


# An Exploration of Facilitators and Challenges to Young Adult Engagement in a Community-Based Program for Mental Health Promotion

Global Qualitative Nursing Research  
Volume 7: 1–14  
© The Author(s) 2020  
Article reuse guidelines:  
sagepub.com/journals-permissions  
DOI: 10.1177/2333393620922828  
journals.sagepub.com/home/gqn  


Anne Marie Creamer<sup>1</sup> , Jean Hughes<sup>2</sup>, and Nicole Snow<sup>3</sup>

## Abstract

Adolescence and young adulthood can be particularly daunting for those with mental health concerns. In one Canadian city, a community-based drop-in psychosocial mental health center (Center) was designed specifically for youth who self-identified as struggling with mental health issues. The purpose of this study was to identify the features of the program that promoted or discouraged engagement. Narrative inquiry was used to guide the project. One-on-one interviews were conducted with 10 Center users. Four major categories were identified: (a) Reasons for Coming: Motivated to Work on Goals; (b) Facilitators of Engagement and Beyond; (c) Challenges to Engagement; and (d) Benefits of Engaging: Finding My Way. These categories were further delineated into themes. All participants had experienced trauma, and the Center assisted them in their coping. The researchers believe that to aid recovery, agencies working with this population need to use trauma-informed and healing-centered engagement.

## Keywords

young adults, mental health, engagement, community program, trauma-informed care, Canada

Received January 22, 2020; revised March 22, 2020; accepted March 30, 2020

The World Health Organization (WHO, 2015) estimates that 10% to 20% of children and adolescents worldwide experience mental disorders, and three quarters of all mental illnesses develop by their mid-20s. Furthermore, in a study of Canadians aged 15 years or older who reported having a mental health care need within the past year, one third stated that their needs were not fully met (Sunderland & Findlay, 2013). Without appropriate supports and services, young adults in particular will struggle to accomplish their developmental tasks that include thinking and behaving autonomously, negotiating relationships and adapting to physical and sexual changes, as well as defining and achieving their life goals (Shlafer et al., 2014). Furthermore, research has shown that the mental health of young adults is closely linked with the nature and pattern of adverse childhood experiences (Ho et al., 2019). Yet, young adults frequently do not seek services in a timely fashion (Salaheddin & Mason, 2016) and, even when they do, there are often service gaps that contribute to further delays and with time, problems may worsen (WHO, 2018). For the purpose of this article, the term “young adult” will be used to identify our study population.

## Literature Review

Although a number of studies have examined the multiple struggles experienced by young adults seeking community mental health services (Barczyk et al., 2014; Ferguson, 2009; Hartley, 2017; Narendorf et al., 2018; Petersen et al., 2015), there is also a need to examine ways of promoting engagement with these supports. In consulting the literature, there was a dearth of information pertaining to young adult engagement with drop-in mental health services or programs. One study by Eklund and Tjörnstrand (2013) explored motivation in a cross section of adults aged 18 to 65 years (mean age = 46 years) participating in community mental health rehabilitation day centers in Sweden. These individuals

<sup>1</sup>Horizon Health Network, Saint John, New Brunswick, Canada

<sup>2</sup>Dalhousie University, Halifax, Nova Scotia, Canada

<sup>3</sup>Memorial University of Newfoundland, St. John's, Newfoundland, Canada

### Corresponding Author:

Anne Marie Creamer, Nurse Practitioner, St. Joseph's Community Health Centre, Horizon Health Network, 130 Bayard Dr., Saint John, New Brunswick, Canada E2L 3L6.  
Email: acreamer@ualberta.ca



indicated that the opportunities for “social interaction and meaningful activity” as well as having some structure to one’s day (p. 442) were of great importance. The participants also noted that the opportunities to learn new skills and knowledge to increase one’s employability were incentives to attend. While the results of younger and older adult participants were not separated, a review of literature pertaining to young adults accessing community mental health services yielded similar evidence to that of older adults. Both Barczyk and colleagues (2014) and Hartley (2017) found that *social support*, in various forms and from various sources, proved to be an important factor in increasing the resilience of individuals addressing mental health and social challenges. In addition, others have found that the presence of *non-judgmental and caring staff* increased the propensity for service use (Garett et al., 2008; Hartley, 2017; Hudson et al., 2008; Kozloff et al., 2013; Thompson et al., 2006). For example, in Hartley’s (2017) study, participants described this as staff being approachable for conversations, and being “warm, friendly and down to earth” (p. 845). Also worthy of consideration was the presence of a home-like comfortable physical environment, which was found to assist some participants with a mental health concern to feel “normal” (Petersen et al., 2015). Other key considerations to engagement have been found to include flexibility and less formal service environments along with a high level of confidentiality (Thompson et al., 2006). Individuals want to have open communication with their mental health workers. In addition, having relevant information and a sense of control have been found to foster a more positive view of the future (Hartley, 2017).

Factors that reduce engagement with drop-in services include services that are located in inconvenient locations, have limited opening hours, have long waitlists, and have age restrictions (Garett et al., 2008), while participant factors include current substance use (Bantchevska et al., 2011; Garrett et al., 2008; Shim et al., 2017).

## Center Background

In 2012, a strengths-based intervention for young adults, aged 16 to 29 years, struggling with mental health needs was established in a small Atlantic Canadian city having close to 12,000 individuals within the age group (Statistics Canada, 2016). A community-based psychosocial mental health center was designed specifically for this population, to help address this service need. Developed by a handful of “on the ground” healthcare providers, community stakeholders, young adults, and their families, the program was designed as a *walk-in* service for young adults with a *self-identified* and *self-defined* mental health problem; yet, participants also could be formally referred. The Center focused on recovery through learning, engagement, goal setting, and enhancing positive social relationships to improve emotional, social, and psychological well-being. The Center included a team of

mental health, clerical, and peer mentor staff. Peer mentoring—involving people with lived experience of mental health problems—was chosen, given that it is a “system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful” (Pelletier, 2019). Staff also provided assistance with issues such as housing, education, health, employment, and social opportunities. Set in an older building in the city hub, the Center provided a comfortable, nonclinical space with a kitchen, fireplaces, and various formal and informal meeting rooms that allowed for a range of activities including art, music, games, cooking groups, and office space. Other activities included volunteering (e.g., walking animals at the SPCA and serving supper at a local church), in-house education programs (such as GED courses, mental health and addiction talks), as well as social gatherings (e.g., bowling) and opportunities to practice social communication. In addition, volunteers provided opportunities for members, defined as those young adults who attend, to engage in sports activities.

The Center shared the building with a dental clinic—a purposely chosen location to reduce stigma among participants who feared being seen accessing a mental health facility. It was close to the bus route, and within close walking distance of two high schools. Although in a separate location, it is also a component of the local community mental health program. The Center was designed to be an innovative community model for expansion across the province as part of the Transformational Research in Adolescent Mental Health (TRAM) initiative. Its aim is to improve services to this population through “innovation in early identification, rapid and flexible access, and appropriate care that is engaging, compassionate, sensitive and evidence-informed” (Canadian Institutes of Health Research, 2014, p. 9).

## Purpose

The Center had been operating for 7 years when we began our study but little was known about the perspectives of young adults who had engaged in the program or which factors they found most, or least, helpful in promoting their engagement. It was important to understand these factors and the impact that they have on promoting young adult mental health. Therefore, the purpose of this study was to answer the questions: What are the features of the program that promote, or discourage, engagement among young adults? Second, we wanted to explore the participants’ perspectives on these promoters and discouragers.

