2.6 DEVELOPING A TRAUMA-INFORMED MENTAL HEALTH GROUP INTERVENTION FOR YOUTH TRANSITIONING OUT OF HOMELESSNESS

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CONTEXT & EVIDENCE

Young people who are homeless experience converging and amplified risk due to their developmental stage, as well as the stress, risk behaviours, and associated trauma that often accompany becoming or being homeless. They tend to be immersed in environments characterized by multiple adversities over their lifetime and it is generally agreed that the mental health of these youth is poorer than that of youth who are housed. Most youth report that their mental health problems began before they left home (Craig & Hodson, 1998; Karabanow et al., 2007). Life on the street and the adversity that accompanies homelessness exacerbate these pre-existing mental health issues. Youth not only lack the basic necessities of shelter and food (Tarasuk & Dachner, 2005), but they also face constant and pervasive threats to their safety and well-being in the form of physical and sexual assault and other types of victimization (Karabanow et al., 2007; Whitbeck et al., 2000). Research has found almost universally high levels of mental health issues among youth who are homeless, with rates ranging from 48% (Kamieniecki, 2001) to as high as 98% (Hodgson et al., 2015; Merscham, Van Leeuwen, & McGuire, 2009). The impact of trauma is particularly salient. Coates and McKenzie-Mohr (2010) found that over 50% of youth who are homeless experience severe effects of traumatic stress.

Most youth with mental illness who are homeless do not receive any form of treatment (Kamieniecki, 2001; Slesnick & Prestopnik, 2005). The barriers to accessing care are readily apparent in the low capacity of community service agencies to provide care for individuals with more severe mental illness. Youth who are homeless also face barriers to psychiatric care (Kidd, 2013). Studies suggest that these youth are often reluctant to access healthcare services because of difficulty navigating the healthcare system, few clinic sites, lack of coordination among service providers, inconvenient operating hours, and long waitlists (Edidin, Ganim, Hunter, & Karnik, 2012).

Currently, the dominant approach to intervention is crisis response, often in the form of general drop-in and emergency shelter services, which, as McKenzie-Mohr et al. (2010) point out, tend to use reactive approaches focused on meeting basic needs and providing education, employment, and skills training (Klodawsky, Aubry, & Farrell, 2006), with the goal of placing these youth into responsible and productive roles in society.

There exists only a small group of studies examining the impact of shelters, drop-in centres, and intervention approaches on youth mental health (Slesnick, Dashora, Letcher, Erdem, & Serovich, 2009), and evidence of the effectiveness of these interventions is generally lacking or unclear (Kidd et al., 2016). While some specific interventions show promise, in general, models that are effective with other marginalized populations have not demonstrated clear benefit for youth (Altena, Brilleslijper-Kater, & Wolf, 2010; Slesnick, et al., 2009). Furthermore, intervention models that target homelessness itself as the core problem (with a focus on housing, employment, and school engagement) are criticized for overlooking the influences of trauma and mental health on the situations and choices of youth. The implications of these challenges are clear, evidenced by very high mortality rates in this population, with drug overdose and suicide as the leading causes of death (Rew, Taylor-Seehafer, & Fitzgerald, 2001).

While few studies have investigated the efficacy of interventions targeted at the broader mental health and wellness needs of youth who are homeless, even less is known about youth who are in the process of transitioning out of homelessness. Many youth experience protracted and complex pathways out of homelessness, with significant challenges in securing decent quality of housing, employment, and engagement in education. For example, one study found that 24% of those recently housed experience a loss of stable housing in a one-year period (Frederick, Chwalek, Hughes, Karabanow, & Kidd, 2014); the remainder struggle greatly with social isolation, complex trauma symptoms, poor physical health, and other challenges (Kidd et al., 2013). The more protracted the process of transitioning out of homelessness, the greater the difficulty youth have in achieving a decent quality of life and a sense of engagement in non-homeless communities, relationships, and self-concepts (Kidd et al., 2016). To date, only a very small and under-developed literature exists on the development and feasibility of comprehensive, evidence-informed, accessible interventions for youth who are homeless and youth attempting to exit the homelessness cycle.

