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Mindful Mornings: Piloting a Meditation Group with Vulnerable Adults in a Drop-in Center

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Piloting a Meditation Group with Vulnerable Adults in a Drop-in Center

by

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Abstract

An accumulation of stress and lack of coping resources can contribute to a higher incidence of mental and physical health disparities. Homeless adults are one of the most vulnerable subgroups who utilize Enterprise Resource Center, a peer-run day-center in Marin County. Because stress from multiple factors was identified in this transient and high-risk population, an intervention for stress reduction and management was explored. The findings from the needs assessment suggested that there was a need for an integrated approach for stress reduction and management. The challenge of sustaining a program was also highlighted during the needs assessment.

A brief mindfulness meditation program was piloted as an evidence-based intervention for its feasibility and potential effectiveness at the day-center. The peer-facilitation model was also explored in order to fit the model and culture of the center. The pilot meditation group was conducted over a six-week period with seven group sessions. The total of nine different individuals participated over the duration of the program. The most common feedbacks received from participants included feelings of calmness and relaxation after meditating for 20 minutes in a group. This suggests that a brief meditation program may be added to the regular programming to create a more integrated approach to manage mental, physical, and emotional comorbidity seen in this highly vulnerable population. Further research should be done to explore the safety of meditation programs especially for vulnerable adults as there is currently no guideline for screening individuals for risks for adverse effects of meditation.

Key words: Mindfulness, Meditation, Homeless Adults, Vulnerable Adults, Community-based

Executive Summary

Homeless adults are one of the most vulnerable populations and are at much higher risk for a wide range of health disparities. Higher rates of physical illnesses are reported among those who experience homelessness, and the mortality rates are four to nine times higher than the general population. Conservative estimates also suggest that mental disorders affect 30-40% of the homeless population, which also contributes to the high mortality rate. In a population that has a higher occurrence of psychiatric disorders, substance use disorders, history of trauma, and chronic illnesses, integrated approaches of care are considered to be best practices.

Enterprise Resource Center (ERC) is a peer-run day-center where a wide range of services are offered including support groups, outreach programs, education programs, peer counseling, employment, and peer care-management. ERC runs on the harm-reduction model creating a low-barrier environment. All services including educational and support groups are provided by trained peer counselors. ERC initially started as a mental health program and often times, the program serves as an entry point to psychological care for those who are homeless. However, while a large portion of the client population experiences homelessness or is at high risk, not everyone has a diagnosis of mental illness.

This explorative study was divided into two major parts. The first part was a needs assessment of the target population at ERC, and the second part was a pilot of a brief morning meditation group over a period of 6 weeks. The needs assessment was conducted to identify needs within ERC as well as in the context of homelessness service in the county. The method for the needs assessment included interviews, group observations, a literature review, and attending learning events about homelessness in the county. Based on this assessment, a gap was identified. Despite the high need for stress reduction skills in the target population, there was no

program in place at ERC which targeted stress reduction and management.

The second part of the study involved the development and piloting of a brief morning meditation. A peer-facilitation approach was also explored as a delivery model. The main goal of the pilot was to test feasibility and effectiveness of a brief peer-led meditation group at ERC. The total of seven group meetings was held over a period of six weeks. Each group meeting was 45 minutes in length with 20 minutes of guided meditation. The total of nine different individuals participated. Five questions were asked at the end of each group meeting to gain insights from participants. The majority of participants reported feeling calm and relaxed after a brief mediation. The findings from the pilot program suggest the potential benefit of incorporating a brief meditation program in the services offered at ERC. The peer-facilitation model needs further exploration as well as safety considerations. Currently, little research exists which explores the safety of brief mediation programs. It is unclear what the best practice is to ensure the safety of the participants especially in the vulnerable population with high occurrence of psychiatric illnesses. For this reason, safety precautions should be carefully considered when implementing a meditation program for vulnerable adults. Today, there is no standard procedure to screen people for risks of adverse reactions from a meditation program, and this is the area which needs further research.

Homelessness Overview

Mr. K is a man in his 60s. He used to teach in high school and coached a football team. He had two children, a wife, and a job he really enjoyed. When one of his sons had a tragic accident at a young age which left him permanently disabled, Mr. K turned to heavy alcohol use as he blamed himself for not preventing the tragic accident. Eventually, his marriage fell apart. He stopped working, and now he is in his 60s completely estranged from his family. Due to his

heavy drinking, a local shelter would not allow him to stay the night, so he slept on the street. He had multiple chronic health issues including kidney failure and heart problems. He was often found with poor hygiene and incontinence near the train rail pushing a shopping cart.