## Method

Narrative inquiry (Duffy, 2007) was used to gather participants’ stories, and the meanings they derived from their experiences. The stories that people build about their experiences and the choices they make explain the “why” of how

they live their lives (Berger & Quinney, 2005). Narrative inquiry provides a means for researchers to develop an understanding of the context in which each participant's story is rooted (Clandinin, 2013). By engaging in this reflexive practice, individuals telling the story can consider their past in a meaningful manner (Berger & Quinney, 2005) and build an understanding of themselves which, in turn, has more influence than a verifiable truth.

Narrative inquiry was ideally suited to understanding why people engaged, or not, in the Center because research participants were allotted control over the creation of meaning (Riley & Hawe, 2005). Using this approach, the researchers posed broad, open-ended questions to begin the development of a comprehensive narrative.

### **Ethics**

This study received approval from the regional health network's Research Ethics Board and ethical integrity was maintained throughout. Written informed consent was obtained. The research team members all have mental health clinical experience. We proceeded with this research from a place that acknowledged the ethical considerations of individuals who have mental health problems. We also recognized the obligation to conduct this work while balancing the need to be respectful and to do no harm (Smith, 2008).

### **Recruitment**

Posters regarding the study were placed in the Center, the local mental health clinic and addiction centers, on the program's Facebook site, and the local Community Health Center (CHC). Center members could make contact with the researcher on their own, and Center staff also identified potential participants and provided them with a summary of the study containing an invitation to contact the researcher to learn more. Furthermore, all members, including those who had attended previously but then stopped coming were contacted by text and/or e-mail, if available, on at least three separate occasions, at a minimum of 2-week intervals. In conducting narrative inquiry, the process can be slow and not amenable to a large number of participants (Clandinin, 2013). As a result, the plan was to conduct in-depth interviews with 16 to 20 purposefully selected individuals, with approximately one half of the participants (8–10) to be recruited among those who were currently engaged in programming at the Center. The other participants were to be those who had visited, but did not return, after a maximum of three visits. Attempts were made to ensure a diverse sample in terms of gender and age range. Inclusion criteria involved young adults who spoke English and were able to provide informed consent. Because one of the investigators was also a mental health clinician, her patients were not included in the study. If the interviewer suspected that the participant was unable to understand the

study to provide consent, and/or was intoxicated on substances, the interview would be canceled or rescheduled.

### **Participants**

Ten participants who engaged with the program regularly were recruited and interviewed. They included six males and four females aged 19 to 29 years. While the study also intended to interview participants who attended with the Center fewer than 4 times, only one potential participant communicated interest in participating but did not leave a method of contact.

### **Data Collection**

Interviews were conducted at the local CHC in a private meeting space. The researcher informed participants before beginning the interview that (a) the interview would be audio-recorded, then transcribed and identifiers removed; (b) all information would remain confidential unless it involved harm to self or others, in which case a report would be made to the appropriate mental health service; and (c) they could stop the interview at any time. If a participant became distressed, the researcher planned to offer assistance in the form of a referral, or if desired, the researcher would provide a list of relevant services that the participant could contact on their own.

The initial interview proceeded after the consent form was signed. Participants were asked to tell their stories about (a) how they came to the program, (b) their experiences while there, (c) the impact that being a part of the program had on their life, and (d) what their life would have been like if they had not come. If we had recruited participants who left the program, we intended to ask (a) why they left and (b) what they thought it would have been like if they had continued to engage.

Detailed, specific descriptions and meanings of participants' stories were elicited, beginning with the questions mentioned above. Interviews ranged in length from 23 minutes to almost 2 hours 40 minutes. Participants were invited for a second interview with a plan to review, clarify, and add any new information since the first interview. Seven of the 10 participants returned for a second interview. The time between the first and second interviews ranged from about 6 weeks to 9 months. Of the three participants who did not return, one declined a second interview, and another agreed to return but did not attend either of two scheduled meetings. The remaining participant who came for one interview became a patient of one of the investigators shortly after and, therefore, as per the study admission criteria, became ineligible for the second interview. Participants were remunerated for each of the two interviews.

The length of time between the first and second interviews with participants ranged from about 6 weeks to 9 months for a number of logistical reasons, including challenges in

contacting the participants. Of the 10 study participants, four of the seven who returned for a second interview reported that they currently were engaging with the Center.

### Data Analysis

Each interview was transcribed and initial analysis started. Thematic analysis was conducted, in keeping with narrative inquiry. The interviews were transcribed following each interview, read and then re-read, looking for the everyday stories in the participants' lives (Parse, 2001). Interesting features in the data were manually coded in a systematic fashion and collated into potential themes that were named and defined. Once analysis revealed no new information or emerging categories in the stories, recruitment ceased. All three investigators independently coded each interview, and the analyses then were reviewed together and compared by at least two, and in many cases, all three investigators. Member checks were requested once data analysis was completed to ensure that the themes accurately captured the participants' perspectives and to guide consideration of future practice (Brit et al., 2016). Unfortunately, only two participants completed the member check; the other participants were unavailable or they declined to meet.

### Findings

During the thematic analyses, four main categories about engagement were identified (see Table 1). These included (a) Reasons for Coming: Motivated to Work on Goals; (b) Facilitators of Engagement and Beyond; (c) Challenges to Engagement; and (d) Benefits of Engaging With the Program: Finding My Way. In addition, in telling their stories, participants had common experiences in being traumatized and isolated.

Without being asked, all but one of the research participants disclosed having at least one self-reported or clinician-determined psychiatric disorder, including learning disabilities, substance abuse and dependence, post-traumatic stress disorder, schizophrenia, hypersexuality, brain injury, Asperger's disorder, difficulty with comprehension, depression, anxiety, obsessive compulsive disorder, attention deficit hyperactivity disorder, oppositional defiant disorder, and borderline personality disorder. Eight of the 10 participants were referred to the program by their mental health worker, and two were encouraged to attend by another Center member. In addition to being unemployed and/or living in poverty, all identified a history of severe physical and/or emotional trauma, including witnessing an unexpected parental death as a child, being homeless and witnessing, or being the victim of, violence.

Several had been involved with mental health services when they were younger and some revealed a chaotic lifestyle, including insecure housing and substance use. For example, Participant 9 described the trauma of being a young

**Table 1.** Engagement Categories and Themes.

I. Reasons for Coming: Motivated to Work on Goals	Pushing themselves to meet their goals
II. Facilitators of Engagement and Beyond	
1. Creating a Safe Space	A comfortable place to be
2. Building Trust	I feel safe, secure, and not judged
3. Encouraging Growth	Helping to push my boundaries
4. Helping to Connect	Making new friends
5. Helping to Transition Forward	I'm working on my goals now
III. Challenges to Engagement	
1. Center Focused: Staff Overlooked Their Responsibilities to the Members	
a. Concerns about confidentiality	Feeling exposed
b. Feeling judged	Am I being rejected? Why do I deserve that?
c. Importance of staff engagement	Being prepared for change
2. Participant-Centered Challenges	
a. Challenges of member dynamics	Who and how many members engage make a difference
b. Personal struggles	My own stuff affects my going to the Center
3. External Factors: Weather, Finances, and Physical Space	Things beyond my control get in the way of my going there
IV. Benefits of Engaging: Finding My Way	
1. Feeling Safe and Developing Trust	The Center is there for me
2. Building Community	
a. Enhancing interpersonal and life skills	Feeling more positive and confident with people
b. Finding someone like me	Realizing that I am not the only one with a mental health issue
3. Process of Building a Way Forward: A Purposeful Life	
a. Building a truer understanding of me	Growing to like myself
b. Finding purpose and giving back	Doing something positive for myself and others
c. Feeling hope and setting goals for the future	Looking forward to a more positive future
d. Taking control/feeling empowered	I am able to do things differently
e. Developing insight into the effects of engagement	If I hadn't gone, I think I'd be in a really bad place

child and alone with her mother when she suddenly died. The participant did not know how to use a cell phone and "had to climb over her (mother's) body to use the washroom. . . . And it was pretty traumatic . . . I was a really messed up kid." Another individual (Participant 8) described being raped by a cousin and an uncle. This individual also witnessed his mother being beaten by a man who was known to be

dangerous: “He started breaking into my house. He tried to burn down my house” (P8). Another participant (P2) told of having gasoline splashed on him while someone threw rocks at his head when he was a child. He was not safe even in his family unit:

[A family relative] slammed this great big metal horse swing . . . into the back of my head and . . . my dad told me stories about him and this other buddy, head butting me as a game when they were drinking as if to cause brain damage [when I was 2 years old].