OVERVIEW

This chapter describes the development and delivery of a mental health group intervention for young people, aged 16–26, who are in their first year of transitioning from homelessness to independent living. This intervention was developed as a piece of a broader pilot intervention that sought to develop a feasible, integrated set of supports for youth within their first year of transitioning to stable housing. The group intervention described is a particularly relevant effort in this transitional time when the pressures of daily survival have to some extent
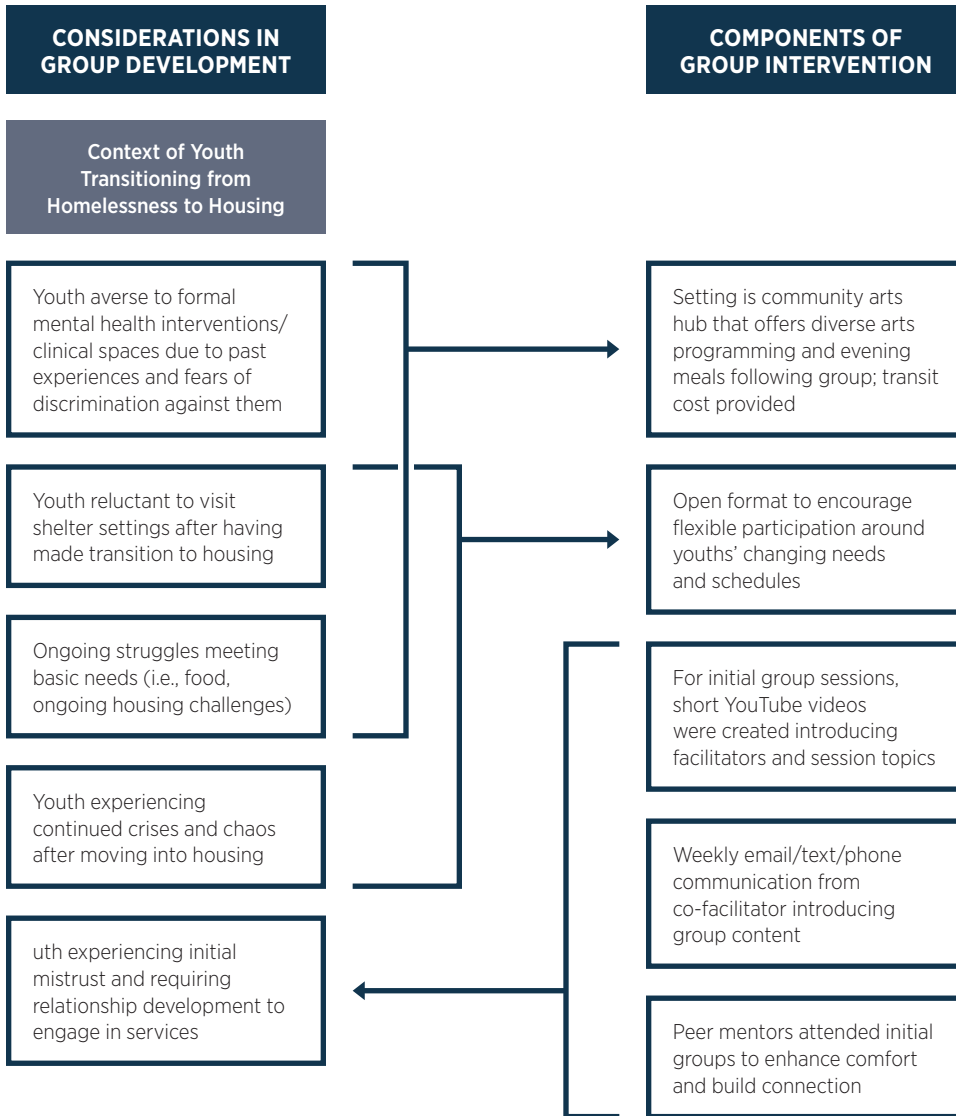
ameliorated, and most youth are struggling to address mental health challenges and develop new coping mechanisms relevant to non-street