Mr. K is one of the many who experience homelessness in the United Sates. According to the 2016 report from US Department of Housing and Urban Development (HUD), homelessness is defined as a lack of "fixed, regular, and adequate nighttime residence" (p. 2). In the same report, it was estimated that 549,928 people were experiencing homelessness in the United States on a single night in January 2016 (HUD, 2016). Of those people, 68% were staying in shelters or transitional housing while 32% were unsheltered (HUD, 2016). Homelessness affects persons of all age groups including children (22%), individuals between the ages of 18 and 24 (9%), and those over age 24 (69%). In terms of gender, 60% of people experiencing homelessness were men while 40% were women and less than one percent were transgender (HUD, 2016). Women were more likely to be sheltered compared to other groups (HUD, 2016). Approximately half of those experiencing homelessness were white (48%) followed by African American (39%), Hispanic or Latino (22%), multicultural (7%), Native American (3%), Pacific Islander descent (2%), and Asian descent (1%) (HUD, 2016). Homelessness is also diverse in its experience (Lippert & Lee, 2015). There are three categories of homelessness: chronic, episodic, and new-entry (Lippert & Lee, 2015), and the majority of those who experience homelessness do so on a temporary basis (Reed, 2014). In fact, 37% of the homeless individuals experience homelessness for one week or less, and 60% of them are homeless for 30 days or less (Reed, 2014).

In the state of California, currently there are approximately 118,142 people experiencing homelessness, which accounts for 22% of all people experiencing homelessness in the U.S (HUD, 2016). Of those, 66.4% of were unsheltered, which makes California a state with the

highest rate of unsheltered homeless people (HUD, 2016). Although between 2007 and 2016, California had the largest decline in number of homeless people (20,844 fewer), between 2015 and 2016, California experienced the largest absolute increase in homelessness with 2,404 more people experiencing homelessness (HUD, 2016). In Marin country, according to the point-in-time survey completed in January 2015 by Applied Survey Research (ASR), there were 1,309 individuals experiencing homeless and 64% of these were unsheltered. Thirty-one percent of those without shelter were in San Rafael, 22% in Richardson Bay, and 13% in Novato (ASR, 2015).

Homelessness and Stress

Stress theory suggests that accumulations of stress and lack of coping resources contribute to higher incidents of mental and physical health disparities in this population (Lippert & Lee, 2015). Hardships and multiple stressful events may be experienced throughout the life course of an individual and during homelessness in adulthood contributing to stress accumulation (Lippert & Lee, 2015). Homelessness is a complex social issue with diverse contributing factors, and exploring certain hardships commonly associated with homelessness may facilitate an understanding of stress and coping in this vulnerable population.

Material Deprivation

Lack of stable housing and means to obtain food and clothing is a major stressor. Persistent poverty, which is a major precursor to losing one's home, can be caused by unemployment, insufficient government assistance programs and eligibility, and disabilities (Lippert & Lee, 2015). In addition, the rising cost of housing in major cities pose a barrier to obtaining housing; the homeless population has increased in cities with rising housing cost (Koh

& O'Connell, 2016).

Physical Health

Higher rates of physical health problems have been reported in homeless populations especially among those who are chronically homeless. Those include higher rates of tuberculosis, HIV/AIDS, heart and lung disease, hepatitis, and other infections (Baggett et al., 2014; Lippert & Lee, 2015). Disproportionately higher mortality rates have also been reported in the homeless population; the mortality rate for a homeless individuals is four to nine times higher than the general population (Plumb, 2000; CDC, n.d.). Crowded shelter environments leave individuals more prone to coommunicable diseases (Koh & O'Connell, 2016). Such environments are often unsafe, unsanitary, and noisy, which makes it difficult to manage chronic health conditions adequately (Plumb, 2000). In addition, lack of access to necessary medical care poses another barrier to the management of physical health conditions (Plumb, 2000).

Psychological Health

Conservative estimates suggest that mental disorders affect 30-40% of people who are homeless with common conditions being depression, schizophrenia, and suicidal ideation (Lee, Tyler, & Wright 2010; Lippert & Lee, 2015). Alcohol and other substance use disorders often co-occur with these conditions (Lippert & Lee, 2015). Poor stress coping through substance and alcohol use contributes to poor physical conditions and worsening of chronic illnesses (Koh & O'Connell, 2016), which leads to the high mortality rate in this population. In fact, one study found that a mortality gap in substance-related death between homeless and non-homeless population is as great as 57% (Baggett et al., 201).

The causal relationship between homelessness and mental health conditions is unclear. It can be hypothesized that increased isolation and reduced employability contribute to one

entering homelessness while the other perspective is that loss of economic stability, safety and social integrity due to homelessness contribute to the mental health problems (Lippert & Lee, 2015).

Trauma and homelessness

Trauma is defined as an experience which creates fear, feeling of helplessness, or horror beyond one's resources of coping (Hopper, Bassuk, & Olivet, 2010). Homelessness itself is a traumatic experience. Losing one's shelter, safe environment, routine, and social roles can create psychological trauma (Goodman, Saxe, & Harvey, 1991). In addition to the experience of homelessness being a traumatic event, a large percentage of homeless individuals are exposed to other forms of trauma including psychological abuse, physical abuse, sexual abuse, and violence during their time of homelessness (Hopper et al., 2010). Furthermore, previous experience of trauma in early life through abuse and neglect make individuals more vulnerable to victimization in adulthood. One study of 95 homeless and previously homeless individuals found that those who had been exposed to high levels of trauma in childhood had an earlier age at first episode of homelessness (Mackelprang et al., 2014). This highlights the nature of trauma as it accumulates throughout an individual's life.

