

Development of a Shelter-based Health Empowerment Program for Pregnant and Parenting Youth Experiencing Homelessness

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ABSTRACT

Background: Pregnancy and parenthood are common among youth experiencing homelessness and are associated with significant health risk for both parent and child. Yet, little is known regarding how to best promote health among this vulnerable population.

Objectives: To understand stakeholder perceptions of needs and factors required for successful implementation of a shelter-based health empowerment program for pregnant and parenting youth experiencing homelessness and their children.

Methods: Applying frameworks from implementation science, we conducted interviews and focus groups with three groups of stakeholders (youth experiencing homelessness [n=17], shelter staff [n=8], community experts [n=5]). We used qualitative content analysis to identify program content areas and design elements required for successful implementation. We then utilized a consensus-building process to engage community stakeholders in selecting and adapting an evidence-informed intervention.

Results: Stakeholders described several desired content areas for a group-based curriculum: sexual and reproductive health, mental health and child health. With respect to program design, stakeholders emphasized: adaptability; a strengths-based, culturally responsive, and trauma-informed approach; skills-oriented focus; staff training; access to healthcare and the integration of youth voices. Driven by these findings, our community-based team proposed a health empowerment program with three elements: (1) a weekly health empowerment group; (2) health training and support for shelter staff, and (3) shelter-based healthcare services.

Conclusions: Our study is among the first to assess the healthcare needs of pregnant and parenting youth in shelter, and to describe factors associated with the development and implementation of a shelter-based health empowerment program specifically targeting this vulnerable population.

KEYWORDS: Homeless Persons, Adolescent Health Services, Vulnerable Populations, Youth homelessness, Pregnancy in Adolescence, Health promotion, Community-Based Participatory Research, Health disparities, Community Health Services

Introduction

An estimated 4 to 13% of youth in the United States experience some form of homelessness annually, including running away, being thrown out of the home, couch-surfing, rough-sleeping (sleeping on the street) and/or staying in shelter.¹⁻⁴ Among them, an estimated 4.2 million youth experiencing homelessness (YEH) are either pregnant or parenting.⁵ These patterns hold true in Minnesota, where an estimated one-third of YEH are parents.⁶

YEH are at risk for adverse health outcomes, including mental health disorders, suicide, substance use, sexually transmitted infections, and victimization.⁷⁻¹¹ Pregnancy while homeless compounds these risks, with significant long-term negative impacts on health, educational attainment, and socioeconomic status, further magnifying existing inequities.^{5,6} Pregnant YEH also have limited access to health care and are at risk for poor pregnancy outcomes.^{12,13} In May 2018, Voices of Youth Count published an alarming brief highlighting the high prevalence of pregnancy and parenthood among YEH nationally and urged the development of holistic services leveraging a two-generation approach.¹⁴

Unfortunately, YEH who are pregnant and/or parenting have limited access to shelter nationally.¹⁴ A Minneapolis youth shelter, The Bridge for Youth (herein, The Bridge), took the first step in addressing this critical community need through the development of Hennepin County's first site-based transitional housing program specifically for pregnant and/or parenting homeless youth, *Marlene's Place*. Transitional housing programs provide interim, longer-term stability (in this case, for up to 18 months) and supports to prepare individuals to transition to permanent housing.¹⁵ In addition to case management and stabilization of housing, The Bridge partnered with the University of Minnesota and Children's Hospital of Minnesota to implement a new shelter-based health empowerment program at *Marlene's Place*, Empowering Parents for

Wellness in Shelter (EMPOWER), with two goals: (1) to promote the physical and mental health of youth parents and their children, and (2) to prevent future unplanned pregnancies. Aligning with the central tenets of community-based participatory research, these program goals were driven by community needs.^{16,17}

There are many evidence-based programs to promote adolescent sexual health and prevent unplanned adolescent pregnancy among youth,^{18–20} including some targeted toward marginalized youth.^{21–23} There are also several home visiting and clinic-based programs to prevent an unplanned repeat pregnancy among parenting youth.^{24,25} However, to our knowledge, none have been implemented in housing program settings specifically for youth experiencing homelessness. There is evidence that community-based sexual health programs that specifically target high needs populations, such as YEH, may be better able to successfully reach those populations.²³ However, to our knowledge, only one program (Wahine Talk) has been specifically designed to prevent pregnancy among YEH and it does not specifically target youth who are already pregnant or parenting.²²

There are even fewer programs that exist to target youth parent and child health more broadly. Home visiting nursing programs focused on parenting skills, maternal health, child development, and linking adolescent parents to community services have shown promise for improving adolescent parent knowledge, parent and child health and long-term mortality among vulnerable populations, though the data are mixed.^{26–29} However, there are no programs that have been studied with the goal of improving health among pregnant and parenting YEH and their children.

The overall objective of this community-based participatory research (CBPR) was to identify which evidence-informed program could be adapted and feasibly implemented within

this transitional housing program, would meet the needs of all stakeholders, and would be acceptable to youth and service providers. In this article, we detail (1) our community needs assessment, as well as (2) our community-engaged process for program selection and adaptation.

Methods

Development of a Partnership

This project was developed through a community-university partnership between The Bridge, the University of Minnesota, and Children's Hospitals and Clinics of Minnesota (hereafter, the EMPOWER team) that formed in response to a critical and growing community need. The Bridge provides shelter and support for youth in crisis, reunites families whenever possible, and fosters the development of independent living skills for youth. Healthcare providers from the University of Minnesota and Children's Hospital of Minnesota (JRGO and JW) provided shelter-based healthcare for youth at The Bridge. When The Bridge launched *Marlene's Place* in Spring 2019, the EMPOWER team formed to address the health needs of youth in the program and their children. Prior to beginning the project, the team utilized a Research Partnership Checklist to: establish respective roles and partnership norms; facilitate effective communication and sharing of resources; and ensure that we were all working towards a unified goal.³⁰

Study Design and Approach

We conducted a community needs assessment, employing a combination of structured key informant interviews and focus groups with three stakeholder groups: currently or previously homeless youth (n=17), shelter staff (n=8), and community experts (n=5). Interview data were triangulated with brief questionnaires. The needs assessment focused on essential elements of program content and design, drawing on constructs from the Consolidated Framework for

Implementation Research (CFIR), a framework developed for implementation research in healthcare that has been widely used across public health and social services settings to inform successful and equitable implementation.³¹⁻³³ After the needs assessment, the full EMPOWER team (including youth and staff stakeholders) engaged in a consensus-building process to select an evidence-informed program and tailor it to community needs. The University of Minnesota Institutional Review Board deemed these activities to not be human subject research.