contexts. The intervention aimed to provide mental health support to a population of youth who often have difficulty engaging with traditional mental health services, despite experiencing significant changes in daily living, increased social isolation, and ongoing mental health needs, as well as having histories of maltreatment and complex trauma. This endeavour is particularly timely given the recent wave of Housing First for youth initiatives that have arisen globally, which highlight the need for developmentally appropriate and practical social and mental health supports to coincide with basic housing for youth (Gaetz, 2014; Hodges, Ferreira, Israel, & Mazza, 2006).
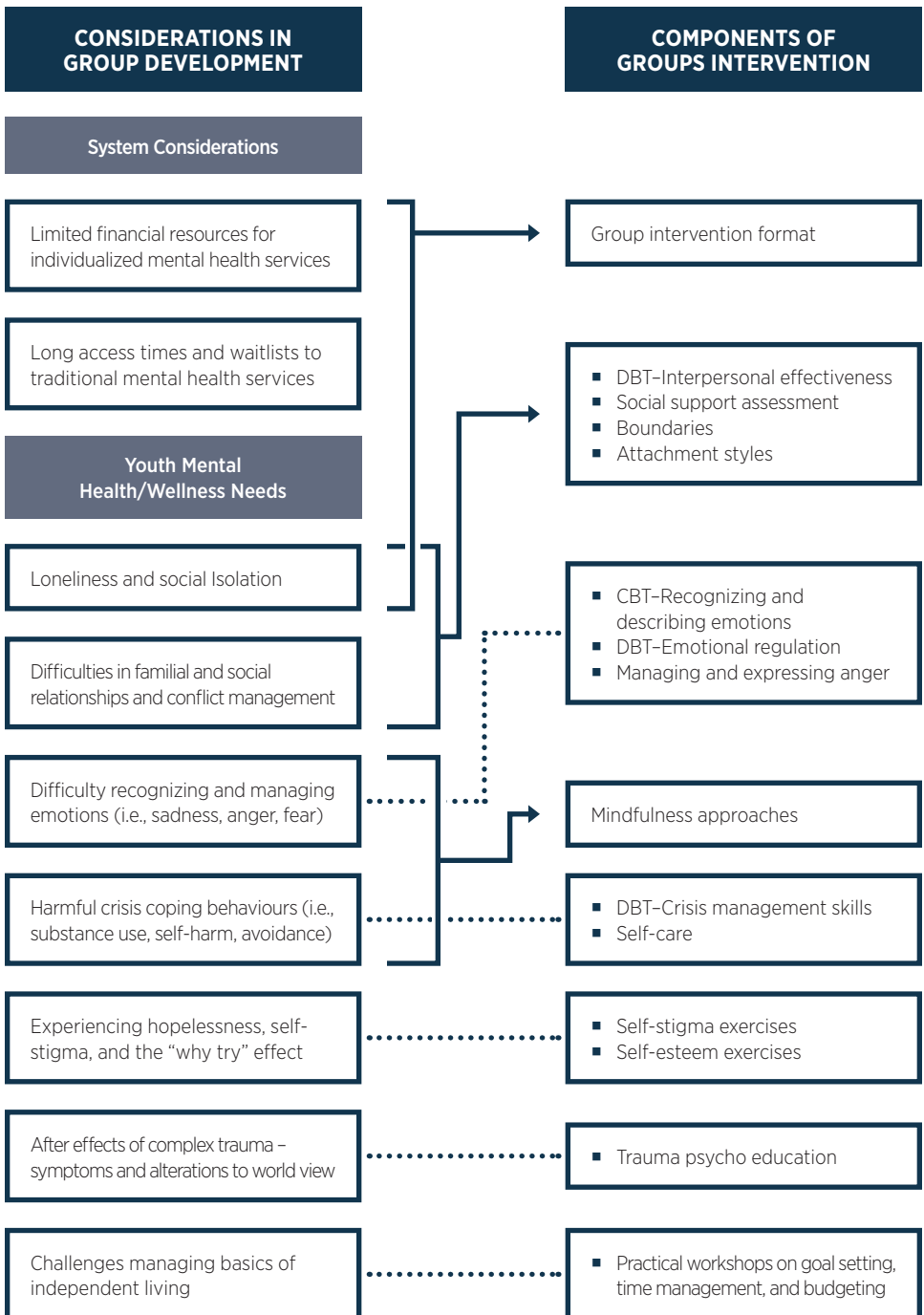
INTERVENTION DEVELOPMENT PROCESS