Stress Management Techniques for Homeless Population

In the homeless population with high occurrence of psychiatric disorders, substance use, and history of trauma, integrated approaches are considered to be best practices (Garland, Roberts-Lewis, Tronnier, Graves, & Kelley, 2016). However, empirical support is limited as few integrated treatment options have been implemented and tested for homeless individuals (Garland et al., 2016). Interventions with more empirical support such as cognitive-behavioral therapy (CBT) might be effective when targeting post-traumatic stress disorders (PTSD) and

substance use disorder (SUD) symptoms (Garland et al., 2016). However, CBT alone might not be as effective for those with history of trauma and co-occurring disorders, and homeless individuals with mood and anxiety disorders can benefit from therapies with broader areas of focus such as mindfulness-based interventions (Garland et al., 2016).

Evidence-Based Interventions: Mindfulness-based interventions

Definitions

Mindfulness-based interventions have gained increasing popularity in recent decades. Mindfulness is defined as the state as well as the practice of intentionally pointing one's awareness in the present moment and experience without forming judgment (Kabat-Zinn, 2003). Meditation refers to an action or a practice which has existed for many centuries in different cultures from India and China to the Western worlds (Manuello et al., 2015). The roots of mediation practice were found in the Indian religion of Hinduism and the philosophy of Buddhism (Manuello et al., 2015). Although there are many different mediation techniques, what they share in common is the fundamental aspect of "sati," a Pali word which means having moment-by-moment awareness and attention (Siegel, Germer, & Olendzki, 2008; Manuello et al., 2015). This word was translated to the English word "mindfulness" in 1920s for the first time (Siegel et al., 2008; Manuello et al., 2015).

Meditation techniques involve a centralized attention on a specific object as a form of mental and attention training (Lustyk, Chawla, Nolan, & Marlatt, 2009; Shapiro, 1984). Under the framework of Mindfulness-based Meditation, there are three different techniques: concentration mediation, mindfulness meditation, and loving-kindness meditation (Siegel et al., 2008; Manuello et al., 2015). Concentration meditation uses a pure focus on a specific object such as one's breath or a mantra, and bringing the attention back to the object when the mind

wanders (Siegel et al., 2008; Manuello et al., 2015). Mindfulness meditation allows a shift in focus from the breath to other phenomena into the field of awareness such as body sensation or sound (Lustyk et al., 2009; Shapiro, 1984). This is done to foster internal awareness (Siegel et al., 2008; Manuello et al., 2015). Loving kindness meditation uses gentle and warm statements to wish others wellness in order to cultivate compassion (Siegel et al., 2008; Manuello et al., 2015).

Therapeutic Use

Mindfulness-based mediation has been integrated into therapeutic interventions, which will be referred to as Mindfulness-based interventions (MBIs). Of those interventions, Mindfulness Based Stress Reduction (MBSR) has been most rigorously studied and supported through a large body of empirical studies (Sharma & Rush, 2014). MBSR was developed by Dr. Jon Kabat-Zinn and the scholars at the University of Massachusetts Medical School in 1979 (Sharma & Rush, 2014). Another widely used MBI is Mindfulness Based Cognitive Therapy (MBCT), which combines the mindfulness meditation training and cognitive behavioral therapy elements (Kabat-Zinn, 2003; Michalak, Schultze, Heidenreich, & Schramm, 2015).

MBSR consists of eight classes of 2.5 hours and one all-day class over the period of eight weeks, and it was constructed in order for participants to fully understand and develop the skill of self-regulation through mindfulness (Carmody & Baer, 2009). Although MBSR has been the most rigorously studied MBI (Carmody & Baer, 2009), implementation of MBSR in a community setting can face significant barriers in terms of resources and consistent participation. For this reason, brief versions of MBIs should be explored to evaluate their effectiveness.

Effects of Mindfulness-based Intervention

Mindfulness-based interventions (MBIs) have been implemented and studied in a wide range of target populations including smokers and alcoholics and those with anxiety, depression,

stress, insomnia, chronic pain, heart disease, cancer, diabetes, hypertension, and HIV (Goyal et al., 2014). For the purpose of this project, this review will focus on psychological conditions including stress, anxiety, and depression.

A systematic review and meta-analysis by Goyal et al. (2013) explored effectiveness of MBIs in adult population with medical or psychiatric diagnoses. The analysis only included Randomized Controlled Trials (RCTs) with active controls in order to generate strong evidence support for the use of mindfulness-based meditation in the management of medical and psychiatric conditions (Goyal et al., 2013). The findings suggest that MBIs were especially effective in decreasing anxiety, depression, and pain (Goyal et al., 2013). In addition, the study also found low evidence support for its effectiveness in improving responses to stress and distress, and mental-health related quality of life (Goyal et al., 2013).

Brief Mindfulness-based Interventions

A systematic review conducted by Carmody and Bear (2009) examined the effectiveness of MBIs of shorter duration on psychological distress including general distress, negative mood or affect, stress, depression, and anxiety (*n*=23). Studies included in the review varied in the number of sessions given, frequency of sessions and duration of each session (Carmody & Baer, 2009). The results showed that the correlation between effect size of programs and number of in-class hours was statistically non-significant (Carmody & Baer, 2009). This suggests that abbreviating the duration of MBIs has potential to reduce psychological distress in the population and setting where longer and consistent participation is a barrier.