These histories are an integral part of participants’ personal stories and, for many, the experiences powerfully influenced how they interact with the world. Many expressed concerns about being able to meet and trust others, and were often very sensitive about how interactions transpired between Center staff and members.

Eight of the research participants also described feeling alone and/or unprotected a lot of the time. For some, isolating oneself from others had become a coping strategy to manage distrust. For example, Participant 9 said that when she was out on the street she would avoid people while walking. Participant 10 talked about having agoraphobia and how, coupled with surviving an abusive relationship, it affected her functioning in daily life: “if it weren’t for school and work I wouldn’t go out . . . I lost all my independence and I was slowly isolated from the friends that I did have because of how abusive my ex was” (P10). Others also described *feeling alone* as not having a social group, or something to do with their days.

Between interviews, circumstances had changed for some participants; in some cases, life had become more positive and for others, life had become more challenging. Some continued to attend and be active at the Center while others stopped attending for a number of reasons. One participant had planned to move to a lower level of home care but did not follow through, while another had a drug relapse, was in a methadone program, and did not engage with the Center because of transportation issues. Two participants had gotten married, but their financial situations did not allow them to live with their spouses. Another had to alter her education plans because of emotional struggles, but was still motivated to progress. These changes and struggles highlight the variable nature of young adulthood and the need to ensure that mental health support continues to be available to members when they become older (i.e., “age out”) and no longer qualify to attend the Center.

The researchers did not explore specific demographic details (such as gender identity, sexual orientation, and ethnicity, nationality, religion, culture, education, or specific trauma history) unless the participant raised the topic. The Center itself collects only basic demographic data from its users. The researchers approached the interviews and data collection process from a place of individuals having control in telling their story, as they wanted it to be told.

### *Reasons for Coming: Motivated to Work on Goals*

Participants described being motivated to work on goals as the impetus for attending the Center and beginning the engagement process. One participant explained,

Like the reason I came here is [Mental Health workers] told me I should come here for my anger and ah, they said ok, we have other people here that are here for the same reason. Ah, this is some of the things we do for anger management. . . . And she went over a couple of strategies . . . she went over that one right away with me. She was like, if you ever feel angry, this is one of the quickest ways to relieve it. And to this day I still use that. . . . And, I calm right down, I don’t know why it works, I’m amazed by that. (P8)

However, for some, even attending the Center in the beginning was a challenging process. Some were very anxious going in the building for the first time, and it took significant motivation to attend.

Other participants attended the Center as it simply offered a place to go and to live for oneself.

. . . it helped me in a way to just be, live for myself and like do things on my own and like. . . . And just independently go there to make myself better rather than have all these people above me direct me and make me go to all these places. . . . Like I wanted to get better and I wanted something, I needed all the resources I could get. (P9)

### *Facilitators of Engagement and Beyond*

Once participants made the decision to attend the Center, they described practices that promoted their engagement in the recovery process. These were grouped into five themes: Creating a safe space, Building trust, Encouraging growth, Helping to connect, and Helping to transition forward. Staff members played an integral role in this process.

*Creating a safe space.* Given the participants’ traumatic personal histories, as well as the precarious and sometimes dangerous situations in which they were occasionally living, the Center needed to build a dependably safe environment. Several features contributed to this feeling of safety. Participants described the physical environment as being comfortable, like a home, given its noninstitutional setting where they could not be identified as mental health consumers and, therefore, they felt less likely to be stigmatized. Furthermore, the participants stated that staff modeled positive interactions and addressed tough interactions in constructive ways.

I needed it because I didn’t have work to go to, you know what I mean, I had nowhere else to go that was positive, you know what I mean? . . . The people, like the guests there, can really bump up my self-esteem a lot. I find I get a lot of compliments there from the staff too, you know what I mean, that I don’t . . .

that I never really got at work when I had that mental breakdown . . . (P4)

**Building trust.** Trust was a key element of engagement for the members as noted by a participant who said, “don’t, don’t trust anybody until they, they prove to you that they can be trusted” (P6). For most participants, trust only began to develop when participants felt they were in a “safe” space in which staff and fellow members were supportive, nonjudgmental, and open to each other:

She’s a good woman [staff member], you know like, just that instant . . . when you are there you feel really safe and secure and you know it’s confidential, you know, she’s really trustworthy . . . She’s helped me out through a lot of stuff. Helped me kind of see the bigger picture. She’s like your personal shrink. It’s really cool . . . I find the past 2 years, I’ve really grown a lot when it comes to really seeing the bigger picture. (P6)

**Encouraging growth.** Participants stated the staff supported their personal growth and pushed their boundaries in many ways. They helped the participants with job applications, and transported them to medical appointments and job interviews. Participants had opportunities to participate in healthy social gatherings or in learning groups and were provided opportunities to volunteer at community events (such as serving at a seniors’ supper) and agencies (such as dog walking at the SPCA), and to develop artistic abilities. They viewed the staff’s individual skill sets as vitally important because, as noted above by Participant 6, many of the participants identified specific staff who played critical roles in their recovery journey. In addition, participants supported each other’s growth, regardless of the individual’s past. For example, a participant who had experience with drug use discussed how Center attendance helped with his cravings:

So when I was going to [the Center], you know the cravings went away. The drugs are no longer in my life now, I just want to turn my life around . . . then when I started doing better, like where I am at right now, at the group home, when I started going to [the Center] and I enjoyed it, I stopped hanging around with those friends. (P1)

This participant also reported that his ability to live more independently had improved with Center attendance:

To tell you the truth, I am going to be moving because the group home I am at is a level 4 group home . . . they say I am doing so good that I am going to a level 2 group home, where there is hardly any supervision and you can do more stuff freely. . . . So tomorrow, I am going to be looking at houses, seeing which house would be good to go to. (P1)

**Helping to connect.** Having a safe place to grow and make healthy friendships countered the isolation that many participants felt. Several activities promoted healthy connections

including a monthly social get together, eating a sit-down meal together, participating in scheduled discussion time by choosing a submitted topic from a sombrero, and volunteering to walk dogs at the local SPCA, or serve dinner to seniors. One participant shared pictures she had taken of paintings she did with another Center member on piles of snow behind the building (P5). Another spoke of art activities that helped her connect with others.