Sample

We recruited a purposive sample of youth, shelter staff, and community experts. Youth ages 16-21 (n=17) were recruited through The Bridge and other local community housing programs for participation in one of four focus groups. The majority of youth (76%, 13 of 17) were female-identifying. Five youth had at least one child at the time of the focus groups. Twelve had participated in programming at The Bridge. Shelter staff and community experts participated in structured key informant interviews. Staff (n=8) were recruited through The Bridge and reflected a range of experience, perspectives and roles within the shelter's existing housing program. Community experts (n=5) were identified by members of the EMPOWER team to reflect diverse expertise related to pregnant and parenting YEH and included public health leaders, researchers, housing program leadership, and healthcare professionals. All participants were provided a small stipend to participate. (See Table 1.)

Data Collection

Youth focus groups were conducted by research staff with experience with semi-structured scripts and included interactive activities (e.g., drawing the most important areas of health to be addressed for youth and their children) based on the Socioecological Model.^{34,35} We used semi-structured interview guides to conduct individual interviews with staff and community

experts. Interviews and focus groups were conducted by facilitators with clinical experience working with youth using a trauma-informed approach.

Analysis

We analyzed qualitative data using content analysis in Dedoose Version 8.3.35 (SocioCultural Research Consultants, LLC, Los Angeles, CA). An initial coding frame was developed based on: (1) existing frameworks (CFIR³¹ and the Hexagon Exploration Tool of the National Implementation Research Network³⁶) and health behavior models (e.g., Socioecological Model);^{35,37} (2) the limited existing literature on the health needs of pregnant and parenting homeless youth;^{9,38-40} and (3) guidance from leadership at The Bridge, shelter staff, and youth advisory board. We then used an unconstrained matrix to inductively code our five expert interviews.⁴¹ During this initial round of coding, additional subcategories were allowed to be added within the bounds of our initial codebook, allowing us to generate a refined codebook (available upon request) before transitioning to an exclusively deductive approach.^{41,42} In this pilot round of coding, two independent coders analyzed each of the five transcripts and then compared findings to assess consistency and trustworthiness.⁴²

Through a structured approach, we used our refined codebook to deductively analyze the remaining transcripts from youth and staff interviews and focus groups.⁴¹ One coder coded the transcript and a second reviewed the initial coder's analysis. The coding team then met to discuss any discrepancies and identify key emerging themes. To identify new concepts that did not fit within the structured matrix of analysis in our refined codebook, we conducted a final inductive review of all uncoded material.⁴¹

Two members of the research team, a physician researcher (JRGO) and masters-level research assistant (EDK) coded all transcripts and met with the full EMPOWER team every

other week throughout the analysis process to support triangulation, contextualization, and interpretation of findings. The team meetings consistently included The Bridge staff, leadership, and healthcare providers, as well as members of the University of Minnesota Research Team, with only limited changes in team members over time as the program developed. In addition to meetings, brief questionnaires were used with youth and staff to triangulate findings regarding program content and design (data not reported).

After completing the initial qualitative analysis, we utilized a consensus-building process adapted from the Technology of Participation to engage youth, staff, clinicians, and researchers in processing the complex findings from the needs assessment and collaboratively selecting and then adapting an existing evidence-informed curriculum for a group-based intervention for youth (**Figure 1**).⁴³ To decide on the group-based component of the intervention, we consulted with the University of Minnesota Prevention Research Center (<https://prc.umn.edu/trainings/sexual-health-training>) to identify a list of five evidence-informed adolescent health programs that could be a good fit, based on the guidance from youth, staff and experts who participated in the needs assessment (available upon request). Whereas some of these programs focused more directly on sexual and reproductive health, others focused on adolescent parenting or positive youth development. We presented a written summary of each option to the community-engaged implementation team and then reviewed them verbally, comparing areas of focus, program structure, and other pros and cons, including costs. We used the Hexagon Exploration Tool to guide program selection and implementation.³⁶ This process involved our community-engaged implementation team, which included: members of the Marlene's Place staff, leadership from The Bridge, researchers from the University of Minnesota, healthcare providers who provide

care at The Bridge from Children’s Hospitals of Minnesota, and youth who had been engaged in the needs assessment with lived experiences in homelessness while pregnant and parenting.

Results

The needs assessment identified several key content areas and design components of importance, which were used to drive program selection and adaptation.

Program content

All three groups (youth, staff and community experts) identified similar key content areas for the group-based youth curriculum and for staff training. Qualitative findings from focus groups and interviews regarding program content are shown in **Table 2**.

Sexual health and relationships. Given the program’s goal of preventing unplanned pregnancies, sexual health and relationships were a focus of structured interviews and were affirmed to be important. Specifically, participants emphasized that the program should be gender - and sexuality - affirming and delivered in a trauma-informed way. While they acknowledged the need to discuss risks, such as unplanned pregnancy and sexually transmitted infections, they also emphasized the value of a strengths-based approach regarding sex, sexuality, and relationships.

The strength-based approach regarding sex and sexuality included presenting birth control as a choice, not a necessity. Youth described apprehension regarding pressure to initiate birth control, stating, *“I feel like we push birth control off on girls instead of educating young men and girls about sex.”* They recommended a more nuanced and less judgmental approach to pregnancy and parenthood, especially among youth parents, *“Stop making having kids such a bad thing but [instead, encourage] it when [a youth’s] ready, because obviously you learned*

your lesson having a kid.” Participants cited both challenges and benefits to pregnancy and parenthood. One youth acknowledged the stigma associated with pregnancy and then said, *“My story is completely different from a lot of other kids. Like my son saved my life. I had my kid at a perfect time in my life.”*

Mental health and child health. Mental health and child health also emerged as related critical topics. They recognized that youth mental health was essential for parenting and child development. One staff participant said, *“how are you expected to parent when you’re probably struggling with some stuff yourself?”* Participants emphasized the role of trauma in mental health and also in parenting.

It’s probably going to be a lot of stress and possibly trauma that comes along with why or how they’re pregnant, and making sure that those situations are supported, whether it be trying to help reengage with the partner that helped create the baby, or if there’s unfortunate circumstances that led to pregnancy. – Staff interview participant

Nutrition. Nutrition emerged as a priority, particularly in the context of food insecurity.

Because, yeah, like literally I’d have two meals a day, and one of them meals would be, you know, eating at school. So, if I didn’t go to school, that means I wasn’t eating....it’s straight poverty... You know, so it’s just like nutrition is a big thing, because that can throw everything off, the growth of your child. – Youth focus group participant

Independent living skills. Across all potential program content areas, there was an overarching theme of promoting independent living skills, with specific discussion of considering these skills as they relate to health and healthcare. This aligns with Marlene’s Place’s larger goal of promoting independence. Participants acknowledged that youth might need help accessing health insurance and healthcare resources. One staff interview participant recommended starting with “the basics,” such as *“where to even start with how to get their own child healthcare and those resources.”* They specifically recognized the relationship between mental health and independent living skills, such as learning how to access housing and

employment, as well as “*housing and employment, and how to get insurance,*” said one youth focus group participant. Participants recognized that fostering the development of independent living skills that allowed youth to meet their basic needs over the long term were an essential part of promoting health.