Key aspects of the challenges faced by youth transitioning to housing include loneliness, maintaining hope, psychological distress, and challenges establishing a sense of meaning, purpose, and place through the transition process. Participants in the Kidd et al. (2016) study reported experiencing mental health challenges, and the re-emergence of symptoms of complex trauma, in particular. In response to these identified needs, as well as in an attempt to maximize often finite clinical and community resources, we aimed to design a weekly group intervention. Given the evidenced high need for but chronic lack of mental health services for these youth, as well as the extremely limited knowledge base on the efficacy of mental health interventions with this population, this group intervention represents a novel investigation into the development and delivery of mental health services for youth who are transitioning from homelessness to housing.

The development process for the intervention included a review of current literature in the area of clinical intervention with precariously housed youth, as well as the broader emerging adult intervention literature, in order to identify promising evidence-based materials. Using a broad team consultation method, which included experts in the fields of youth homelessness, mindfulness, and dialectical behaviour therapy, as well as our broader intervention staff (i.e., peer mentors, case managers, researchers), and our community organization partners, key intervention domains and materials were vetted and prioritized. This process identified 10 key intervention domains with multiple modules in each. The group development process continued throughout the provision of the group, as participants' requests and needs were integrated into group content. Several significant development considerations and their integration into group structure and content are mapped out in Figure 2.6-1.

**FIGURE 2.6-1: HOUSING OUTREACH PROGRAM COLLABORATION WELLNESS &
MINDFULNESS GROUP DEVELOPMENT**

CONSIDERATIONS IN GROUP DEVELOPMENT	COMPONENTS OF GROUP INTERVENTION

Context of Youth Transitioning from Homelessness to Housing

Youth averse to formal mental health interventions/ clinical spaces due to past experiences and fears of discrimination against them

Youth reluctant to visit shelter settings after having made transition to housing

Ongoing struggles meeting basic needs (i.e., food, ongoing housing challenges)

Youth experiencing continued crises and chaos after moving into housing

uth experiencing initial mistrust and requiring relationship development to engage in services

Setting is community arts hub that offers diverse arts programming and evening meals following group; transit cost provided

Open format to encourage flexible participation around youths' changing needs and schedules

For initial group sessions, short YouTube videos were created introducing facilitators and session topics

Weekly email/text/phone communication from co-facilitator introducing group content

Peer mentors attended initial groups to enhance comfort and build connection

CONSIDERATIONS IN GROUP DEVELOPMENT

System Considerations

Limited financial resources for individualized mental health services

Long access times and waitlists to traditional mental health services

Youth Mental Health/Wellness Needs

Loneliness and social Isolation

Difficulties in familial and social relationships and conflict management

Difficulty recognizing and managing emotions (i.e., sadness, anger, fear)

Harmful crisis coping behaviours (i.e., substance use, self-harm, avoidance)

Experiencing hopelessness, self-stigma, and the "why try" effect

After effects of complex trauma – symptoms and alterations to world view

Challenges managing basics of independent living

COMPONENTS OF GROUPS INTERVENTION

Group intervention format

- DBT–Interpersonal effectiveness
- Social support assessment
- Boundaries
- Attachment styles

- CBT–Recognizing and describing emotions
- DBT–Emotional regulation
- Managing and expressing anger

Mindfulness approaches

- DBT–Crisis management skills
- Self-care

- Self-stigma exercises
- Self-esteem exercises

- Trauma psycho education

- Practical workshops on goal setting, time management, and budgeting

INTERVENTION COMPONENTS

SESSION LOGISTICS

Sessions were 90 minutes long, including a 15-minute break for provided meals. The group was held in a non-clinical setting, in our case, a community arts hub, in order to limit barriers to participant engagement, including stigma associated with receiving treatment in formal settings such as hospitals and agencies serving youth who are homeless, associations to previous challenging experiences with formal service settings, and triggers that can attend contacts with youth post-transition. The group was open, meaning that any participant could attend any given week and attendance was voluntary. Other than the criteria for involvement in the broader intervention (aged 16–26, formerly precariously housed, and currently stably housed), there were no inclusion or exclusion criteria based on mental health or cognitive functioning.

TRAINING

Co-facilitators of the intervention were a post-doctoral–level clinical psychologist with specific expertise in trauma, and a master's-level mindfulness therapist who was completing her doctoral training in clinical psychology. Given the degree of youth participants' complex clinical needs (i.e., often multiple mental health comorbidities; high incidence of complex trauma; ongoing instability in relationships, housing, and mental health), it was essential that clinicians had a high level of professional training in mental health care. Training in approaches to trauma-informed care and treatment was a particular asset as group discussions and relational dynamics often necessitated a trauma-informed approach. Future iterations of this group should be facilitated by at least one mental health specialist (i.e., psychologist, psychiatrist, experienced master's-level social worker) with expertise in trauma. Our group benefited from the expertise of a mindfulness therapist with experience engaging youth and adults from diverse contexts in mindfulness practice. With at least one mental health specialist as lead facilitator, co-facilitators can be other care professionals who interact with youth in different contexts (e.g., case managers, nurses, peer support workers) and can be supported by a lead facilitator.

GROUP FORMAT

Participant-generated group guidelines (3–5 minutes to review/discuss/revise; 20–30 minutes to develop initially). During the group's first sessions, group participants developed a set of group guidelines that could be modified in subsequent weeks. These guidelines were reviewed at the beginning of each session and participants were given the option to add, modify, and discuss any guidelines on the list.