Fieldwork Agency

Enterprise Resource Center (ERC) is a peer-run facility and a day drop-in center in Marin County. The center started as a mental health program as part of Community Action Marin, and

has been serving the community since the 1980s (Community Action Marin, n.d.). Major services provided at the center include support groups, outreach programs, companion programs, education programs, peer counseling, telephone counseling, employment, and peer care management (Community Action Marin, n.d.). Three to five group meetings are scheduled daily, Monday through Saturday every week. All the groups offered are open-enrollment, and participation is voluntary. All services including classes and groups are provided by trained Mental Health Peer Counselors creating a welcoming and low-barrier environment (Community Action Marin, n.d.). The center operates on the strengths-based and harm-reduction approach in order to achieve client-centeredness (Marin Health and Human Services, n.d.).

For many years, ERC has been a point of first contact for resources and care as well as socialization for those who experience homelessness and other vulnerable conditions. Many individuals have been utilizing ERC regularly for few years to decades. For this reason, developing a program has the potential to reach individuals over a long period of time.

Demographic Data of Target Population

ERC's target population is transition-age youth who are older than 18 years of age, adults, and older adults with mental illnesses who may or may not be involved in the mental health system (Marin Health and Human Services, n.d.). These individuals often suffer from co-occuring substance abuse disorders and/or other health conditions, and many also suffer from homelessness and housing instability (Marin Health and Human Services, n.d.). According to the center manager, most of the individuals who utilize the center are between 26 to 60 years of age with the largest age groups in the 40s and 50s. Approximately 25% of the ERC clients are homeless at any given time. Undiagnosed mental illnesses co-occurring with substance use disorders are commonly seen in this subgroup. A large portion of clients also live in board-and-

care housings. ERC receives referrals from other mental health facilities as well as homeless service facilities in the community. Most commonly seen challenges among clients are mental health conditions including schizophrenia and bipolar disorder, high anxiety, chronic pain, chronic physical conditions, and substance use disorders. The number of people who utilize the facility per day range between 35 to 70 with an average of 50 people per day.

Needs Assessment

Method 1: Needs within ERC

In order to learn about the needs in the population at Enterprise Resource Center (ERC), three approaches were employed. First, a one-on-one interview with the center manager was conducted in order to understand the needs for programs as well as the feasibility of providing a mindfulness-based intervention. The second approach was attending and observing the programs offered at ERC including the Life Management and Crisis Planning Group, Women's Group, and Dual Diagnosis Group over a two-month period. These groups provided an opportunity to build relationships with participants who regularly utilize the facility as well as learn about emerging themes in life management in the population.

Finding 1

Through these two needs assessment approaches, it became evident that common challenges shared in the population include management of mental health symptoms, management of relationships, housing insecurities, and stress management. During group meetings, many participants highlighted the power of physical activities including dance, walking, and bicycling in reducing their stress. Most of the participants who regularly join this group have mental health diagnoses including obsessive compulsive disorders, anxiety, depression, and bipolar disorder. To manage stress and anxiety, some participants shared coping

methods such as journaling recommended by their psychologist or psychiatrist. Others talked about alcohol and substance use. It was clear that the level of coping and support in place varied significantly among individuals.

Another point to highlight is the component of peer-facilitation. Groups that have been successfully ongoing for more than 5 years are all facilitated by peer-counselors who are trained through the program at ERC. The peer-facilitation model has been the core aspect of ERC, and it seems to be one of the key factors to having highly sustainable programs.

During the interview with the manager, it was pointed out that collecting data in this particular population is especially challenging due to their lack of permanent residence, and some simply prefer not to give such private information. In particular, many feel their diagnosis of mental illness is very private so not many would share the information. When asked about the potential for offering mindfulness meditation classes, the manager believed that it could be an appropriate option. In fact, a meditation class had been offered in the past and was well received by the population at ERC. In terms of challenges as to what contributed to the failure of the programs in the past, the major barriers identified include arranging schedule to fit users' needs as well as the availability and commitment of instructors and peer counselors. Sometimes classes were scheduled at a time that was difficult for clients to attend due to transportation related challenges since clients can be far from the center depending on their housing arrangement at the time.

Method 2: Current and Future Approaches to Homelessness in Marin Country

In order to have a better understanding of the target population, it is essential to have a county-level perspective as the approaches employed by the county closely affect the vulnerable adults especially those who experience homelessness. Attending the following two learning

events facilitated the understanding of the future evidence-based approaches to homelessness in Marin Country. In addition to attending these events, a literature review on Housing First Model was conducted to explore key aspects of the model as well as the role of ERC in the care for homeless population.

- *Sharpening Our Focus: Housing as the Answer to Homelessness* by Iain de Jong hosted by Marin Country on April 7th, 2017.
- *Health and Human Services Learning Lab* with the guest speaker Dr. John Banberger on June 6, 2017.