Applications to pregnancy and parenthood. Additionally, participants consistently suggested that all these health issues should be discussed in the context of pregnancy and parenthood. For instance, conversations surrounding mental health should include discussions about post-partum depression and, as one staff interviewee described, managing their “*mental and physical health while being pregnant or raising a child.*” Similarly, conversations around nutrition should focus, not only on nutrition generally, but also on the context of nutrition during pregnancy or breast-feeding.

I feel like a lot of them don't know, just nutrition. Like when it comes to like delivering a baby, like breast-feeding, or even just like, “What should I eat? What's good for my baby to have while I am pregnant?” like stuff like that. I feel like it's very important.

– Staff interview participant

Multi-pronged, holistic approach. Staff and community experts advocated for a more holistic or “well-rounded” approach, rather than focusing the curriculum for the group-based intervention on a single topic (e.g., sexual health or mental health). Others also commented on the need for a range of strategies, beyond simply direct patient care. One community expert recommended, “*a multi-pronged approach to youth wellness... it's not just the physical exam, it's you know being able to talk about education and being able to have mental health involved and substance abuse prevention and in a positive way. But all the different things we've talked about; all the different domains of health.*”

Program Design and Approach

Participants identified several key elements of program design and approach, which aligned across youth, staff and community experts (**Table 3**).

Youth-driven, adaptable and engaging program design. All three groups emphasized that the program should be youth-driven, adaptable to youth needs, and engaging. Participants across groups agreed that the program should be built on youth input, generate group discussion, and create opportunities for youth to lead. As such, the program needed to be flexible enough with respect to content and approach to adapt and tailor to youth needs, which were likely change over time, rather than rigid in their structure and curriculum. Finally, participants across groups emphasized that the group components needed to be fun, engaging, and interactive and build community and trust among youth.

Access to healthcare, insurance and childcare. Participants consistently recognized the importance of ensuring access to healthcare, suggesting on-site healthcare and assistance with accessing primary care. Staff and community experts also emphasized the importance of ensuring that youth and their children have access to health insurance. All stakeholder groups also described the importance of providing childcare during groups and incentives to support engagement.

Critical role of housing program staff and group leaders. All stakeholder groups described the role of housing program staff and health group leaders as critical for promoting youth health.

Lots of times you can do all kinds of research and it kind of comes down to who we hired, who's there, who's showing up with them, who's there when the teen is having a crisis, what their skill level is. – Community expert interview participant

Youth and staff identified several important characteristics of housing program staff and group leaders, including being supportive and “genuine.” Youth and staff felt that staff should be culturally diverse, and representative of the youth being served with respect to race and ethnicity. Youth mentioned that staff with similar lived experiences (e.g. experience of homelessness, adolescent pregnancy, similar cultural background) might be better able to relate. For example, multiple youth agreed as one participant said, if someone came in from a “*suburban area [...] I might feel like you don’t even know – you don’t know what I’ve been through.*” Another youth specifically mentioned the importance of racial concordance, suggesting that “*it’s better to relate to somebody of your race, because then you know what they’ve been through.*” Staff described the value of one-on-one conversations with youth, identifying their strengths and setting individual goals.

Youth and staff also emphasized the benefits of having consistent group leaders, with whom youth could form a sustained relationship while in the housing program, whereas community experts felt there could be some benefit to having a variety of leaders with unified goals but perhaps different approaches.

Staff and community experts highlighted the importance of staff training related to both adolescent health (e.g., mental health, sexual health, trauma) and child health (e.g., child development). One staff noted that “*if we want our young people to be knowledgeable, then we kind of need our staff to be knowledgeable.*” Another shared,

There needs to be some specialized training, especially with early childhood development and those sort of things...it’s kind of like you have to have a dual approach. You know, we’re working with young people who are in crisis, first of all, so there has to be a focus on the young person’s individual needs outside of being a parent, and then there also has to be support for them to be a parent and focusing on the child’s developmental needs and making sure that the program is set up to ensure, you know, some of those basic

early childhood things are going on, assessments, testing, lots and lots of training for staff. – Staff interview participant

Specific to sexual health, respondents acknowledged that with additional training, staff could play a key role in these conversations. One participant noted the relationship between staff and youth may help “*them to open up a little bit more and ask some of those questions that they might be afraid to ask.*”

Trauma-informed, strengths-based approach. Participants articulated two specific preferences regarding program approach. First, all three groups also discussed the high prevalence of trauma and emphasized the importance of a trauma-informed approach as a cornerstone of the program. Second, participants preferred a strengths-based approach rooted in positive youth development that empowers youth, promotes their agency, and encourages them, rather than focusing on risk. One youth focus group participant noted that, this lens should even permeate the physical space, “*there should be...decorations to like liberate pregnant people and young parents.*”

Program Selection and Adaptation

Based on our needs assessment findings and consensus-building process (**Figure 1**), our community-based implementation team selected the Rights, Respect, and Responsibility (3Rs) curriculum from Advocates for Youth as the basis for the group-based intervention for youth and tailored the intervention to address identified content areas and elements of program design.⁴⁴ The team then met for an additional full-day retreat focused on adapting the program to meet the needs of youth at Marlene’s Place, drawing on findings from the needs assessment and evidence-based practice on the delivery of adolescent health curricula. We ultimately proposed a weekly

hour-long curriculum to be delivered over 12 sessions, which were chosen and scaffolded with support from the University of Minnesota Prevention Research Center.

Recognizing the suggestions for a multi-pronged approach, program staff engagement, and the need for healthcare access, we coupled the group-based curriculum for youth with staff training and support regarding key adolescent health content areas of interest to staff and ready access to onsite healthcare for youth. Thus, the EMPOWER Program contained 3 key elements: (1) a weekly health empowerment program for youth based on the 3Rs curriculum, tailored to meet the needs of youth; (2) training and ongoing support for shelter staff regarding adolescent health; and (3) shelter-based healthcare services (Figure 2).

Soliciting youth feedback and review prior to implementation

To further ensure that the proposed plan for implementation aligned with youth needs, members of the EMPOWER team also presented the findings from our needs assessment and the proposed plans for implementation with The Bridge Youth Advisory Board. Youth provided written and verbal feedback on the plans which was reviewed and integrated by the team prior to program implementation.

Discussion

This community-engaged study provides new insights into the healthcare needs of pregnant and parenting youth in shelter,^{45,46} and, to our knowledge, is the first to describe factors associated with the development and implementation of a shelter-based health empowerment program specifically targeting this vulnerable population. Drawing on the tenets of CBPR, we engaged youth, staff and community experts in every step of the process. The application of frameworks from implementation science allowed us to select and tailor a health empowerment

program to address the unique needs of the youth and the partnering community organization, highlighting the advantages of drawing on implementation within a CBPR approach.