Optional participant check-in (10–20 minutes, depending on group size). Participants were given time for a flexible narrative exploration of past and present challenges and successes following the practice principles of process-oriented group psychotherapy (Yalom & Leszcz, 2005).

Interactive teaching and application of wellness skills (30–40 minutes). An eclectic group of evidence-based coping skills based on dialectical behaviour therapy (Linehan, 2015) and cognitive-behavioural therapy frameworks, as well as other topics of relevance and interest to the group (self-care, self-esteem, trauma psychoeducation, self-stigma, practical skills such as budgeting, goal setting, and time management) were delivered weekly. Research suggests that among at-risk youth and individuals experiencing complex trauma, emotion regulation, interpersonal effectiveness, and mindfulness coping strategies are feasible and effective (Cloitre et al., 2011; Kerrigan et al., 2011; McCay et al., 2015).

Mindfulness-based intervention (15–20 minutes). Easy to engage in mindfulness activities were offered at each session. They were chosen each week to relate to the wellness skill presented in the session. After each mindfulness practice, the group debriefed the experience of the practice, as well as its potential utility in daily life. Mindfulness-based interventions have previously been demonstrated as feasible with youth who are homeless (Grabbe, Nguy, & Higgins, 2012).

GROUP CONTENT

Much of the content was developed in advance of the group, based on broader research on effective group intervention and specifically with young marginalized populations. Several additional topics were developed based on the suggestions and needs of participants. For example, the practical skills sessions (budgeting, goal setting) were not initially planned but were developed in response to suggestions by participants. Table 2.6-1 outlines session topics, rationale for inclusion, and selected references.

TABLE 2.6-1: GROUP TOPICS, RATIONALE FOR INCLUSION, & SELECTED REFERENCES

DIALECTICAL BEHAVIOUR THERAPY	
Group topics	**Rationale for inclusion**
Interpersonal effectiveness Relationship skills/Arguing 101 (GIVE and DEARMAN skills); validating self and others; keeping your self-respect in conflict (FAST skills); saying "no" and setting boundaries	The need for enhanced interpersonal effectiveness skills permeated across life domains for many participants. Participants regularly identified ongoing difficulty with managing conflict and maintaining boundaries across relationships and circumstances.
Emotional regulation Wise, reasonable, and emotional mind; self-care/accumulating positive experiences; PLEASE skills for self-care; distracting and soothing coping skills	Coping with emotional distress, particularly feelings of frustration, anxiety, and sadness, was an important goal for many participants. Maintaining mental and physical balance, building positive experiences, and coping with difficult emotions were emphasized.
Crisis management Quick coping techniques (TIPP skills); identifying a crisis and STOP skills; healthy vs. unhealthy coping	Sessions on crisis management were intended to build and expand participants' repertoire of skills and coping techniques for dealing with emotional crises. Skills that were immediate, hands-on, and easy to use were a predominant focus.
References Deschene (2013); Miller, Rathus, & Linehan (2007); Linehan (2015); McCay et al. (2010); Rathus, Miller, & Linehan (2015)	

COGNITIVE-BEHAVIOURAL THERAPY	
Group topics	**Rationale for inclusion**
Emotion awareness Recognizing and describing emotions and experiences (thoughts, feelings, behaviours): myths and facts about emotions; anger, sadness, happiness, fear	Sessions focused on myths and facts about emotions, as well as identifying thoughts, feelings, bodily sensations, and behaviours associated with the experience of emotions. Participants often discussed "turning off" and lacking awareness of their emotional states. Sessions focused on the importance of being able to identify and understand one's emotions and parsing one's experience into its component parts (thoughts, emotions, body sensations, behaviours).
Managing and expressing anger Anger management strategies; barriers to expressing anger (conflict styles); conflict resolution	Participants discussed difficulty managing anger when threatened or in conflict, as well as difficulties feeling safe expressing anger. Sessions centred on practical tips for expressing anger in an assertive and safe way.
References Centre for Mindfulness Studies (2015); Centre for Mindfulness Studies & Jaime C. Bulatao, SJ Center for Psychology Services (2015); Kendall, Choudhury, Hudson, & Webb (2002); Wilansky-Traynor & Warling (2011)	