Yeah, just, hmm, just really vibes from, ’cause . . . if [in the art room] someone was drawing there and I was drawing here and we had our right side of our brains working, you’d stop for a second, be “oh, hi, I’m [name].” And you’d start conversation and make a new friend. . . . your energies kind of collide a little bit and you make a friend. (P9)

**Helping to transition forward.** Almost all participants reported that they had met, or were in the process of meeting, their goals. Some reported not attending regularly for positive reasons such as finding a job, returning to school, and feeling that they had met their personal goals. However, the recovery journey was not a linear process. And while some participants described returning to the Center when they had a setback, another participant reported having a drug relapse and feeling too embarrassed to return. Furthermore, participants reported that staff did not call Center members if they did not come regularly, and instead left it to the member to inform them if and why they stopped attending; however, they noted that staff were always available to encourage members to take the next step forward:

[The staff were] trying to nudge me, ’cause I more often than not, kind of just, like, see something on the resume or something like that and worry. And they’ll be like, “it’s probably nothing. Try it anyways.” So it’s like, ok, so it’s a little confidence boost, while, while giving me a push [chuckles] off the diving board that I need sometimes. . . . ’Cause I get nervous, well and a bit of a procrastinator at the same time. So, it’s good for that, that they’re good to kind of give me a nudge . . . (P7)

### Challenges to Engagement

The participants provided some insight into the challenges they experienced in maintaining their engagement with the Center. These challenges were divided into three themes: Center-focused, Participant-focused, and External. These themes were further subdivided and organized into various groupings of experiences and contextual considerations that contributed to the difficulties that participants encountered while attending.

**Center-focused challenges.** The Center-focused challenges often related to the staff, some of whom (according to participants), in their actions and responses, appeared to be overlooking their responsibility to recognize and acknowledge the participants’ vulnerability. There was no indication

given by participants that this staff behavior was intentional or routine. Instead, it was more so evident in staff oversights and misunderstanding of the context and challenges that members experienced and, in the opinions of some participants, failing to consider these in their interactions and policies, which resulted in a negative impact on participants.

Some participants described feeling exposed and concerned about their confidentiality being breached while at the Center. One individual noted that some staff at the Center were “blabber mouths. . . . They don’t know how to keep their mouths shut” (P5). Another participant noted an occasion when the Center had given permission to a specific group to tour the facility—without notifying Center members—and how uncomfortable it was when she realized that she knew some of the touring group. The participant noted,

I was there one time and then [they] walked in and I am like, “hey there, how’s it going?” . . . It was awkward [laughs]. They [the visitors] were like, “oh what are you doing here?” and I’m like, “just chillin.” (P10)

It was clear throughout the study that mental health continues to carry great stigma. Indeed, even during the study interviews many participants expressed a deep concern for maintaining confidentiality, possibly reinforced by the fact they all signed confidentiality agreements when they became members of the Center. They also stated that they did not want to provide any unnecessary information that would identify other Center members while participating in the study.

Some participants described feeling judged while attending the Center. This often left people wondering what they had done to deserve such a negative response. One participant noted feeling judged when he told a Center staff person that he had been on “homicide watch”:

They [the staff person] put it on my form and underlined it. Like [they] wrote it in all uppercase and underlined it like 3 times. Was like homicide watch, like um, which I kind of took offence to. It’s like, “I’m not going to come in here and kill you all.” Or something like that, you know what I mean? (P8)

Another participant described how he had issues with engaging in appropriate social behavior. However, this individual stated, rather than working *with* him, staff simply did not invite him to many Center activities because of this:

I felt left out cuz, like, when they weren’t going to let me come at times when there wasn’t something scheduled for me . . . well there was at one time I would only come for like the SPCA or something because that was scheduled and I was part of it, but they didn’t want me coming for a while for anything besides that . . . it hasn’t happened that much now, but I have been watching what I say a lot more. ’Cause sometimes I say a lot of jokes with sexual innuendo behind them . . . I just would wonder why the hell don’t they want me around? What’s wrong with them? (P2)

Participants stated that the staff at the Center played an integral part of their lives. Any changes in the staff, or their performance, ultimately affected what the participants experienced at the Center, many of whom found it difficult to adapt. For example, participants stated that they were given no warning of multiple and sudden staffing changes at one time in the Center, which left them feeling challenged in adapting to staff turnover. Participant 7 recounted fears of building trust with someone new. He described some of the Center members feeling “*lost*” when the staff changes occurred. However, he stated that he, “[got] over it a little more quickly . . . once the few days went by, I just kind of reintegrated myself, . . . like it doesn’t have to exactly change everything about [the Center]” (P7). At the same time, Participant 9 noted that, because of the staff changes, “People stopped coming for some reason. . . . That’s what we used to say outside [members talking privately among themselves]. [The Center] is changing . . . it stopped being enjoyable, certain staff left and things started changing.” This participant further elaborated on how the changes had affected the Center milieu:

But then I go there now and there’s staff that I don’t know they don’t necessarily know me and everyone I find there, they’re not talking to each other. They’re in their own shells . . . . So we had a couple of [Center] support workers . . . and they would play guitar and kind of teach some of the people to play guitar. That would also give you a bigger opportunity to, like for one, to ask questions and then mingle and then connect but you don’t see a lot of that now. [The new Center] support workers just walk around I guess. And they just sit there. They’re there if you need their help. They’ll talk to you but it’s not like, let’s go do an activity. (P9)

According to participants, fluctuations in staffing levels also affected the delivery of supports and activities at the Center. For example, if there were too many staff off work at any given time, this could affect outings as the staff “just can’t leave like one person there [at the Center]” (P7). This participant expressed no ill will against people taking time off, acknowledging that “sometimes things can come up.” However, there was also a concern with the level of services provided after the staff changes occurred. One participant described the Center as “gone downhill a lot” (P6). Some participants noted that some staff did not deal with requests or issues as quickly as they had experienced in the past, and questioned if this could be related to the changes, or shortages, in the Center staff. Two participants recounted issues when requesting assistance with resume printing and described how staff stated that the file could not be found, or the staff member took longer than expected to respond to the request. Participants also noted that staff needed to be more prepared and responsive when planning events to give members time to prepare to attend:

They're very slack and when we get them, the program or something, is the day after and we already have plans. I'd like it at least a week earlier, like, that's not too much to ask. I don't think, a week. That way we can get stuff we need, make plans, organize stuff. It'd be nice. And they don't. Their internet, they have a web page, they don't even update it. You go on it right now and it's last year . . . (P5)

**Participant-centered challenges.** Participants identified challenges that they themselves experienced that affected their engagement with the Center.

Member-centered challenges related to the individual's issues or the Center's milieu, which were affected by those who engaged with the Center. As stated above, participants noted that at one point, people stopped coming to the Center with the same frequency as before and, as a result, there were fewer familiar faces and the Center felt less engaging:

It's not the same. I'll probably walk in there now, go to the art room, say "hi" to maybe two faces that I know and just draw for 5 minutes and just get bored 'cause there's nobody there and just leave. Yeah [laughs] which is crappy, 'cause in the beginning it was so awesome and it helped people. Helped them get friends who were dealing with problems and also, I don't know, just have a place to go for a little bit. (P9)

The reduced member attendance also affected the nature and variety of activities planned for members. Participants 5 and 6 reported having waited "for weeks" to attend bowling, only to hear that it had been canceled due to a low number of interested members. Another participant revealed feeling uncomfortable about possibly encountering a person at the Center with whom they had had a previous relationship.

One of the people I got in a relationship did go to [the Center] as well, so, I felt kind of awkward, during that, did not really want to be around that place as much, for fear of bumping into them, and being out of shape about it, so that might have. Yeah, I think that was part of what impacted my going there aside from the mood, well intertwined with the mood. Oh, it got better with that person, so that was nice. (P7)

Participants discussed a variety of personal challenges and issues that they believed affected their ability to engage with Center activities. For one participant, who had a history of substance dependence and experienced a relapse, attending the Center became very awkward. While the participant felt supported by staff during recovery, she feared facing members and staff during relapse.