There was consensus around several key content areas of interest, including sexual health, mental health, child health and development, and nutrition. Stakeholders in all groups emphasized the importance of a skills-oriented approach for this demographic, aligning with the Marlene's Place goal of transitioning to independence. Consistent with prior literature in this area, they favored a more holistic program, as opposed to focused on a single topic, given the diverse needs of youth.²² This contrasts with existing recommendations for evidence-based sexual and reproductive health programs to focus on specific outcomes (e.g. HIV, pregnancy).^{18,47}

With respect to program design, stakeholders emphasized that the program should be youth-driven, flexible, and engaging, aligning with prior research on YEH.²² They emphasized the importance of several practical elements of the program, such as the availability of childcare during groups and incentives for participation. Building on prior literature regarding the value of shelter-based healthcare, all stakeholder groups agreed that access to health insurance, healthcare (generally and on-site) were critically important.^{22,48} They highlighted the key role of program staff in ensuring the program's success, recommending that the staff be diverse and representative of the youth they were serving. Youth and program staff discussed the advantage of building sustained relationships with consistent staff members over time, whereas community experts explained that a variety of approaches by different staff could be useful.

In discussions about content and design, stakeholders emphasized, both implicitly and explicitly, the importance of a strengths-based and trauma-informed approach. Not only do these

approaches align with The Bridge philosophy of care, they also align with national recommendations for supporting YEH and the limited prior research on this group.^{22,49}

Applying frameworks from implementation science,^{31,36} our research describes a process for community-engaged needs assessment, coupled with a consensus-building process to engage key stakeholders in program selection, adaptation and implementation. Prior research has highlighted the value of utilizing implementation research approaches to improve programing for people experiencing homelessness.^{50,51} In our case, these frameworks helped ensure consideration of program- and site-specific factors that could influence successful implementation.

Our team encountered several challenges associated with this process that could be important to consider for others addressing the needs of pregnant and parenting YEH. First, although many evidence-informed health programs addressing parent-child health or family planning among pregnant and parenting youth exist,²⁴⁻²⁹ few have been designed, implemented, or evaluated for historically marginalized communities, such as YEH.²¹⁻²³ Additionally, all stakeholders emphasized the need for real-time program adaptability based on the particular and fluid needs of youth in the program. Thus, implementation of an existing program with fidelity could pose a challenge in this unique population. To navigate this challenge, we engaged key community stakeholders in a consensus-building process to review the data, then selected the existing evidence-informed program that could be most adaptively tailored to meet the needs of the youth and the community partner.

Stakeholders also identified a diverse range of important content areas that related to the health of both the adolescent parents and their children. Most existing programs focus on a specific area of health, and health programs for pregnant and parenting youth typically focus on

either the parent or the child, rather than the dyad.^{18,24–29,47} Even when we prioritized the top content areas, there were no programs that existed to holistically address a broad range of needs. Again, this required us to select a highly adaptable and less structured program that allowed us to add key content areas based on participant needs and apply a dyadic lens to implementation.

This study has several notable strengths and limitations. We used multiple forms of triangulation and drew on existing conceptual frameworks to guide analyses. Aligning with the tenets of CBPR, community stakeholders were engaged throughout the process from planning the needs assessment, conducting analyses, program implementation, and sharing/disseminating findings. We reported on the process and findings from stakeholders in a single community organization in a particular geographic location; findings regarding programmatic preferences may not be generalizable to other settings and populations. As with CBPR more broadly, the process we outline here is time intensive and required significant trust-building between partners which may not be feasible for all programs.

Our findings have implications for other shelters and communities supporting pregnant and parenting YEH. Despite the commonality of pregnancy and parenting among YEH and a national call to address health risks among this population,³⁹ few programs have been developed to respond to their unique needs. As the characteristics of youth and implementation climate may vary by housing program and community,⁵⁰ these findings highlight the value of a community-engaged process for assessing youth needs and implementation factors in selecting and tailoring programs. This work lays the foundation for future research on the feasibility and long-term effectiveness of health empowerment programs for pregnant and parenting YEH and their children.

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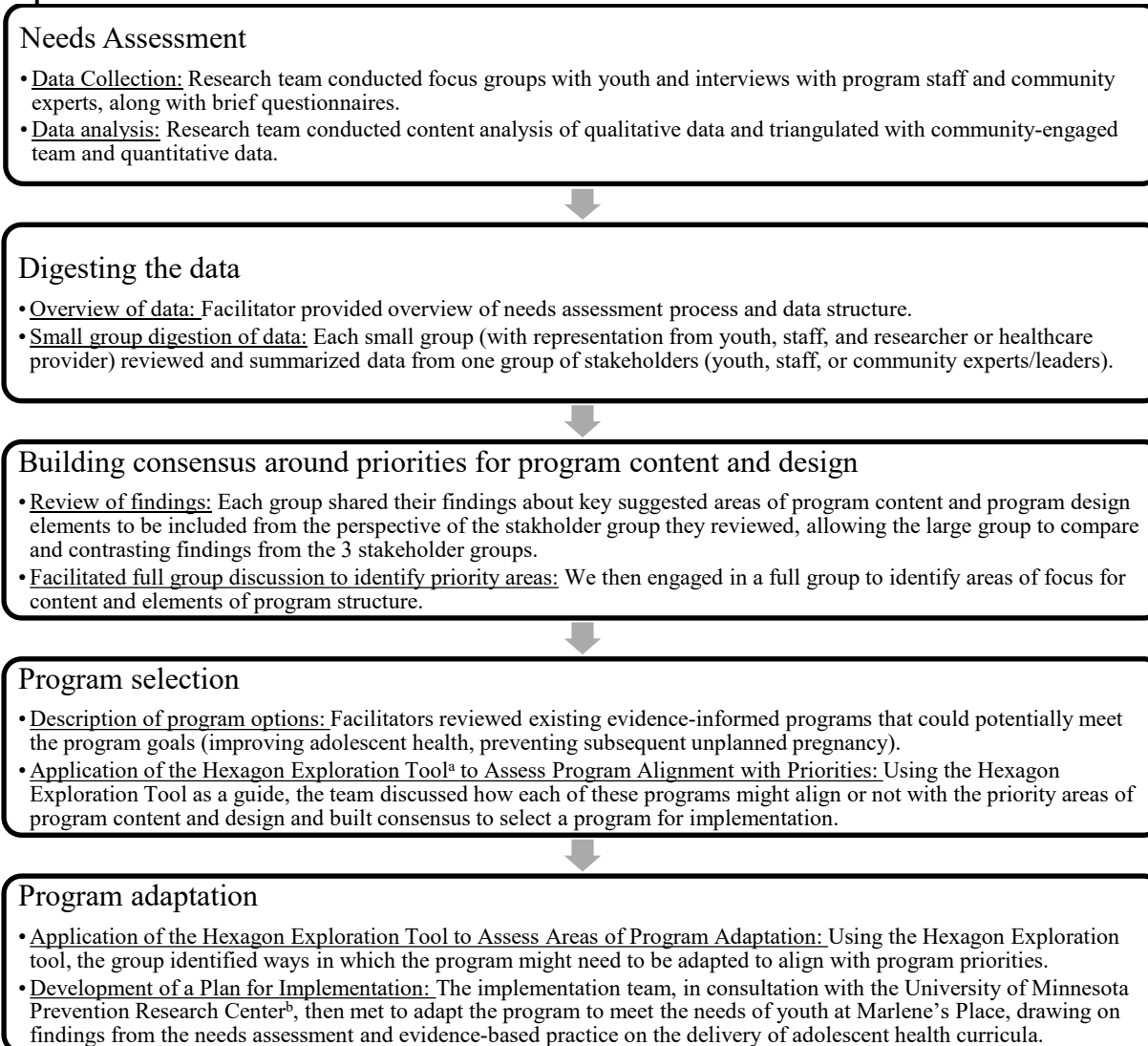
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Figure 1. Schematic of Community-Engaged Consensus-building Process for Program Selection and Adaptation



