.g., discussed opportunities to be involved in mental health and peer support with clients) and non-HOP-C resources (e.g., navigating referrals to an external furniture bank), and support as needed building skills (e.g., cooking with clients), navigating broader systems (e.g., mentoring communications with ODSP worker), or managing challenges of daily life. Close communication with the HOP-C psychologist facilitated case managers' provision of trauma-informed care and helped them to feel better supported when working with challenging or complex clients. Case managers and the psychologist were, with clients' permission, able to conference client needs and this allowed clients to have added support implementing coping strategies/considerations learned in individual or group therapy in their daily lives. Case managers could also flag and support clients to access specialized mental health services as the need arose, frequently providing an endorsement for the client beginning a relationship with mental health supports.

Peer Workers
Planned and hosted social community-based events, designed and implemented special skills-based projects for clients, and were available for individual meetings and phone check-ins with clients experiencing social isolation and loneliness. Peers established validating and hopeful relationships with clients in the community. Peers often provided active listening support, encouragement, and companionship in daily activities (e.g., studying in the library, walking to the subway together to get to an appointment). Close communication with HOP-C case managers psychologist enabled peers to navigate tricky situations as they arose and ensured quick access to further professional support as it became needed (e.g., when client reached out expressing suicidal ideation).

Post-Doctoral Fellow/PhD-level Psychologist
Co-led and designed weekly Trauma-Informed Wellness and Mindfulness Group and provided scheduled but flexible short-term and long-term trauma-informed and trauma-specific individual therapy to clients wanting to engage in these services. Ongoing and close communication with case managers and peers provided supervision and consultation on all HOP-C cases and allowed for wrap around care for clients engaged in mental health supports wherein goals and skills generated in therapy could be implemented in the community directly via client relationships with peers and case managers.

M.A.-level Mindfulness Therapist

Co-led and designed weekly Wellness and Mindfulness Group. Advised on ongoing client needs based on a mindfulness perspective and assisted in coordinating access to additional mindfulness-based events and resources for clients. Provided individual therapy to participants who completed the HOP-C program but could benefit from ongoing therapeutic intervention.

Project Lead/Supervising Psychologist

Supervision and support to all team members as needed and in weekly project meetings. Regular consultative and supervisory meetings with front-line psychologist in order to maintain and provide ongoing team-based approach to care.

Who Delivers Services: The HOP-C North Example

Youth Coordinators: Fostered nurturing and supportive relationships with each youth. They would help coordinate and attend appointments and pick them up and bring them to group sessions when needed. They would help youth navigate various services including attending related meetings when asked by the youth. They would regularly check in with the youth to see how they were doing and remained flexible with how they could best support them. The coordinators would also facilitate a monthly feast as means to check in with the youth. The coordinators understood the complexity of the issues facing the youth, including the difficulty they may have with engaging with services and with the coordinators themselves. When youth would be disruptive or antagonistic to the coordinators, they would remain consistent and patient in their support provided to the youth.

Peer Mentors: In HOP-C North, peer mentorship was not established at the onset but instead was a gradual process. Youth who engaged in the program eventually progressed into leadership roles at their own speed and as confidence in their own strengths emerged. HOP-C North provided youth the structure to explore their strengths (e.g., group leadership, cultural leadership, artistic mastery) and engage as peer mentors in ways they felt comfortable doing so. For instance, as one youth progressed through engagement with HOP-C, he began to engage with cultural practices regularly. He moved into a peer mentorship role which involved leading smudging at the beginning of each group and continuously immersed himself in cultural teachings.

Clinical M.A.-level Social Worker: Provided individual counselling sessions to youth on an as-needs basis and facilitated weekly group sessions. Individual sessions varied based on the needs of clients but included trauma-based therapy, Cognitive Behavioural Therapy (CBT) for anxiety, and Dialectical Behavioural Therapy (DBT) for difficulties with emotion regulation. Individual sessions also incorporated cultural teachings when possible. Group sessions involved DBT skills, CBT fundamentals, and psychoeducation on a variety of topics (i.e. self-esteem, sleep hygiene, assertive communication). Ongoing communication with youth coordinators occurred to best meet the needs of the youth. The provider also regularly attended non-mental health related groups to build and maintain rapport with the youth.

Project Lead/Assistant Director of Mental Health of facilitating organization: Provided support to each area of the team as needed. This included connecting resources and programs within the organization to the HOP-C North team. Also provided support in troubleshooting challenges that occurred at both the staff and organization level.