I didn't want them to see me like that, I was embarrassed, like you guys seen how much I did then I, I just ruined it in one day. . . . That and the mind of a drug addict, I just want to be high and do my little thing over here 'cause my mind was not staying [clear] I guess. (P9)

Participant 7 described how he struggled with experiencing a number of personal losses that staff at the Center would not have predicted:

[nothing they] could have foreseen, or they could have helped . . . but, now I think I was just shocked, reclusive state of mind that I just didn't really reach out for help as much as I should . . . parents split, girlfriend left, few family members passed away . . . just little by little bit, like brick by brick stuff, that just . . . I don't know, affected me deeply at the time.

**External factors—Weather, finances, and physical space.** Participants described a number of factors affecting their ability to attend the Center that could only be considered as outside of their personal control. For many, the weather and transportation played key roles. One participant did not like the winter, so enjoyed engaging in group activities in the summer (P1). Others did not have personal transportation and took public transit; however, their ability to regularly attend the Center depended on purchasing a monthly bus pass (P5). For another participant, "I haven't been going for a while because I lived at [place] with Mom and Dad." If this person did not have a ride, it would have been a "4½ hour walk" to get to the Center (P6). While he did not do this, he did walk several hours to the Center from another residence.

The physical space of the Center itself was another factor that affected engagement for some of the participants. While one participant noted that he only felt comfortable in the smaller spaces (P7), another mentioned how having a larger kitchen would be helpful for members to eat together, as this practice is "almost beneficial for mental health" (P10). Similarly, another participant noted his challenges in feeling comfortable and safe in some of the smaller rooms as he had been physically restrained in the past. He believed the *home-like atmosphere* of the Center increased his comfort level:

Ah, like, first, when I first walked in, I was like, ok, I'm in an office, and then I went in the actual door to go into the building, like there's the area with the Xbox and the computers and that, and that was like, I felt like I was in someone's living room. Right? I was just hanging out with some friends in someone's living room. Their kitchen, same idea, it was just, looked like a normal kitchen, right? I mean it was a big kitchen, but, it just looked like a normal kitchen. (P8)

### **Benefits of Engaging With the Program: Finding My Way**

Participants described many benefits of engaging with the Center. Their stories revealed a pattern of personal growth and, while not a linear path, many positive developments occurred as a result of engaging. Three major themes were identified: Feeling safe and developing trust, Building community, and Process of building a way forward. These were



further broken down into subthemes that captured the experiential nuances of each theme.

*Feeling safe and developing trust.* The development of trust was a gradual process, with participants testing and observing those with whom they worked. Participant 3 stated, “I make friends at [the Center], and I actually feel safe at [there].” However, another participant had developed trust with some but not all:

I gave a little information, like very little, to see if I can trust them . . . I just stopped talking to certain people. A couple people I really liked 'cause they, they were trusting, they were trustworthy, they earned it . . . I don't trust anyone. That's me personally, that's how I grew up. (P5)

*Building community.* As participants developed trust, their sense of community grew. Participants identified strategies that helped them build a community.

The Center provided a safe environment for participants to enhance their communication skills. Because they did not feel judged, they could express themselves and challenge each other's communication if they felt the need. Individuals needed this opportunity to develop more confidence and feel more positive about themselves.

Just talking, talking to people, jumping over those little barriers that my, my mind kind of set for myself. Like. Don't talk to people, don't look people in the eyes. Um, little, little worries that you have with anxiety well, would jump right over them and just trial and error, try something and I wouldn't get negative feedback from it so then I would do it more often and then just apply it to my job too after I stopped going. Yeah. (P9)

As they met and shared with other members of the Center, participants began to realize, and often were very surprised to find, that they were not alone in their troubles and mental health concerns.

I was really timid and a little bit scared and hesitant and just anxiety ridden really . . . trying to meet all the people, get their names, but I was excited to be in like, a room full of people with other mental illnesses and stuff and even some had opiate addictions and I've never met anybody with an opiate addiction before . . . it was always oh, [her name] is the junkie and this and that so I never could really talk with people and you know, have them understand where I'm coming from. (laughs). (P9)

*Process of building a way forward.* In moving forward, research participants described their journey in creating a more purposeful life.

Some participants described feeling very negative about themselves, but when they saw that they were not alone and were accepted, even liked by others, their view of themselves began to change and they grew to like themselves:

Well, it used to get pretty bad, that . . . well even having a mental disorder, I used to call myself a monster. . . . 'Cause I, even using words like that in my own head, monster, freak or something like that, it used to come up a lot. (P7)

The participants described how engaging in Center activities added to their sense of doing something positive for themselves and others. Participant 3 talked about a video that he made, with the help of another Center member, regarding mental health promotion and posted it on the internet. The purpose of the video was to “inspire others to live in the here and now, the present moment.” Another participant reported,

[I] usually tried to do a bit of volunteering even through churches or any crowded events, I'm not big on that sort of thing, so I had to, it also helps me kind of break me out of that shell so I could be a productive member of society and stand being in large groups. (P7)

As the participants grew and began to feel more positive about themselves, their hopes and dreams began to grow. Occasionally, there were relapses, but having the Center available as a support helped maintain the feelings of hope for a more positive future:

Yeah. I mean it gives me a sense of hope for my own future. And a lot of times we talk about goals at [the Center], like, just goals for life, you know. It's really fun to get to talk about your life goals. And it's really neat to see how things actually pan out. Right now I'd say, if you asked me like years ago what I expect for my life at this age, my life looks completely different from what I would have expected . . . I never would have imagined that I would have been working . . . being in [education]. . . . But look where I am now [laughs]. (P10)

Participants described a sense of empowerment with their enhanced life skills, feeling more positive about themselves and feeling supported in their personal growth, “. . . it hasn't happened that much now, but I have been watching what I say a lot more. Cause sometimes I say a lot of jokes with sexual innuendo behind them, or talking about [conspiracy theories] . . .” (P2). Another participant talked about overcoming anxiety and supporting a co-worker, using skills learned at the Center:

It helped . . . a lot of just beating, jumping over that anxiety to talk to people [who] came from [Center] and it helped me with my job (laughs) . . . when I worked at [store] one of my coworkers were dealing with a really sketchy, creepy customer. I walked right up to them, what's going on? (Laughs) Need any help? No? Ok, I'll be, I'll just be standing here. (P10)

Participants described a number of ways in which they had come to understand the importance of the Center in their lives. One individual believed that the services offered “impacted [them] in a good way” (P1). Participant 6 stated

that the Center helped him through a low point in his life when he was feeling “pessimistic” and “angry, very verbally aggressive, very snappy, very moody.” The Center “helped out with a lot of that among other things, so I’m very grateful” (P6). Another participant had a previous view that the world was a “scary place.” He attributed a change in perspective to the Center, as he now sees the world with “uncertainty”; it has “shades of grey” and is no longer “black and white” (P3).

Participants also discussed what they thought life would be like without their experience at the Center. There were a variety of responses, all negative in nature. Some individuals believed that they would be “in jail” (P1 and P8) or “dead” (P1, P7, and P8) because “drugs can do that to you” (P1). Others believed that they would be a “drug addict” (P9), “drinking” (P10), into “heavy meds” (P7), or “wouldn’t have recovered as well” (P4). For still others, life would be “boring and isolated” (P5), or with “poor relationships” (P4), “worsening depression” (P7), or “PTSD” (P2), leaving some feeling “rejected” (P8), or with nothing to do but “stay in bed all the time” (P4).

## Discussion and Future Directions

Our study findings highlight some of the mental health challenges experienced by a number of young adults who engaged in a community-based drop-in psychosocial recovery center. The study revealed factors that both promoted and discouraged engagement in the Center as well as the benefits that resulted from engagement in this program. Unfortunately, we did not discover why some did not return after they were introduced to the Center. However, those who did attend regularly disclosed struggles they experienced even though they continued to attend.