Notes. This consensus-building process was adapted from the Technology of Participation to engage youth, staff, clinicians and researchers in processing the complex findings from the needs assessment and collaboratively selecting and then adapting an existing evidence-informed curriculum for a group-based intervention for youth.⁴⁰ This process involved our community-engaged implementation team, which included: members of the Marlene's Place staff, leadership team members from the The Bridge, researchers from the University of Minnesota, healthcare providers who provide care at the The Bridge from Children's Hospitals of Minnesota and the University of Minnesota, and youth who had been engaged in the needs assessment with lived experiences in homelessness while pregnant and parenting.

^a The Hexagon Exploration tool from the National Implementation Research Network identifies six contextual fit and feasibility factors for program implementation.³³ Facilitators engaged participants from each of the stakeholder groups represented in a discussion around how each program might fare with respect to each of these factors.

^b The implementation team then met for an additional full-day retreat done in consultation with the Director for Adolescent Sexual Health Training and Education at the University of Minnesota's Prevention Research Center, who has expertise in the implementation of adolescent sexual health programs and assisted the team with planning for and adapting the selected program. She also provided training for group facilitators on the delivery of adolescent sexual health curricula in a trauma-informed, inclusive and strengths-based manner.

Figure 2. Elements of the Empowering Parents for Wellness in Shelter (EMPOWER) Program

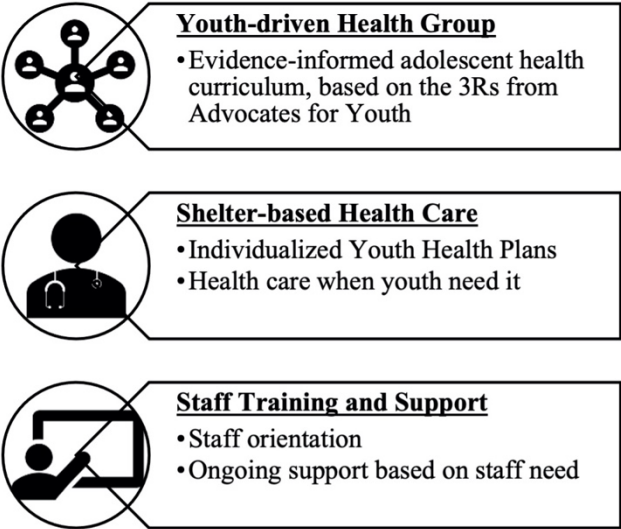


Figure depicts the three elements of the EMPOWER program that launched at Marlene’s Place in 2019. The program was developed based on youth, staff and community expert input.

Table 1. Sample Characteristics

	<i>N</i>	(%)
Youth (n=17)		
Age		
Minor (16-17)	5	(31.2)
Young adult (18-21)	11	(68.8)
Gender		
Female-identifying	13	(76.5)
Male-identifying	3	(17.6)
Trans-/non-binary	1	(5.9)
Experience parenting		
Not parenting	12	(70.6)
Currently parenting	5	(29.4)
Staff (n=8)^a		
Gender		
Female-identifying	5	(62.5)
Male-identifying	2	(25.0)
Trans-/non-binary	1	(12.5)
Role ^b		
Direct care with youth	8	(100.0)
Management/Program supervisor	2	(25.0)
Community experts (n=5)		
Gender		
Female-identifying	4	(76.5)
Male-identifying	1	(17.6)
Role ^b		
Public health professional with expertise in adolescent pregnancy and parenthood	2	(40.0)
Clinician with experience providing healthcare for pregnant and parenting youth experiencing homelessness (MD/RNs)	2	(40.0)
Leaders of housing programs or shelter-based health programs for youth experiencing homelessness	2	(40.0)
Researcher with expertise in youth experiencing homelessness	1	(20.0)

Note. Percentages may not sum to 100 due to rounding.

^aA total of 8 staff participants completed interviews and an additional 10 completed the brief questionnaire used to triangulate these findings.

^bRole categories are not mutually exclusive. Participants were frequently involved with more than one role.

Table 2. Perspectives on Program Content from Youth, Staff, and Community Experts

Sexual health and relationships	
<i>Emphasis on gender- and sexuality- affirming, trauma-informed and strengths-based approach</i>	
<i>Youth</i>	And it's okay to want that, you know, where a lot of people be like, "Oh, you're having sex? Get out of my house." You know, or, oh, you think you're doing this, this, and that, like a parent, they try to say — put a stop to it. But, really, in all reality, we're all human, we all hit that stage in life, and that's okay. You know, we need to learn how to teach them like, okay, yes, this is okay, so this is how we do it, you know. Yes, you want to have kids, yes, but, you know, how about we do this, this, and this, or try to do this first, you know, because — and that's where the education will come into place, you know. But instead of shaming or blaming, I feel like we should be like, "Okay. Yes, this is okay, but, you know, this is how you do it,"
<i>Staff</i>	Absolutely. I think there's stuff that kids don't know, and it's not really cool to say, "I don't know about sex," because you're supposed to be perfect at it when you're a teen, right, you know. So I think the more education that we can offer without it being circumstantial, the better. Like let's not wait until there's a kid with an STD to do an STD group, you know, so nobody feels like it's — So sexual health through the lens rather outside of the lens of heteronormativity is very important, because we're going to have youth up there who — I mean, maybe they identify as bisexual.
<i>Community experts</i>	Oh my gosh. First of all, contraception immediately if it's a pregnant teen or a parenting teen what are the plans for contraception going to be after the pregnancy has come to fruition. And certainly for a parenting teen in an attempt to forestall you know an unplanned second pregnancy. Understanding the risks of STDs during pregnancy, we know that you know, certain STDs could be very deleterious to a baby. And so if sex is going to be practiced while pregnant, you know what is appropriate safe sex during that time. And of course that doesn't change once you're not pregnant anymore, but there's unique risks for pregnant and parenting.
Mental health	
<i>Specific focus on trauma and post-partum mental health concerns</i>	
<i>Youth</i>	And I feel like also too, the therapy services would be absolutely amazing, because, you know, you've got a lot of people who don't work well in groups or who aren't trusting... And, to me, I'll say personally I had a therapist when I was 18 or 19, you know, and that helped me a lot going through postpartum depression. That was real after having a baby. And during, though, I had, you know, my therapist because I was just so stressed out, gaining weight, you know, worried about jobs, working, going to school, so I think the health part is just really — mental health, to me, is a big thing, and I think that's what a lot of these kids suffer with, because I don't think they don't want to do the work or like to get better, to have a good pregnancy and be healthy... But I think depression and anxiety is real. I think historical trauma is real when it comes to them, and I think it's time to tell them like it's okay to feel that way, but let's help. Because usually we just send them off.
	So, I think, there's a lot health issues or disparities associated with PTSD just given how much that they've faced or they may face, because, yeah, it's a situation where they come — we're crisis intervention, right? I mean that's the purpose of the work that we do here specifically while trying to maintain our mission, specifically with a residence house program, but this is going to be a completely separate program. I get that. But, even so, the matter of fact is likely they're going to come from pretty adverse circumstances. So, yeah, disparities or issues, health issues associated with PTSD, management of that PTSD if at all, which nine times out ten, it's not really manageable for them just because they're not equipped with the appropriate tools and the support to ensure that.