Finding 2

In both learning events, the Housing First Model was emphasized in order to address homelessness at the country-level. A traditional linear recovery approach involves a continuum of stepwise services from emergency shelters to transitional housing to longer-term stable housing (Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009), and this is currently what we see in Marin County. These facilities in the linear recovery model often have addiction-related policies which require abstinence and treatment participation (Kertesz et al., 2009). Few people successfully graduate through the steps in this linear approach to obtain permanent housing (Ly & Latimer, 2015), and enforcing these addiction-related policies can create a gap in housing options for those who experience homelessness chronically.

Housing First (HF) is a supportive housing model with client-centered approach which provides immediate permanent housing with no requirements for sobriety or treatment for mental illnesses or substance use disorders (Davidson et al., 2014). HF model has been widely studied in recent decades in North America and Europe often in comparison with the traditional linear approach (Ly & Latimer, 2015).

Meaningful Daily Activities

During the presentation by Ian De John, the importance of Meaningful Daily Activities (MDA) was highlighted. Meaningful Daily Activities (MDAs) are how the individual or the family spend time throughout the day (De John & Kovacs, n.d.). Given that high rate of episodic homelessness, MDAs hold a key in the prevention of re-entry when they provide a healthful and satisfying pattern of daily activity that are sustainable within their current circumstances (De John & Kovacs, n.d.). Boredom, isolation, and lack of meaningful activities were found to be contributing factors to returning to homelessness for those who were formerly homeless (De John & Kovacs, n.d.). Providing programming which can be engaging and productive to participants who utilize Enterprise Resource Center and other shelter programs can be significant part of preventative measures for those who have experienced homelessness in the past or are currently homeless. As the Marin County moves towards Housing First approach, it is natural to assume that low-barrier facilities such as ERC will be integrated in the continuum of support where a variety of MDAs are provided, and act as another contributor to successful housing retention.

Problem Statement

Despite the high need for an integrated approach for stress management in this target population which experiences high adversity, there is no program in place which targets stress reduction and management. Past implementations of several programs including yoga and meditation groups failed due to their high dependency on trained individuals from outside of the peer community.

Development of the Pilot Program

Method

The following four methods were used in the development of the pilot program: (a) consulting experienced practitioners and meditation teachers; (b) attending a meditation teachers training; (c) attending local mediation groups; and (d) literature review. In order to develop a base for the pilot meditation program, experienced meditation teachers were consulted. Questions were asked to learn about working with vulnerable adults and ways to sustain a meditation program. One meditation teacher had worked with people with severe mental illnesses in a residential facility for over 5 years. Another meditation teacher, who has facilitated meditation teachers training, has also worked with vulnerable populations in San Francisco including those with psychiatric illnesses and are homeless. In addition, attending local meditation groups further helped gain insight on how to construct a group meeting. Furthermore, to deepen understanding of the topics that surfaced during the interviews, topics were more deeply explored through a literature review.

Finding

Sustainability of the program

In order to sustain the program, it was suggested from experienced meditation teachers that having several facilitators is ideal. One teacher shared the past experience of programs being discontinued as instructors became unavailable. Especially if the program depends on volunteers, it would be ideal to secure few facilitators. Most meditation group meetings started with meditating for about 20 to 30 minutes, and this will be piloted to test for feasibility with the population of the ERC.

Safety Consideration

Both experienced meditation teachers emphasized on the importance of having staff on site when working with the vulnerable populations for safety. As many individuals who utilize ERC cope with mental health conditions, substance use disorders, and history of trauma, safety precautions were discussed with the manager of ERC in preparation for implementing the pilot program. Literature exploring safety of brief meditation programs for vulnerable adults is scarce while a large body of studies report beneficial effects for meditation programs. However, adverse effects that have been reported in the literature include mental, physical, and spiritual consequences (Lustyk et al., 2009). Most adverse effects were reported after a high intensity of meditaion practice during retreats and residential programs; however some reports did not include the intensity of the meditation practice (Lustyk et al., 2009).

In terms of the risks of brief meditation programs, it is unclear as benefits seem to outweigh the risks and this could be due to insufficient exploration of the topic. Studies including one meta-analysis suggest beneficial effect of mindfulness-based interventions (MBIs) in managing symptoms of psychotic disorders especially as an adjunct therapy for treating negative symptoms (Khoury, Lecomte, Gaudiano, & Paquin, 2013; Tabak, Horan, & Green, 2015). One pilot study explored the feasibility, beneficial effects, and adverse effects of MBI with patients who are recovering from a first episode of psychosis (van der Valk, van de Waerdt, Meijer, van den Hout, & de Haan, 2013). One-hour sessions were offered eight times over the four-week period, and no significant increase in psychotic symptoms as well as no increased intrusive thoughts or hallucinations were reported (van der Valk et al., 2013).

Clearly, exploring the safety of MBIs is the area that needs further research and exploration. According to the manager of ERC, there were no incidents reported when the

mediation class was previously offered at the center a few years ago by a peer facilitator. Although the discussion with the manager led to the conclusion that adverse effects seem unlikely, following precautions were implemented to ensure safety.

1. Trained staff on site: trained peer counselors are always on site while the group is on including the manager.
2. Low intensity: guided meditation is short with about 20 minutes in duration.
3. Clear instruction: guidance on how to meditate and what to expect during meditation is discussed at the beginning of each group meeting to manage expectations.
4. Voluntary and open participation: participants are told in the beginning that they are free to leave the group if discomfort arises.