All Center members who participated in the study disclosed a history of trauma, for some, quite horrific stories. More recent research is highlighting the links between many mental health problems and traumatic life experiences (Bombay & Austin, 2019; Els & Kunyk, 2019; McCay, 2019). In addition, the participants were isolated, whether as a self-imposed attempt to cope with how they perceived the world, or as a result of life events, such as a job loss and having few supportive connections. They engaged with the Center because they were motivated to work on goals, and while there were challenges to engagement (in the form of Center-focused, participant-focused, and external factors), participants also identified many benefits of engaging. They felt safe there and began to develop a sense of trust in people. In addition, they became part of a community which resulted in their enhanced interpersonal and life skills as well as finding people like themselves. They were no longer alone. At the same time, participants also realized that life often includes changes and struggles but many learned ways to persevere.

A number of mental health service models for youth and young adults have evolved in the literature since we began

our study. For example, specific features that promote engagement are described in the Orygen, Australia’s National Centre of Excellence in Youth Mental Health literature (B. Cole, 2018). The key principles of youth mental health models to enhance service access include (a) a self-referred, drop-in access point; (b) including youth and family participation in developing, planning, implementing, and evaluating the service; (c) focusing on early intervention, including timely treatment, mental health promotion, and prevention; (d) using evidence-based care; and (e) ensuring that the mental health workforce has a specific set of attitudes, skills, training, and education. Similarly, a Canadian survey of patients, family, and staff from primary care clinics and mental health clinics including four clinics for youth mental health ( $N = 455$ ; of whom 185 were between the ages of 16 and 35 years) examined design attributes of an early intervention service (EIS) that people with psychiatric illness would be most likely to contact (Becker et al., 2016). Participants identified that people would contact an EIS if (a) there were no wait times, (b) the service had been endorsed by others who had experienced mental health problems, (c) it incorporated direct contact with mental health professionals, and (d) provided information about psychological treatment. More recently, another Canadian research team (Ramey et al., 2019) has generated a number of evidence-based practices when working with youth and young adults (aged 15–29 years) to promote engagement in health systems and program planning. These include (a) providing a consistent platform for youth input; (b) appreciating different forms of knowledge, expertise, and communication methods; (c) investing in relationships and building mutual understanding among youth and adults; (d) adult allies being patient and comfortable with the ambiguity and unpredictability of working with youth; and (e) continually revisiting and renegotiating structure and flexibility.

Taken together, the above research identifies critical features of a holistic service approach. Participants in our study also commented positively on many of these features. Positive Center design features included a member drop-in and self-referral process, mental health professional and peer support workers on staff, member involvement in activity planning, and serving as an access to formal mental health services. In addition, while participants identified a few negative Center features around staff challenges, for the large majority of time participants noted that staff focused on engagement, building relationships, and mutual understanding with members.

The participants in this study engaged with the Center because they were motivated to work on their goals and identified many positive outcomes as a result of their engagement. Similarly, Watsford and Rickwood (2014) surveyed 228 young people between 12 and 28 years of age and found that those who wanted to be more committed and involved in therapy were more likely to have higher psychological functioning as an outcome. In addition, it was believed that the

young person's first experiences of therapy were critical and that taking an optimistic approach to one's future gives strength to this endeavor (Barczyk et al., 2014). One might hypothesize that the initial experiences of those young adults walking into the Center and the positive interactions they described affected engagement. Indeed, many of the participants spoke positively about their initial impressions, including feeling safe.

Many other features that promoted engagement were identified in this study. For example, participants identified feeling positive about the effect that Center attendance had on reducing their drug use. Guo and Slesnick (2017) also noted that increased attendance correlated with decreased drug use in their study and speculated that attendance was connected to the "low demands" and "few restrictions" (p. 913) for which many drop-in centers are known.

Activities that took place at the Center promoted engagement, friendship development, and personal growth. Many of the participants talked about the art and music rooms and opportunities to share their work. Creative arts have been found to aid in promoting engagement (A. Cole et al., 2018). When given the opportunity to share their art, individuals can better process grief, be understood, and connect with other group members. It also has positive effects on stress and mental illness symptom management, aids in recovery from trauma, and improves self-awareness and self-esteem (Schwan et al., 2018).

Having a sense of not being alone and having access to others for socialization is helpful for the recovery process (Petersen et al., 2015) and is associated with lower levels of self-stigmatization (Denenny et al., 2015). Similarly, community-oriented participation—such as volunteering at the SPCA and serving at a local church supper—helped participants believe that they were contributing to their community. In addition, participating in group activities, such as those offered at the Center, can help build a greater sense of purpose and life goals (Kaplan et al., 2012).

Several barriers that young adults face when accessing mental health care have been described in the literature. These include environmental barriers (such as lack of family support, transportation difficulties, service location), structural barriers (such as waitlists and resource deficits), societal barriers (such as stigma), and personal barriers (such as lack of awareness about treatment benefits and a poor relationship between the mental health clinician and the patient) (Sylwestrzak et al., 2015). Participants in this study described some of these same barriers. Of note, the relationships that participants had with the staff affected their engagement with the Center. Some participants were concerned about several confidentiality breaks (e.g., inviting a tour group into Center without notifying members) and feeling judged at times (e.g., being excluded from events due to sexual comments), although they did not believe that the staff errors were intentional. Participants described other factors about which staff could be more sensitive, such as the interpersonal dynamics

between Center members. These points reinforce principles identified by Orygen (B. Cole, 2018) and Ramey and colleagues (2019) that promote engagement. Staff need to have positive attitudes as well as aptitude and be trained specifically to work with this population. Furthermore, their roles and work expectations must be clearly defined to support the member's need (Kemp & Henderson, 2012).

In addition, staff need to consider how the members' personal stories interact with the Center's policies and programming, including how the Center space itself affects some members, both negatively and positively. From reviewing the data, the glaring impact of the participants' histories filled with significant trauma was most disturbing. Given the propensity for documented rates of trauma experienced by youth (Ferguson, 2009) and young adults (Devi et al., 2019; Sonu et al., 2019), our findings underscore the need for staff, policies, and programming at the Center to integrate approaches to care that involve both *trauma-informed* and *healing-centered engagement* (Ginwright, 2018).

A trauma-informed approach is considered essential to the context of care and is grounded in a set of assumptions:

*realizing* the widespread impact of trauma and understanding potential paths for recovery; *recognizing* the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and *responding* by fully integrating knowledge about trauma into policies, procedures, and practices, and seeking to actively *resist re-traumatization*. (Substance Abuse and Mental Health Services Administration, 2014, p. 8)

In addition, the Government of Canada has created *Trauma and Violence-Informed Approaches to Policy and Practice* (Government of Canada, 2018) that are considered essential to the context of care by (a) increasing attention on the impact of violence on people's lives and well-being, (b) reducing harm, and (c) improving system responses for everyone. Trauma and violence-informed approaches require fundamental changes in how systems are designed, organizations function, and practitioners engage with people. In addition to a *trauma and violence-informed approach*, Ginwright (2018) calls for *healing-centered engagement* that "offers an asset driven approach aimed at the holistic restoration of young peoples' well-being . . . and also advances the move to 'strengths-based' care" (p. 11).

If the Center formally adopted consistent *trauma and violence-informed* and *healing-centered engagement* approaches, staff would be alerted to the need to partner with members to level power differences and engage in *transparency* by *proactively informing* members of anticipated actions/changes. In addition, staff also would be aware of the need to *collaboratively* discuss with members about how they were reacting (e.g., through regular staff and member debriefing chats), to foster opportunities for *choice* (e.g., providing a private room for members if they did not want to engage with a tour group), and to invite *members to suggest ways* to assist with

change (e.g., members creating a group coffee time to meet new staff; opportunities for private chats with member-chosen staff or peer supports). Such actions would reinforce to members that *they* are the creators of their own well-being and reinforce *strengths-based* approaches. Clearly, the ability to develop trusting relationships between members and staff, as well as among staff, is a key component of success in integrating a trauma and violence-informed approach and healing-centered engagement (Bowen & Murshid, 2016; Brown et al., 2017). However, it requires a *shift in culture, formal adoption of policy, and staff training* to be regularly integrated into practice.