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<i>Community experts</i>	And I forgot the most important one of all mental health. Oh my gosh, let's go back to all youth, mental health. You know, first of all, making an appropriate diagnosis, you know whether it's depression, anxiety, whether it's ADHD, I mean all the different maladies that impact all of us. And I think one lesson and inadequately sheltered kids are bigger, even even bigger. And so not only access to therapy but access to medication. But to understanding what's going on...We know in people who have good supports how depression and anxiety in parenting is just a huge barrier, huge challenge. And with pregnant parenting teens with all the other stuff that they have to deal with the uncertainty of the future, you know not being in school, all their health issues those mental health things can be just overwhelming. And when I do [depression screen] and talk to my young pregnant parenting teens I mean it's almost a given that there's depression and or anxiety and other things.
Child health and development <i>Includes routine child care, developmental milestones and parenting</i>	
<i>Youth</i>	And I would say also too, to me, the child development is the most important, because a lot of people don't understand that between the ages of zero to five years is the most critical years of the kids' lives and what they develop. I feel like a lot of people don't understand. They think when their kids are babies, because they're one and two, that they don't need to go to school. I think that is very important, because I've noticed like delays in education with a lot of kids, so they don't talk or some of them won't be as verbal, things like that.
<i>Staff</i>	Even just like general like when should I call the doctor for my baby, like what is normal and what's not as far as like development, like kind of just looking out for like those red flags and when someone needs attention.
<i>Community expert</i>	Really major this is a step that so many of my teen parents, not so many, many of my teen parents misconstrue what normal child development is and feel that their child is either bad or wrong. I see a lot of discipline in the exam room. You know stop grabbing my purse, well that's what two year olds do - they do grab. You know how do we -- and what's appropriate response to normal infant and toddler behavior because that's the age you're having as infants and toddlers. And a lot of my young people have not been disciplined in an appropriate way when they were young so they are you know just obviously -- and some of that it is embarrassment if your to your two year old is shrieking in the room the whole time. Yesterday I had a mom slap a baby's hand for just crying during the exam. I said "No, your baby is afraid of me. It's okay, normal...Normalizing infant toddler behavior so they're not labeled as bad child. And that just carries on.
Nutrition and Exercise <i>With emphasis on the impact of food insecurity</i>	
<i>Youth</i>	I felt like health — what else — health — pregnancy was just not eating not good food. I worked at McDonald's on [street] my whole pregnancy, so that was not good like to eat. Yes, I did, until I was ten months pregnant. I worked right at the school right there at McDonald's. Yeah, I used to go to school all day and then I would go to work. And I did that too after [Redacted] was born. I worked there for a whole like year and a half. Like so I would go to school all day. My mom would have to meet me. I was just very stressed. I wasn't getting sleep being pregnant. I was very sick. So it was like schools wouldn't care, though. You know what I mean? So it was like I would say those were the hardest health — like I had no really support. Like I had support, but there was always judgment with it. Like, you know, it was always, "Oh, you won \$300, but you have to give \$20 to the State." It's like, you know, like you have to pay taxes. That's just how I think about pregnancy being so young. It was always, "Oh, that's nice, but this and that." It's like that really sucked.

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<i>Staff</i>	<p><i>Nutrition</i> – I think the reason why a lot of programs kind of fail — or when it comes to health, the issue is they don't pay attention to the foods that the youth are eating. So I think it would have to be a program where they're focused on healthy eating not so much as quick food. So just making sure that they have some kind of — it can be cooking classes or just making sure that they incorporate something where they are giving the youth healthier options to pick rather than quick foods.</p>
	<p><i>Exercise</i> – And also paying attention to exercising, so incorporating exercising somewhere in there, whether it's having activities where they walk to the lake or just walking around the neighborhood so they can see, you know, people within the community. So incorporating, I know, food and exercise and that would be a good way to get the kids outside also.</p>
<i>Community experts</i>	<p>Nutrition is a huge; I think a health issue that affects homeless youth overnutrition in a bad way, under nutrition in all the ways that that means, access to food.</p>
<p>Independent living skills <i>Especially as they relate to health care and health systems, connections with community resources</i></p>	
<i>Youth</i>	<p>You know, I've had girls ask me that, "What's a credit score?" A lot of people don't know about real life, so when they go into the world, they're surprised. Or like they don't like rules or structures, and I think preparing them, okay, teaching them job interviews, resumes, not only that, but, okay, what's a credit score, okay, if I have a bank account, how many deposits do I — how many times can I use my card a month, or teaching them things like that, because they're like, "I didn't know," or what's the late fee on rent. You know, a lot of people don't know these things, and I feel like those are the biggest skills to life.</p>
<i>Staff</i>	<p>You have so many questions come up, I think, when you're a first-time parent, also, so I think even some way where you have something in place where understanding when they should go to the ER and when it's something that they can do without the child having to go to the ER. Because I know when I had my son, again, I was going to the ER for everything. They were like, "No, all you need to do is this." So kind of something where they understand certain guidelines. But, of course, if they want to go, also let them know that they can go, but just kind of figuring out what you can do to where they don't get scared so fast and think that's the first thing that they need to do</p>
<i>Community experts</i>	<p>Well, I would think it would need to be rather holistic I think you would want to take a look at kind of all the needs of the youth that are there. What are their just basic social service needs? Are there assistance programs that they need to get on? Do they need childcare? Are they enrolled in school? Do they have a medical home? Are they you know, what are the support people formal and informal supports that are within their community?</p>