Pilot Program

Based on the literature review and needs assessment, a brief meditation program utilizing peer-facilitation and recordings of guided meditation was piloted over a six-week period in seven group meetings. Goals of the pilot program were as follows.

- Goal #1 of the program was to test feasibility and effectiveness of a peer-facilitated meditation program using recorded audio guidance for stress management and reduction.
- Goal #2 of the program was to provide a place and an opportunity for participants at ERC to learn stress-reduction techniques to improve their overall, perceived well-being.

Delivery of the Pilot Program

The first group meeting was held on June 19th, 2017. A total of seven group meetings was held over the six-week period. Group flyers were placed at the entrance of ERC to recruit participants two weeks prior to the first group meeting (Appendix A). The total of nine different

individuals, six of whom were female and three of whom were male, participated in group meetings on different dates over the total period of six weeks. Out of those nine individuals, five of them came back twice.

The duration of each meeting was 45 minutes, which included 20 minutes of guided meditation with a track from Jon Kabat-Zinn's Guided Meditation CD (Kabat-Zinn, 2012). The class began with an introduction of participants to each other, and brief check-ins about how they were doing. Participants were encouraged to talk about their previous experience with mindfulness meditation as well as their intention in joining the group. Then a brief instruction on how to meditate was given to participants before starting the meditation. After completing the meditation, participants were asked five questions to reflect their experiences.

Findings of the Pilot Program

The following five questions were asked to participants at the end of each meeting in order to learn what has worked and what needs to be modified. Common and representative responses to each question are presented in a chart below. Direct quotes from participants are presented in italics.

Question	Common/ Representative Responses
1. How was the experience?	• *"It was very calming"- Multiple participants* • *"I noticed myself thinking about the future and the past a lot."- Male participant in the 30s* • *"I feel relaxed now. I notice now how beautifully decorated this room is now" – Female participant in the 50s* • *"I felt the gentle energy moving through my body" - Male participant in the 50s*
2. What did you like about it?	• *"We used to have a meditation class here, and I really liked it. I am glad it's back." – Female participant in the 50s*

	• *"Thank you for taking my suggestion for music!" - Female participant in the 40s* • *"I really liked the music." – Multiple participants*
3. What needs to be improved?	The following suggestions were made by participants: • Placing a "quiet" door sign • The use of music/ background sound • Suggestions for different times and days • Use of female voice in the audio guidance
4. How was the length of the meditation?	Most participants found the length appropriate and doable.
5. Was the guidance easy to follow?	• *" His voice [in the recording] is very directive. It's too cut and clean, and I feel like I am given a direction, not guidance" - Female participant in the 40s* • *"I think female voice might be better if there are more women in the room" – Female participant in the 40s*

Most participants reported feelings of calmness and relaxation after the 20 minutes of guided mediation. Some people shared what they noticed about the thoughts which came up during mediation and reflected on them. Also, few participants reported feeling the energy move through the body as well as seeing images when their eyes were closed.

The most common reason for joining the group was that they were looking for relaxation and stress reduction. One participant reported having a difficult time sleeping in a shelter environment so she appreciated simply having a quiet space. One person reported that meditation helps with chronic pain.

The feedback received from participants for improvements was implemented throughout the duration of the program, using a continuous quality improvement approach. The day and time for the group meetings were also modified based on the feedback from the participants. For example, many of the people who come to ERC tend to call for beds at homeless shelters at 10:30am, and a suggestion to move a group meeting earlier or later to avoid that time was implemented. The detail of the findings is found in Appendix B.

Deliverable: Morning Meditation Group Facilitation Guide

Based on the findings of the pilot program, the deliverable was developed. The book *Inner Tranquility. A Guide to Seated Meditation* by Main (2014) and *Getting Started with Mindfulness* by Mindful.org (n.d.) were used as additional resources. These resources can potentially be utilized by a peer-counselor who wishes to facilitate a meditation group in the future. The total duration of the group was approximately 45 minutes per session and the content of each meeting was the following.

1.	Check-in with everyone	5 minutes
2.	Decide on more guidance or less guidance (tracks are all about 20 minutes long) More guidance → Use CD1-track1 or 2 Less guidance → Use CD-1-track 3	1-2 minutes
3.	Go over the brief guide to meditation **1) Sit comfortably and upright.** - Find a comfortable seat, but not too comfortable to where you fall asleep! - The most important rule is to <u>keep the spine straight and tall (open chest).</u>	5 minutes