OTHER MODULES	
Group topics	**Rationale for inclusion**
Self-care Maintaining life balance; self-care checklist; pleasurable activities; nourishing/depleting activities	Sessions focused on maintaining both essential self-care (i.e., safety and health), as well as wellness-based self-care to maintain mental and physical health. Sessions aimed to help participants maintain balance, reduce stress, and shift from managing crises of survival to managing daily stress and balancing daily responsibilities.
Relationships Social support assessment; relationship boundaries; relational styles (attachment styles)	Activities focused on participants observing and identifying both strengths and weaknesses in their current social relationships. This included discussions of how relationship to others may change throughout participants' transitions away from homelessness and into housing.
Self-esteem Identifying and acknowledging positive traits; Howard's rules of unconditional self-worth; positive affirmations	Sessions took a strengths-based approach to identity exploration as emerging adults. These sessions focused on identifying and acknowledging participants' personal strengths and discussions of negative vs. positive thinking patterns.
Self-stigma Myths and facts about homeless youth; the "why try?" effect	Self-stigma may serve as a risk to social isolation, as well as a significant barrier to engagement in needed services. Sessions focused on correcting myths about homelessness and youth to reflect participants' truths.
Trauma-specific Posttraumatic stress psychoeducation	A psychoeducational session helped participants better understand the body's response to trauma, as well as symptoms of posttraumatic stress disorder (PTSD) and complex PTSD.

References

Bartholomew & Horowitz (1991); Centre for Mindfulness Studies (2015); Corrigan, Larson, & Rusch (2009); Fisher (2009); Home Alive (2015); Najavits (2002); Schiraldi (2001); Teen Talk (2016); Yanos, Lucksted, Drapalski, Roe, & Lysaker (2014)

PRACTICAL SKILLS	
Group topics	**Rationale for inclusion**
Goal setting Setting goals (SMART goals); long- vs. short-term goal setting; time management	Sessions focused on practical ways to plan for both short- and long-term goals. Applied practices with real goals were used. Challenges and barriers to goal setting and achievement were also discussed.
Budgeting Mindful money management; budgeting game	Practical budgeting tips along with a real-world based budgeting game were presented at the request of participants.
Guests/workshops Ask a criminal lawyer anything; ask a formerly precariously housed youth anything; mindfulness drumming and photography workshops	These engaging workshops were open to the broader community and highlighted novel mindfulness or art activities, or specific areas of knowledge identified as relevant to participants.
References Academic Success Center (n.d); Blair (2015); Locke & Latham (2002)	

MINDFULNESS	
Group topics	**Rationale for inclusion**
Introduction to mindfulness What is mindfulness?; seven attitudes of mindfulness	Participants received an introduction to mindfulness practice and its benefits.
Mindful movement Light stretching; walking; confidence and power pose	Movement-based mindfulness practices were often easier for participants to engage in because they involved activity. At times, movement could also be experienced as overwhelming. Participants were asked to "take care of their bodies" and only do movements that felt comfortable.
Short mindfulness practices Loving-kindness practice; taking in the good practice; three-minute breathing space; mindful self-compassion; SOBER practice (for urges); STOP practice	Easy to engage mindfulness practices lasting one to three minutes were offered and discussed across several sessions to introduce mindfulness practice and its utility in daily life.
Mindful communication Mindful speech; mindful listening	Mindful communication tied in well with interpersonal effectiveness groups and offered strategies for attentive and careful communication.
Mindful awareness Five senses exploration (touch, smell, taste, sight, hearing); mindful eating; sense and savoury walk	These activities focused on awareness of the environment and sensory experiences. The aim was to build participants' capacities to remain in the moment and to focus on the present.
References Bowen, Chawla, & Marlatt (2010); Burggraf (2007); Center for Mindfulness Studies (2015); Center for Mindfulness Studies & Jaime C. Bulatao, SJ Center for Psychology Services (2015); Germer (2009); Goldstein (2012); Hanson (2005); Segal, Williams, & Teasdale (2013)	

IMPLEMENTATION CONSIDERATIONS

MEETING BASIC NEEDS BEFORE ENGAGING YOUTH WITH MENTAL HEALTH INTERVENTION

In order for youth to be able to able to engage in any meaningful way with a mental health group intervention, it is necessary that their basic needs are met, such as nourishment and shelter (long-term residence or shorter-term shelter housing). The intervention must take place in a safe and secure environment, where youth are not fearful for their physical or emotional safety. Youth in immediate crisis or whose primary needs are not met will very likely struggle to engage and benefit from this intervention. Likewise, the group format is generally inappropriate for youth who are actively intoxicated. That being said, it is likely that substance use, management of withdrawal symptoms, and urges to use substances will be clinical needs for some group participants. Facilitators should be prepared to discuss and offer strategies to manage these needs. The current intervention generally took a harm reduction approach and welcomed youth at various stages of substance use recovery.