Project Lead/ Psychologist: Consultation and support to each area of the team was as needed. This included regular consultation meetings with the M.A. level Social Worker in order to help support the provision of mental health interventions.

HOP-C SOUTH CASE EXAMPLE

Mental Health Needs

Maria was a young woman who had experienced significant loss and trauma in her early life, including the death of her mother at a young age. She had previous diagnoses of Post-Traumatic Stress Disorder, depression, as well as non-verbal learning disability. Maria accessed HOP-C through the support of her case manager at one of HOP-C's partner agencies during the first month in which she moved from shelter to a low-support transitional housing program. Maria was experiencing difficulty motivating herself and balancing her life needs and daily schedule. She frequently reported feeling lonely and isolated in her new housing arrangement. Maria was introduced to and advised to engage in HOP-C group and individual mental health supports, as well as peer support, by her HOP-C case manager.

Over time, Maria established a close-knit net of support within HOP-C. In her individual mental health sessions work focused on managing emotional distress in high stress scenarios (i.e. grounding, coping with difficult situations), interpersonal effectiveness (i.e. how to approach people in ways that adequately met her social needs while also setting boundaries with those who might pull her into more negative scenarios), as well as goal setting and self-care in daily life. These skills were enhanced and supported by her regular attendance at the HOP-C Wellness and Mindfulness Group at which Maria became an active participant. Maria and her case manager quickly built a strong relationship and her case manager helped her navigate difficulties with her roommates as they arose (in close contact with her psychologist in order to help her implement interpersonal effectiveness strategies she was working on in therapy), as well as to navigate practical supports such as ODSP funding, school applications, and assistance with making a weekly budget.

Maria also developed a strong relationship with a HOP-C Peer. Maria asked the peer to study with her in order to help her stay motivated and engagd in her academic pursuits after generating this strategy in individual therapy. Maria found that the outings and supportive social contact with a caring and enthusiastic peer helped her feel less isolated and more engaged in her new community.

Staff (Case Manager, Peer and Psychologist) would regularly discuss Maria's engagement, goals, and progress in their weekly team meeting in order to maintain communication and wrap around care among the team.

HOP-C North Case Example

Jennifer was a young mother who resided in geared-to-income housing. She struggled with severe symptoms of social and generalized anxiety and found it difficult to attend public settings without becoming overwhelmed. She had previously been diagnosed with both anxiety and PTSD and had experienced a variety of abusive and unhealthy interpersonal relationships. The HOP-C team began to facilitate programming in Jennifer's building, and from here she was able to access the program with the support of the building's Program Coordinator. Although attending group programming was difficult for Jennifer, she pushed herself to attend on a weekly basis as she found the content of the program to be beneficial and enjoyable. The barrier-free nature of the program allowed for her to attend the program in the comfort of her building with her child present, which made it easier for her to attend.

Shortly after Jennifer joined the program, she was able to connect with the HOP-C Counsellor for weekly individual counselling sessions to address her anxiety. These sessions were exposure-based in nature and focused on treating symptoms of social anxiety, addressing negative core beliefs, and managing distorted thought patterns through cognitive restructuring. As time went on, Jennifer became increasingly comfortable with speaking up in the group. Eventually, she was willingly relating her own experiences to the program's subject matter with the group. Jennifer was approached by the HOP-C team and offered the position of Peer Mentor- she was to be compensated weekly for her contribution and engagement with the group. This opportunity allowed for Jennifer to offer valuable insight about her own experiences during weekly groups, and she served as a role model for other participants who had questions about the effectiveness and practicality of the skills and ideas discussed in group. As Jennifer settled into her role, she began to make a habit out of showing up early to prepare coffee and snacks for the group as well as assist the facilitators in preparing the materials for the program. She was able to offer insight as to which topics the participants would find beneficial and was able to speak on these topics from her own perspective in the group setting. Jennifer reported an increased sense of self-confidence and self-efficacy due to taking on the Peer Mentor role.

WORKSHEET 7

Walking in Balance

Purpose: The purpose of this worksheet is multi-dimensional. Primarily, it serves as a reminder to engage in proper self-care in order to live a balanced life. However, it can be used as an educational tool for individuals and service providers to reflect on as you learn about topics such as addiction, mental illness, or other wellness concerns.

It is said in Ojibwe teachings that there are four aspects of the self: mental, emotional, physical, and spiritual. Teachings say that in order to live "the good life", or "Bimaadzwin", we need to do our best to ensure we are taking care of each of these domains. When these domains are balanced, it is said that we are "walking the red road", or living a life of balance according to the teachings of the Creator. When we take time to self-reflect and look closely at each of these domains, we may find there are aspects of us that may have been put on the backburner due to the stresses of life, illness, or simply because we are too busy to notice. This activity allows us to check in and take a moment to reflect inward.