Table 3. Perspectives on Program Design Elements and Approach from Youth, Staff, and Community Experts: Qualitative Data

Youth-driven	
<i>Built on youth input, generates group discussion and creates opportunities for youth leadership</i>	
<i>Youth</i>	I think talking to the youth. I think talking to the community around you, like I said before, not only the community, not just young people that you may see, people who are older who have been through what we've been through, because I know a lot of people that's older that's been teen parents. And they was like, "Well, I wish we had more programs," and I think it's good. So I think with you guys, more communities, you know, just speaking to our community, that's it, really, and letting them know.
<i>Staff</i>	My job, this is what we do, this is what we — the best part about my day job or my main job is that we rely on youth to tell us how to do our job, to tell us how to create programming. We ask them for help on addressing issues that we see in the community. I don't know. I think we could talk until we're blue in the face, but they always have the best ideas and the most raw truth, so it's very important to talk to them.
	<i>"Opportunity for group discussion among youth about health-related issues,"</i> I think that's extremely important too, because they are probably one of their most important educators. You know, they share the experience together, and they can teach each other, and they can teach us too, but we definitely need to listen to them.
	Yeah. Well, I see the opportunity for group discussion. I think getting them involved in talking with each other just helps create an open space and a space where we can respond to them rather than coming up with a curriculum based on what we think they need.
<i>Community experts</i>	<i>Youth leadership opportunities</i> – You know I guess I would just flip most of them and say opportunities for youth to really develop and lead. I think applicants need to periodically provide input to the program I think they need to provide input every single session. How does this work for you? What worked well? What didn't work well? How did you know, were they're really using those groups skills? [00:46:00] And they're given agency in it I think.
	<i>Youth leadership opportunities</i> – So here in [place] you can look at the program called [program] it is kind of a faith based program but it's not like to force religion down your throat. But they've done a really nice job of taking older kids and kind of peer mentoring with the younger kids. Again, they have to kind of be careful make sure staff is around so there's no vulnerability issues. But I think especially with parenting and pregnant teens you have opportunity there to take the mature kids, especially if there's going to be some little in there really work with them and kind of build in some sort of peer support along with the case management that you -- that you're likely already talking about.
	<i>Youth input</i> – I think what would be really helpful is having young people's input in how it's been designed what I've seen and when people come in and think that they know what's best and design something and then get their feelings hurt when it doesn't work out. I think just offering young people an opportunity to do as much in the same as they possibly can and give feedback to what the program looks like, how it's decorated, more meaningful opportunities to provide input around programming and woos and group topics and I think that that's something that can't be stated enough...But I still think that anytime you can have young people giving input into how things are going to be done that they're going to buy into it a lot more.
Adaptable and tailored to youth needs	
<i>Allows flexibility to change according to youth needs</i>	

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<i>Youth</i>	“The ability of the program to be adjusted to youth needs” – like caring about their input. I’m not saying like if one person suggested something, change the whole flow, but like if you hear multiple complaints about one particular thing, that’s different. If more than one person complaining about something, it might not be right. Knowing that you care, the kids are more comfortable being there.
<i>Staff</i>	<i>Flexibility in approach</i> – What I tell maybe new interns or new staff before they kind of like facilitate a group is, “You have to know your audience. In what ways are they going to engage, and how do they learn most effectively?” So we have a group right now that responds well to like kind of hands on. We like to draw pictures. “What does love look like? Let’s make a mood board. How are we feeling today?” those kinds of things. But we’ve had groups in the past that respond to, you know, we circle up, “Let’s have a conversation.” We’re bouncing back and forth and talking about a particular topic. We’re bringing up questions. So in that regard, I think it — that’s where it’s important to have the staff and the young adults come together to talk about the — what context do they want to learn and how do they want to learn it?
	<i>Flexibility with content</i> – I think it would have equal parts built in curriculum as well as room for anybody in the Marlene’s Place program to say, “I would like to learn more about this,” so that they can tell us what they need as opposed to staff determining what they need.
<i>Community experts</i>	The adaptability is critical. We have changed and adapted thousands of time at [program]. I mean, over and over and over again based on what we’re seeing with the youth that are coming in or differences in things. Yeah, it’s critically important.
<p>Fun, engaging and interactive sessions that build community and trust <i>Engages youth in interactive activities, community-building, safe spaces</i></p>	
<i>Youth</i>	<p><i>In response to “What makes groups go well?”</i> Youth 1: Good staff. Youth 2: I mean, they need to be fun and entertaining.</p>
<i>Staff</i>	Nuts and bolts, I think you're looking for a lot of participation. That's the first thing. You're looking for a lot of participation. That could be kids presenting, that can be kids — like here's one thing that’s really cool. If you're going to do a group on something, I'll pick out a kid and I'll be like, “Hey, you're going to co-facilitate with me,” and you kind of put them in the driver’s seat. It could be that. I think that the nuts and bolts of it is, yeah, there's going to be lots of participation — if it’s going to be a staff member or the group — whoever it is, right, doing a lot of the talking, then you need to make damn sure that they've got everybody’s attention and people aren’t just glossing over, because I think adults can tend to be like, “Okay, well, I'll do this because this is a function of why I have to be here.” Kids don't have that kind of discipline. Eventually the frustrations are going to come out, “This isn't meeting my need,” you know, that sort of thing.
<i>Community experts</i>	I think probably the first thing that makes them successful is being super authentic and open and honest and willing to engage. And I mean just their level of comfort in talking about health and especially sexual health and just them being really engaging. What I have found doesn't work is when people are coming in and doing kind of lecture style, presenting information it's really dull. The young people want to play games, they want to have things be exciting and entertaining. They're already a little grumpy that they have to attend the meeting anyways when they really just want to do their own thing. So I think just anything that you can do to make it engaging and have the folks who are coming in to do that presentation they have to like teenagers that’s not everybody’s forte. And they’ll pick up on it really fast if you're not comfortable or you're not wanting to be there and that won't be successful.