PROVIDING OPPORTUNITIES TO BUILD RELATIONSHIPS

Often, participants were enrolled in the larger project for many months before attending their first group. Some expressed reluctance to attend initially because they were unfamiliar with the setting, group leaders, and fellow participants. Participants indicated that having an already trusted connection introduce them to the group, often a case manager, or having the opportunity to meet with group facilitators individually before attending the group helped establish safety in the group. Some participants commented that short videos, hosted by the co-facilitator of the group, allowed them to check out who was running the group and eventually make the decision to attend.[1] Once participants were enrolled in the larger project, the weekly communication via text, phone, and/or email was maintained, reminding them of weekly group and topics covered. Generally, frequent communication and opportunities to build personal connections and trust prior to beginning the group improved chances of engagement. Future iterations of this group could implement individual orientation sessions for participants, as is often done before commencing more formal group treatment.

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[1] For an example of a video, see www.youtube.com/watch?v=TuIB7hX87iw&t=22s

TAKING A FLEXIBLE APPROACH TO SERVICE DELIVERY FOR YOUTH IN TRANSITION

Due to the open style of the group, attendance was difficult to predict on any given week. It was common for participants to go through phases of engagement, disengagement, and re-engagement depending on other aspects of their lives, such as school and work commitments, mental health, and their general management of life events and responsibilities. Many participants who attended the group frequently for several months at a time eventually "graduated out" of the group by moving into job and school programs that, understandably, dominated most of their time. Many of these participants maintained a sense of connection with group co-facilitators after they had stopped attending the group, either through ongoing individual therapy work or via email/phone check-ins and updates on their continued transitions (i.e., moving away for work/school, beginning a new job, participating in training programs). Given that youth transitioning from homelessness were undergoing, by necessity, shifts in multiple life domains over the course of their involvement in the intervention, we found that a flexible approach to service provision was essential.

USING A TRAUMA-INFORMED FRAMEWORK & KNOWLEDGE

Many participants had been formally diagnosed with or would likely meet formal criteria for PTSD or complex PTSD. Given the high rates of maltreatment and traumatic stress among youth who are homeless (Coates & McKenzie-More, 2010; Kidd et al., 2016), the intervention was developed using a trauma-informed framework. Participants quite often asked questions about the impact of trauma and about trauma-related symptoms, even during the presentation of topics that did not seem to be related to trauma. Particularly in sessions about identifying and expressing emotions, relationships, and interpersonal effectiveness, participants wanted to know how and why trauma-related symptoms develop, and how to cope with them.

Youth often discussed experiences of further retraumatization and marginalization within service contexts that were not trauma informed. In response to participants' expressed needs, we developed psychoeducational group sessions that focused on trauma.

Our trauma-informed approach involved other features:

- Both co-facilitators had backgrounds in trauma-informed care and/or trauma-specific treatment.
- Group rules encouraged participants to take safe breaks from topics if they needed to.
- There was a strong focus on present-minded coping techniques to help participants manage trauma-related reactions and symptoms.
- Individual support was available for participants outside of the group setting.

Facilitators who are trained and able to engage with participants around trauma are an essential component of trauma-informed group interventions with youth who are homeless.

SOLICITING FEEDBACK & USING RESOURCES THAT ENGAGE YOUTH

Participants indicated that most material presented in the group was relevant to their lives. They were regularly prompted for suggestions to ensure that topics were meaningful and interesting. In the pilot intervention, practical transition-specific groups focused on goal setting, time management, and budgeting were developed based on participant requests. Participants were responsive to this; for example, following a budgeting group session presented in game format, one participant independently modified the game to better capture the life experiences of young people transitioning to independent housing. A mixture of pre-planned and adapted topics helped balance group content and engagement.

Weekly sessions were designed to include highly engaging materials that spanned various modalities, such as games, role play, and humorous or inspirational videos illustrating skills and topics. Clips from popular movies and TV shows illustrated the use of particular skills. Through role play, participants learned and practised interpersonal effectiveness skills. They also engaged in playful hands-on activities across sessions. For example, a budgeting game taught real-world skills in a fun and engaging manner. An activity that required the group to pass multiple objects to one another around a circle emphasized the importance of balance in various life domains. Sessions involved accessible mindfulness practices that engaged the senses (e.g., making and eating ice cream sundaes, listening to music, smelling teas). They also included movement and mindfulness activities practised in novel settings, such as a large urban park.