	- Tip: Tilt your pelvis slightly forward. This will encourage the spine to be straight and tall. - Your mind is connected to your body, so it is important to put your body in a position which says "attention." 2) **Notice your legs.** - If you are sitting on a chair, rest the bottoms of your feet on the floor. 3) **Notice your arms**. - Rest your palms on your legs wherever it feels most natural. 4) **Soften your gaze, or close your eyes.** - Drop your chin a little to let your gaze fall downward. 5) **Feel your breath.** - Take a few deep full breaths to allow your body to relax, then bring your attention to the physical sensation of breathing: the air moving through your nose or mouth, the rising and falling of you belly and chest. - You don't need to change the quality of the breath, simply watch it move in and out. 6) **Get distracted.** - It is expected that your mind frequently wanders. <u>This is natural.</u> Simply notice the thoughts that come up without trying to block them or make them disappear. 7) **Gently bring your attention back to your breath**. - Be kind about your wandering mind and come back to your breath over and over again without judgment or expectation. 8) ** Meditation is like physical exercise; it is not intended to be blissful, and it can be uncomfortable as some thoughts might be unpleasant. **However, <u>if discomfort continues, please stop and notify staff at ERC.</u>**	
4.	Play a track on a CD (about 20 minutes)	20 minutes
5.	When the bell rings, bring the attention back to the breath by taking a deep inhale and an exhale. Then gently open your eyes. Take a moment to notice how your body feels right now. Notice thoughts and emotions.	1-2 minutes

6.	Check-in again and ask how everyone's mediation practice was this morning.	10 minutes

Implications for Practice

Although the purpose of meditation is to cultivate non-judgmental awareness to all experiences and phenomena through mental and attention training, most individuals who participated in this pilot program reported the sense of calmness, ease, and relaxation after a brief guided mediation. This suggests the potential benefit for integrating a mindfulness-based programs in community settings which target vulnerable populations.

Some participants who are currently homeless reported not being able to sleep in the shelter environment, and simply having the time to quietly sit in silence to meditate in the morning might be a valuable time regardless of the quality of mediation practice. In low-barrier settings where groups are offered openly to anyone who wishes to participate and data collection is challenging due to the ethical concerns in the highly vulnerable population, it seems unrealistic to conduct vigorous data collection as well as to screen participants for risks for developing adverse reactions based on their medical diagnosis. For this reason, in order to ensure safety, having an experienced mediation practitioner as a teacher who can oversee the development and the process of the program seems ideal. As it was suggested by experienced mediation practitioners that more guidance in mediation might benefit those who are more anxious and restless, utilizing a recorded guided mediation in a group setting seems most appropriate.

Discussion

Homeless adults are one of the most vulnerable subgroups who utilize Enterprise Recourse Center, which a peer-run drop-in center in Marin Country. Working with the transient

and high-risk population where stress runs high, an intervention for stress reduction and management was explored. The findings from the needs assessment suggested the need for an integrated approach for stress reduction and management in the vulnerable adult population. The challenge of sustaining a program was also highlighted during the needs assessment. A brief mindfulness meditation program was explored as an evidence-based intervention for its feasibility and potential effectiveness at the center. A peer-facilitation approach was also explored in order to fit the model in the center which other programs are designed. The pilot meditation group was conducted over the period of six weeks in the total of seven meetings. The total of nine different individuals participated, and common feedback from participants included feelings of calmness and relaxation after meditating for 20 minutes in a group. This suggests that a brief meditation program may be added to create a more integrated approach to the management of mental, physical, and emotional comorbidity seen in this highly vulnerable population. This pilot adds to the vast body of research which suggest the effectiveness of mindfulness-based interventions in the management of physical and psychological conditions.

There were several limitations in this project. First, as the culture of the center promotes a low-barrier welcoming atmosphere, collecting basic data including demographic information about the target population was limited and challenging. It was pointed out by the manager that one must be sensitive when collecting data as many of the clients prefer keeping their mental illness diagnoses private, and they would only share information when they are willing. In addition, because ERC can be the first entry point to the mental health services especially for those who are homeless, it seemed unethical to ask questions to extract data as it could risk turning people away. A tight time line imposed by school schedules was another barrier to conducting a pilot program over a longer period. In terms of the pilot program, there were only

nine different individuals who participated. Although their feedback was valuable and making the changes they suggested contributed to people returning to the group, the findings from the pilot may not be generalizable to the larger proportion of the target population.

Lastly, the peer-facilitation model was explored as a possible option for sustainability of the program. A peer is a person from within the ERC community, and the hope was to transfer a facilitation role to a participant who comes to the group on a regular basis. However, due to the short duration of the program, voluntary participation, and small number of participants, this model of delivery was not possible to be piloted. This aspect will continue to be explored over the next few months as the pilot program continues to be offered at ERC.

When implementing a brief mediation program in a highly vulnerable adult population, it is essential to consider safety as well as to determine the optimal form and dose of delivery. As exercise is beneficial yet accompanies risks for injury, it is also important explore the potential risks and adverse effect of meditation. Although adverse effects of meditaion programs were reported after a high intensity of meditaion practice during retreats and residential programs (Lustyk, 2009), the safety of meditation programs is a very poorly explored area in reaseach. Thus, further research is suggested to explore the risks and safety of meditation programs especially brief meditation interventions with vulnerable populations. There currently is no guideline for screening individuals for risks for adverse effects of meditation (Lustyk, 2009). A screening tool seems especially importatnt to implement in a community setting where diagnoses of mental and physical illnesses are not openly shared in order to insure the safety of a meditation program for the vulnerable adult population.