### Limitations

While limitations in recruitment and retention exist in any study, there are specific concerns when conducting mental health research (Woodall et al., 2010). Some of these were evident in our study. Individuals with a history of adverse encounters with health providers and trauma might have been hesitant to speak with a researcher about their past, or current, lives. It is also possible that individuals who were current members of the Center might have been hesitant to discuss their experiences with a service in which they continued to participate. This is despite being informed that their participation would be confidential and in no way affect their standing with the Center. Some of the research participants expressed their desire to move to different housing locations and might not have been reachable by their previous contact information. The original intent of the study was also to recruit participants who had not returned after a maximum of three visits. Unfortunately, we were unable to recruit from this group and, as a result, we were unable to ascertain factors that contributed to their disengagement from the program. Although qualitative findings are not generalizable, findings here raised issues of critical concern that deserve close reflection by Center staff and could help those who provide similar services and encounter similar challenges.

### Conclusion

The purpose of this study was to identify facilitators and challenges to engagement with a community-based drop-in psychosocial mental health program for young adults. Four major categories were identified: (a) Reasons for Engaging: Motivated to Work on Goals; (b) Facilitators of Engagement and Beyond; (c) Challenges to Engagement; and (d) Benefits of Engaging: Finding My Way. Each of these needs to be understood within the contextual challenges the participants had to overcome. As a result of their engagement, participants were able to grow. In moving forward, the Center and other community-based organizations like it need to be more mindful as to how policies and practices can be interpreted by individuals affected by trauma. They must also meaningfully incorporate healing-centered engagement practices

wherever possible and work from a position of a strengths-based approach to care.

### Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

### Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Funding was received from a grant awarded by the regional health authority for the area in which the research was conducted. To preserve confidentiality, the organization and grant name will not be identified.

### ORCID iD

Anne Marie Creamer  <https://orcid.org/0000-0002-3603-6502>

### References

- Bantchevska, D., Erdem, G., Patton, R., Liney, J., Letcher, A., Bonomi, A., & Slesnick, N. (2011). Predictors of drop-in center attendance among substance-abusing homeless adolescents. *Social Work Research, 35*(1), 58–63.
- Barczyk, A. N., Thompson, S. J., & Rew, L. (2014). The impact of psychosocial factors on subjective well-being among homeless young adults. *Health and Social Work, 39*(3), 172–180.
- Becker, M. P. E., Christensen, B. K., Cunningham, C. E., Furimsky, I., Rimas, H., Wilson, F., & Zipursky, R. B. (2016). Preferences for early intervention mental health services: A discrete-choice conjoint experiment. *Psychiatric Services, 67*(2), 184–191. <https://doi.org/10.1176/appi.ps.201400306>
- Berger, R. J., & Quinney, R. (2005). The narrative turn in social inquiry. In R. J. Berger & R. Quinney (Eds.), *Storytelling sociology: Narrative as social inquiry* (pp. 1–11). Lynne Rienner.
- Bombay, A., & Austin, W. (2019). *Trauma- and stressor-related disorders, crisis, and response to disaster*. In W. Austin, D. Kunyk, C. A. Peternelj-Taylor, & M. A. Boyd (Eds.), *Psychiatric and mental health nursing for Canadian practice* (pp. 318–350). Wolters Kluwer.
- Bowen, E. A., & Murshid, N. S. (2016). Trauma informed social policy: A conceptual framework for policy analysis and advocacy. *American Journal of Public Health, 106*(2), 223–229.
- Brit, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation. *Qualitative Health Research, 26*(13), 1802–1811.
- Brown, J. D., King, M. A., & Wissow, L. S. (2017). The central role of relationships with trauma-informed integrated care for children and youth. *Academic Pediatrics, 17*(7S), S94–S101.
- Canadian Institutes of Health Research. (2014). *News release: CIHR and Graham Boeckh Foundation launch mental health research network*. <https://www.canada.ca/en/news/archive/2014/06/cihr-graham-boeckh-foundation-launch-mental-health-research-network.html>
- Clandinin, D. J. (2013). *Engaging in narrative inquiry*. Left Coast Press.
- Cole, A., Jenefsky, N., Ben-David, S., & Munson, M. R. (2018). Feeling connected and understood: The role of creative arts in