We can apply the 7 Grandfather teachings of *respect, love, humility, wisdom, honesty, bravery,* and *truth* to our daily lives by treating ourselves- and others- in a way that is in line with these teachings. When we take stock of how we are mentally, emotionally, physically, and spiritually functioning, we are embracing these very teachings. We are checking in on our wellness out of respect and love for ourselves. We are humble and honest with ourselves in understanding that we may need to make changes to our lives in order to improve each of these domains. We are exercising wisdom and bravery in understanding that we cannot function at our very best when we are feeling run-down or depleted in one or more domains. We live our truth when we choose to engage in fulfilling activities to restore our balance.

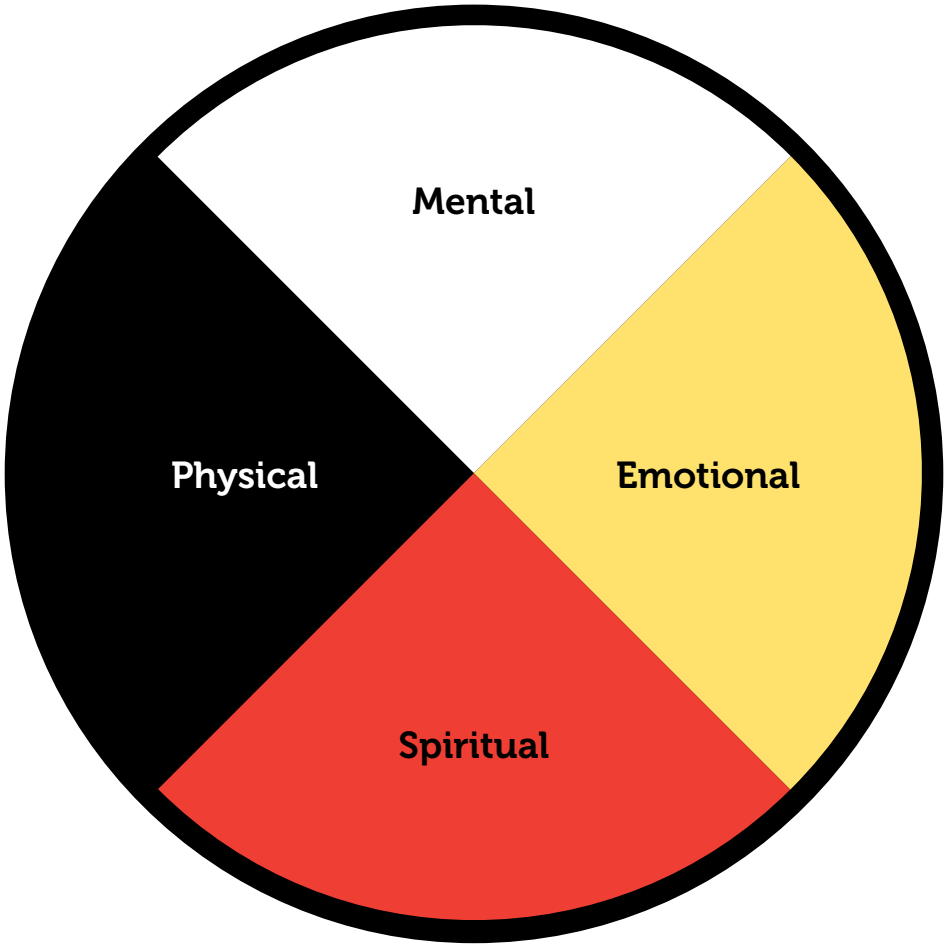
Instructions

This worksheet is designed to be as fluid as possible to ensure the teachings can be applied to a number of topics and situations.

When utilizing this worksheet to address self-care, take a moment to check-in with yourself and reflect on these domains. Be as honest as you possibly can, and ask yourself: am I living a balanced life right now? Utilize the attached worksheet to either write down where you are feeling depleted, or utilize the worksheet to brainstorm ways in which you can work on increasing your capacity in each domain.

Alternatively, the attached worksheet can be used in group discussions or individual counselling to reflect on educational topics pertaining to mental health. For example, how might homelessness impact the four aspects of the self? How might we utilize such a tool when discussing addictions recovery? How can we utilize such a tool to identify and foster individual strengths within each domain?

Walking in Balance



Mental	Emotional	Spiritual	Physical

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