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	<p>And I would say they in terms of is a group that you can get that group of teens to coalesce as a community. and to kind of view themselves not only individually, but as a group of people is having some agency and empowerment I think peers are really important at that age of their life. And so having those peers be there and feel that they're part of a peer group that has some collective voice is very important thing. Friendship is really important for them and fun. I mean I think that you just can't underestimate the power of having fun, cool.</p>
<p>Healthcare and health insurance access <i>Onsite health services and connections with health care</i></p>	
<p><i>Youth</i></p>	<p><i>Accessing primary care –</i> Youth 1: Making sure they get checkups especially for the kids because kids have milestones that they have to get checkups at. Young parents don't really know that they need to go to the doctor for checkups. They only bring their kids when they get sick. They need to know that they have to bring their kids in for like a 16 month check up or 1 kyear checkup or something like that. [baby crying]. If they don't know that, someone should educate them on that. Youth 2: I think checkups for the parents too because like they probably don't know whats going on with their own bodies because they not in a stable situation.</p> <p><i>On-site healthcare –</i> I know it would be a lot of money to have a nurse always [at the shelter] all the time but it might be something when they're sick there.</p>
<p><i>Staff</i></p>	<p><i>Connecting with insurance –</i> Insurance, insurance, insurance, first and foremost. I think having somebody just work with the young person to help navigate that. I know that my program only — I mean, we work with 10 to 17, so we do a lot of, “You have an appointment at this time. You're getting a cab. This is what's happening,” which I think can be very effective, but again, it's for younger individuals. Could be effective for 16 to 20 year olds, but maybe they want more autonomy. So that's why I say like working with instead of like working for. Yeah, unless they request it. If they say like, “Yes, please make me an appointment,” then like, let's do it. I think that just like listening to them about what they need is going to be the most effective.</p> <p><i>Accessing primary care –</i> The biggest health issue is not having a health provider, not having a health history, not having an environment that I think considers health a priority. I think a lot of the youth folks that we work with, health is addressed on an emergency basis and not a preventative basis, and it's just all about priorities. When you're in unstable situations, you're not going to go get preventative care, you're going to deal with stuff as it comes up, and so it's kind of built this habit of the way healthcare is used. So I think programming can help change that too with these young folks, to like instill some sort of regular check-ups with the kids and with the parents, to build that habit of, you know, you need to just check on stuff on a regular basis even if you don't feel like something's wrong necessarily, which is a hard thing to understand. I'm XX years old, and I still don't really understand. I've been sick for two weeks, and I haven't gone to the doctor.</p>
<p><i>Community experts</i></p>	<p><i>Accessing primary care –</i> And again, the kids even like the kids at the emergency shelter here who are newly pregnant, they usually get plugged into healthcare pretty quickly and easily. So there's some preventative stuff that's happening. And case management kind of kicks in from the [other city] health type of organization. So it's really just, the basic acute care stuff that goes along with new pregnancy. It's making sure that they're going through their visits.</p>

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	<i>Connecting with insurance</i> – The system for connecting youth with health insurance is critical but that's a natural component at [other housing program] because all of our moms get on [financial assistance]. And that's part of that but I think that that's critical. The accessing healthcare for youth and their children when needed is also really critically important but probably more so is their access to dental healthcare.
Child Care <i>Emphasized need for child care during group sessions</i>	
<i>Youth</i>	And childcare during group sessions, because this is an example [gesturing to screaming children during focus group, others agree]
<i>Staff</i>	Childcare, absolutely. You have to give them an opportunity to focus on their own needs for a little bit. We always encourage our youth to bring their kids if that's the only option that's available, but it is always a huge distraction to try and care for your child. There's so many things that are taking place. You know, you don't want to be embarrassed in front of other people, that you're not a good parent, and so that automatically becomes your priority and, you know, you lose focus on what you're there for, for yourself.
<i>Community expert</i>	The childcare [for sessions] is critical. You can't expect a mom to pay attention if she has to pay attention to her child or children.
Incentives for program participation <i>Recommended incentives for participation, built into the structure of the housing program</i>	
<i>Youth</i>	Reachable goal-setting, I should say, because, you know, a lot of kids feel like — they feel helpless, they feel like they're — you know, they don't feel like they're able, you know, like — and it's like just as far as going to a group, like just what you did with us right now, like, okay, and even if it's not money-wise, you know, like being able to offer, okay, well, you know, you've got to start on one of these groups. You know, the more groups you attend, the more, you know, points you get or the more — you know, and however many points you get, you receive this, or, you know, you get a gift card after every group, you know, but you actually have to participate in the group, you know. And some kids might at first just participate to get the money, but once you participate so much, you start to catch onto it. [Other youth affirm]
<i>Staff</i>	Definitely an incentive for the youth to be there, whether it be like pizza — because I think like one of the hardest things is getting the youth to actually get in that physical space, so I think like making sure it's a time that works for most youth, incentive to be in the group.
<i>Community experts</i>	Incentivizing as much as you can young people participation.
Key Characteristics of Housing Program Staff and Group Leaders	
Supportive and “genuine” group leaders and program staff	
<i>Youth</i>	Not only staff that can handle some things, but they handle genuine situations and can be real [multiple other respondents agree] Like they need to feel like staff actually listens to them and care about what they are feeling.
<i>Staff</i>	Also, anything where it's a group about encouragement, because being young and having a child is already a lot, so anything that's offering some kind of encouragement will be beneficial too, because I know when I was — I had my son at 19, and the support was not there. So making sure that they have support and they're always being encouraged is going to be very helpful.

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<i>Community leaders</i>	Moderator: What do you think makes [programs to improve youth health] successful or not successful? Respondent: The staff 100%. The staff who can meet a teen where he or she is and so much of the things that we have said before; be a good listener, reflect back, really, and I'm very passionate about this, show a sincere interest and know each kid something about them that you can.
Representative and culturally diverse staff and group leaders with lived experiences	
<i>Youth</i>	Youth 1: The staff should be diverse. Some staff that may have went through pregnancy. Youth 2: Different minorities and different races. It affects — [Other youth affirm]
<i>Staff</i>	And, also, simply having somebody that reflects the identities of our youth. We serve primarily black or African American youth, and I don't think we have a medical professional that comes in that shares that identity, and so, I don't know, that can be difficult. I think it's also difficult for young people to have their concerns taken seriously. So that's what I would say.
<i>Community experts</i>	I think having and - I can't specify enough - having role models and mentors that look like them. It's probably the biggest factor when you hire people; representation really does mean it and I'm saying that as a XX-year-old white woman. But it's essential.
Consistent group leaders	
<i>Youth</i>	<i>Youth 1:</i> I feel like, you know, that, you know, when you've got a leader, you know, and because it's like if I go to a group every time and it's a new leader, I'm going to be like, dang, this is a new person that don't know nothing about me. [Other youth affirm] <i>Youth 2:</i> Or nothing I said last time. <i>Youth 3:</i> They don't truly care about me, yeah. <i>Youth 4:</i> Yeah, you're just throwing somebody in there to run the group, you know. Where if I had the same person and every single time they hear me, they're getting to know me, you know, as I'm getting to know you, you know.
<i>Staff</i>	I mean, everything I focus on is relationships. When we're working with kids, everything has to start with the relationship. So consistency in leaders for our group, same leader every time, that would be the most important thing, because you're building — I mean, when you're trying to help people learn something, it's a step-by-step process, and so each group should be a build off of the last one, right? And then, you know, when you're getting into leading a group, there's a lot of trust that gets established, or that can be established, and that is what's really going to take a group beyond the surface stuff, so absolutely extremely important.
<i>Community experts</i>	Yeah, I don't think having consistent leaders is important as matter of fact I think that they love having variety. So I wouldn't say that that's important.