- engaging young adults in their mental health services. *Social Work with Groups*, 41(1–2), 6–20. <https://doi.org/10.1080/01609513.2016.1258619>
- Cole, B. (2018). *Key principles underpinning youth mental health models*. [https://www.orygen.org.au/Education-Training/Resources-Training/Resources/Free/Fact-Sheets/principles\\_youth-mental-health-models](https://www.orygen.org.au/Education-Training/Resources-Training/Resources/Free/Fact-Sheets/principles_youth-mental-health-models)
- Denenny, D., Thompson, E., Pitts, S. C., Dixon, L. B., & Schiffman, J. (2015). Subthreshold psychotic symptom distress, self-stigma, and peer social support among college students with mental health concerns. *Psychiatric Rehabilitation Journal*, 38(2), 164–170.
- Devi, F., Shahwan, S., Teh, W. L., Sambasivam, R., Zhang, Y. J., Lau, Y. W., Ong, S. H., Fung, D., Gupta, B., Chong, S. A., & Subramanian, M. (2019). The prevalence of childhood trauma in psychiatric outpatients. *Annals of General Psychiatry*, 18, 15.
- Duffy, M. (2007). Narrative inquiry: The method. In P. Munhall (Ed.), *Nursing research: A qualitative perspective* (4th ed., pp. 401–421). Jones and Bartlett Publishers.
- Eklund, M., & Tjörnstrand, C. (2013). Psychiatric rehabilitation in community-based day centres: Motivation and satisfaction. *Scandinavian Journal of Occupational Therapy*, 20(6), 438–445.
- Els, C., & Kunyk, D. (2019). Care of persons with concurrent substance-related, addictive, and other mental disorders. In W. Austin, D. Kunyk, C. A. Peternelj-Taylor, & M. A. Boyd (Eds.), *Psychiatric and mental health nursing for Canadian practice* (pp. 866–876). Wolters Kluwer.
- Ferguson, K. M. (2009). Exploring family environment characteristics and multiple abuse experiences among homeless youth. *Journal of Interpersonal Violence*, 24(11), 1875–1891.
- Garett, S. B., Higa, D. H., Phares, M. M., Peterson, P. L., Wells, E. A., & Baer, J. S. (2008). Homeless youths' perceptions of services and transitions to stable housing. *Evaluation and Program Planning*, 31(4), 436–444.
- Ginwright, S. (2018, June 1). The future of healing: Shifting from trauma informed care to healing centered engagement. *Medium*. <https://medium.com/@ginwright/the-future-of-healing-shifting-from-trauma-informed-care-to-healing-centered-engagement-634f557ce69c?fbclid=IwAR2NeL8NbUZfPScYwm7ysSaYzVfJQIGSPOBO2EXLzay3tNBQTjwiU5t890>
- Government of Canada. (2018). *Trauma and violence-informed approaches to policy and practice*. <https://www.canada.ca/en/public-health/services/publications/health-risks-safety/trauma-violence-informed-approaches-policy-practice.html>
- Guo, X., & Slesnick, N. (2017). Reductions in hard drug use among homeless youth receiving a strength-based outreach intervention: Comparing the long-term effects of shelter linkage versus drop-in center linkage. *Substance Use & Misuse*, 52(7), 905–915.
- Hartley, S. E. (2017). Service users' perceptions of an outreach wellbeing service: A social enterprise for promoting mental health. *Community Mental Health Journal*, 53(7), 842–851.
- Ho, G. W. K., Chan, A. C. Y., Chien, W. T., Bressington, D. T., & Karatzias, T. (2019). Examining patterns of adversity in Chinese young adults using the Adverse Childhood Experiences-International Questionnaire (ACE-IQ). *Child Abuse & Neglect*, 88, 179–188.
- Hudson, A. L., Nyamathi, A., & Sweat, J. (2008). Homeless youths' interpersonal perspectives of health care providers. *Issues in Mental Health Nursing*, 29(12), 1277–1289.
- Kaplan, K., Salzer, M. S., & Brusilovskiy, E. (2012). Community participation as a predictor of recovery-oriented outcomes among emerging and mature adults with mental illnesses. *Psychiatric Rehabilitation Journal*, 35(3), 219–229. <https://doi.org/10.2975/35.3.2012.219.229>
- Kemp, V., & Henderson, A. R. (2012). Challenges faced by mental health peer support workers: Peer support from the peer supporter's point of view. *Psychiatric Rehabilitation Journal*, 35(4), 337–340.
- Kozloff, N., Cheung, A. H., Ross, L. E., Winer, H., Ierfino, D., Bullock, H., & Bennett, K. J. (2013). Factors influencing service use among homeless youths with co-occurring disorders. *Psychiatric Services*, 64(9), 925–928.
- McCay, E. A. (2019). Care of persons with a history of abuse. In W. Austin, D. Kunyk, C. A. Peternelj-Taylor, & M. A. Boyd (Eds.), *Psychiatric & mental health nursing for Canadian practice* (pp. 877–918). Wolters Kluwer.
- Narendorf, S. C., Bowen, E., Santa Maria, D., & Thibaudeau, E. (2018). Risk and resilience among young adults experiencing homelessness: A typology for service planning. *Children and Youth Services Review*, 86(C), 157–165.
- Parse, R. R. (2001). *Qualitative inquiry: The path of sciencing*. Jones and Bartlett Publishers.
- Pelletier, J. F. (2019). The transcendent voice of recovery mentors in mental health: A philosophical reflection. *AIMS Public Health*, 6(2), 135–142. <https://doi.org/10.3934/publichealth.2019.2.135>
- Petersen, K. S., Friis, V. S., Haxholm, B. L., Nielsen, C. V., & Wind, G. (2015). Recovery from mental illness: A service user perspective on facilitators and barriers. *Community Mental Health Journal*, 51(1), 1–13.
- Ramey, H. L., Rayner, M.-E., Mahdy, S. S., Lawford, H. L., Lanctot, J., Campbell, M., Valenzuela, E., Miller, J., . . . Hazlett, V. (2019). The Young Canadians Roundtable on Health: promising practices for youth and adults working in partnership. *Canadian Journal of Public Health/Revue Canadienne de Sante Publique*, 110(5), 626–632. <https://doi.org/10.17269/s41997-019-00254-9>
- Riley, T., & Hawe, P. (2005). Researching practice: The methodological case for narrative inquiry. *Health Education Research*, 20, 226–236.
- Salaheddin, K., & Mason, B. (2016). Identifying barriers to mental health help-seeking among young adults in the UK: A cross-sectional survey. *British Journal of General Practice*, 66(651), e686–e692. <https://doi.org/10.3399/bjgp16X687313>
- Schwan, K. J., Fallon, B., & Milne, B. (2018). “The one thing that actually helps”: Art as a self-care and health-promoting practice amongst youth experiencing homelessness. *Children and Youth Services Review*, 93, 355–364.
- Shim, R., Compton, M., Zhang, S., Roberts, K., Rust, G., & Druss, B. (2017). Predictors of mental health treatment seeking and engagement in a community mental health center. *Community Mental Health Journal*, 53(5), 510–514.
- Shlafer, R., Hergenroeder, A., Emans, J. S., Rickert, V., Adger, H., Spear, B., Irwin, C. E., Kreipe, R. E., Walker, L. R., & Resnick, M. (2014). Adolescence as a critical stage in the MCH Life

- Course Model: Commentary for the Leadership Education in Adolescent Health (LEAH) Interdisciplinary Training Program Projects. *Maternal and Child Health Journal*, 18(2), 462–466. <https://doi.org/10.1007/s10995-013-1243-8>
- Smith, L. J. (2008). How ethical is ethical research? Recruiting marginalized, vulnerable groups into health services research. *Journal of Advanced Nursing*, 62(2), 248–257.
- Sonu, S., Post, S., & Feinglass, J. (2019). Adverse childhood experiences and the onset of chronic disease in young adulthood. *Preventative Medicine*, 123, 163–170.
- Statistics Canada. (2016). *Census profile, 2016 census*. <https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CMACA&Code1=310&Geo2=PR&Code2=13&Data=Count&SearchText=Saint%20John&SearchType=Begins&SearchPR=01&TABID=1&B1=All>
- Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA'S concept of trauma and guidance for a trauma-informed approach* (HHS Publication No. (SMA) 14-4884).
- Sunderland, A., & Findlay, L. C. (2013). Perceived need for mental health care in Canada: Results from the 2012 Canadian Community Health Survey-Mental Health. *Health Reports*, 24(9), 3–9. <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=24258361&site=ehost-live&scope=site>
- Sylwestrzak, A., Overholt, C. E., Ristau, K. I., & Coker, K. L. (2015). Self-reported barriers to treatment engagement: Adolescent perspectives from the National Comorbidity Survey-Adolescent Supplement (NCS-A). *Community Mental Health Journal*, 51(7), 775–781. <https://doi.org/10.1007/s10597-014-9776-x>
- Thompson, S. J., McManus, H., Lantry, J., Windsor, L., & Flynn, P. (2006). Insights from the street: Perceptions of services and providers by homeless young adults. *Evaluation and Program Planning*, 29(1), 34–43.
- Watsford, C., & Rickwood, D. (2014). Young people's expectations, preferences, and experiences of therapy: Effects on clinical outcome, service use, and help-seeking intentions. *Clinical Psychology*, 18, 43–51. <https://doi.org/10.1111/cp.12034>
- Woodall, A., Morgan, C., Sloan, C., & Howard, L. (2010). Barriers to participation in mental health research: Are there specific gender, ethnicity and age related barriers? *BMC Psychiatry*, 10, Article 103. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3016310/>
- World Health Organization. (2015). *Maternal, newborn, child and adolescent health: Adolescent development*. [http://www.who.int/maternal\\_child\\_adolescent/topics/adolescence/dev/en/](http://www.who.int/maternal_child_adolescent/topics/adolescence/dev/en/)
- World Health Organization (2018). *Mental health: Adolescent mental health*. Retrieved October 31, 2018 from [http://www.who.int/mental\\_health/maternal-child/adolescent/en/](http://www.who.int/mental_health/maternal-child/adolescent/en/)

### Author Biographies

**Anne Marie Creamer**, RN, PhD is a primary health care nurse practitioner at the Horizon Health Network in Saint John, New Brunswick.

**Jean Hughes**, RN, PhD is a Full Professor at the School of Nursing, Dalhousie University, Halifax, Nova Scotia.

**Nicole Snow**, PhD, RN, CPMHN(C) is an Assistant Professor at the Faculty of Nursing, Memorial University, St. John's, Newfoundland and Labrador.