MANAGING INDIVIDUAL DIFFERENCES & CRISES

The pilot intervention took an open format, with no mental health inclusion or exclusion criteria. This meant that participants often had different clinical needs and profiles. For example, some participants had active substance abuse needs while others did not, and, at times, clear differences in cognitive and learning profiles were evident. As a result, participants sometimes struggled to relate to one another's experiences or had to catch up on group material through repetition or re-explanation. In addition, a few times a participant's level of distress was challenging to address and contain in a group context. These challenges emphasized the critical need for two facilitators to lead the group, with one attending to the participant in need of extra support while the other focused on leading the other participants. Despite these occasional challenges, participants were consistently respectful, patient, and kind with one another.

Grounding strategies were also used to contain and support participants experiencing high levels of distress. For example, facilitators invited distressed participants to take care of themselves by remaining in the room in the position (e.g., lying down, sitting, standing) or space (e.g., near or at some distance from the group) that most suited them in the moment, or by leaving the room to enter a safe nearby space where facilitators could later check in with them. We also used post-group check-ins and communicated with participants' broader care teams for ongoing monitoring. Future iterations of the group could involve an initial screening process to determine whether participants' individual mental health needs could be addressed in a group setting or whether individual treatment would be more appropriate.

OFFERING A GATEWAY TO SERVICES

In our experience, the open-format group seemed to serve as a gateway to accessing additional formal mental health services for about half of our participants. Many participants went on to engage in individual therapy, while others attended mindfulness and dialectical behaviour therapy groups at partner community organizations. Several participants reported having begun their own daily mindfulness practice as a result of their group experience. Many went on to make connections to broader programming such as peer-led social activities, as well as arts and community activities via partner organizations. Given that youth who are homeless are often reluctant to trust service and

mental health professionals, this style of "no pressure" open-format engagement seems to help them develop the trust and confidence to participate later on in more individualized, in-depth, and closed-format services.

KEY MESSAGES FOR PRACTITIONERS

Young people transitioning from precarious housing can be engaged in mental health and wellness group activities. It is too often believed that young people experiencing homelessness cannot or will not effectively engage in mental health and wellness care. Our experience indicates that this is not true. While there are challenges to constant and consistent engagement, a flexible approach to intervention with these youth, who by necessity are undergoing multiple transitions in several life domains at once, is essential.

Relationship building is key. The more opportunities for introductions and relationship building that participants have before attending the group, the higher the likelihood of engagement. We strongly recommend individual orientation meetings with potential participants in future iterations of this group. Short summary videos of group content, as well as weekly outreach from and access to group facilitators through email, text, phone, or web are also effective ways to build relationships.

Trauma-informed groups, practitioners, and broader systems are essential given the pervasiveness of trauma-related mental health difficulties and symptoms among young people who are homeless. Both research and our experience with this group intervention highlight the significant trauma-related needs of young people experiencing homelessness. Our participants often discussed experiences of further retraumatization and marginalization within service contexts that were not trauma informed and that these experiences often served as a deterrent from seeking out community, mental health, and housing services. Participants often discussed and asked questions about the impact of trauma in their daily lives. This means it was essential that facilitators be well trained to address these issues. Trauma-informed approaches to self-care, grounding, and participant safety are critical to group interventions.

Group interventions may serve as a stepping stone to other services and care. Our experience indicates that attendance in an open-style group may be the gateway into other mental health and wellness services, including more formal group treatment and

individual therapy. As young people experiencing homelessness are often hesitant to trust mental health and other service professionals, this kind of "no pressure" engagement and introduction to mental health and wellness care helped many participants build the trust and confidence they need to go on to engage with more individualized and in-depth services.

CONCLUSION

Given the complex needs, varied levels of acuity, and ongoing challenges faced by young people experiencing the cyclical nature of homelessness and transitions to independent living, the delivery of mental health services to this population has traditionally been viewed as quite challenging and has typically been inconsistent and idiosyncratic, if it has existed at all. Certainly, typical methods of measuring intervention feasibility and effectiveness are extremely challenging to implement with this population. As such, systematic trial-and-error efforts for service provision, such as the one we have described, are often the critical first level of investigation into effective treatment models. Future investigations will examine the design and feasibility of the group for unique populations (i.e., settings with a predominantly Indigenous clientele), as well as the effectiveness of the group as a briefer (8–12 sessions), stand-alone intervention for youth who are homeless or who are transitioning with support from community-based shelters and service organizations.

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