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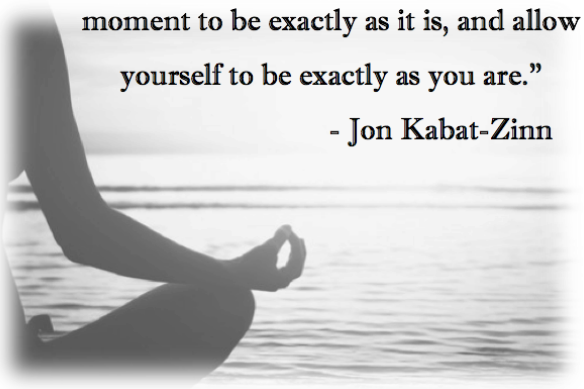
Appendix A: Group Flyers

Morning Mindfulness Meditation Group



"Give yourself permission to allow this moment to be exactly as it is, and allow yourself to be exactly as you are."
- Jon Kabat-Zinn

Let's simply gather and

Meditate together in a group

Dates: Mondays (June 19th — July 24th)

Time: 10am – 10:45am

Place: Enterprise Resource Center

Morning Mindfulness Meditation Group

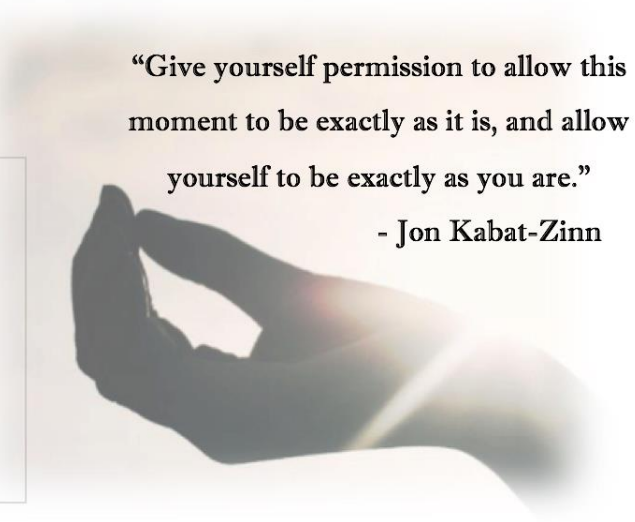
Let's simply gather and

Meditate together in a group

Date and Time:

* Mondays 9:30 am – 10:15 am
* Fridays 11:00 am – 11:45 am

Place: Enterprise Resource Center



"Give yourself permission to allow this moment to be exactly as it is, and allow yourself to be exactly as you are."
- Jon Kabat-Zinn

Appendix B: Findings of the Pilot Program

Meeting #	Date & Time	Total # of Participants	Male	Female	# of returned persons	Track Used	Q1: How was the experience?	Q2: What did you like about it?	Q3: What needs to be improved?	Q4: Length of the meditation?	Q5: How was the guidance?	Notes
1	6/19/2017 (Mon.) 10:00-10:45am	4	2	2	0	Breathcape CD1- 1 (Length 20:21)	“It was very calming” (Everyone) “I did a lot of meditation in jail, and I am still trying to know what meditation is. Thank you for this class” (Male participant #1) “I noticed myself thinking about the future and the past a lot.” (Male participant #2)	“I was able to get thoughts float by.”- Female participant #1 “We used to have a meditation class here, and I really liked it. I am glad it’s back.” – Female participant #2	Suggestions made by participants include using a door sign to limit the flow of people coming in and out of the room, and use of objects to grab so participants can focus on sensations rather than breathing.	All participants found 20 minutes appropriate and doable.	All participants found that the language was easy to follow.	
2	6/26/2017 (Mon.) 10:00-10:45am	0	0	0	0	___	___	___	One person in the common area commented that 10:15am is when people have to call Mill Street shelter, and changing the time of group might help gain more participation.	___	___	
3	7/10/2017 (Mon.) 9:30-10:15am	4	1	3	1	Breathcape CD1- 1 (Length 20:21)	"It was difficult to quiet the mind" (Male participant) “I liked it a lot. I saw images and different colors---like purple, and blue.” (Female participant #1) "It was good meditation practice" (Female participant #1) "I like this class, thank you for doing this" (Male and Female participant #2)	"It was good meditation practice" (Female participant #1)	One female participant suggested the use of background music or sound while meditating. She requested sounds of flute, rain, or water. "something soothing" Two participants commented "no, nothing needs to be changed."	All participants found 20 minutes appropriate and doable.	All participants found that the language was easy to follow.	

4	7/17/2017 (Mon.) 9:30-10:15am	2	0	2	2	Breathcape and Bodyscape CD1-3 (Less guidance) With Japanese flute background sound (Length 20:38)	"It was good, and I am sorry I had to leave in the middle. " (Female participant #1)	"Thank you for taking my suggestion for music!" (Female participant #1)	No suggestion made from participants. People in the dining area suggested to experiment with Friday mornings are Fridays are usually much busier. Will experiment with Friday.	Appropriate	Appropriate	
5	7/21/2017 (Fri.) 11:00-11:45am	1	0	1	0	Breathcape and Bodyscape CD1-3 (Less guidance) (Length 20:38)	"I was able to feel the air against my skin and going in and out of the body" (Female participant) "Of course my mind wondered, and most of what came up was neutral like an image of my friend's living room" (Female participant)	"I feel relaxed now. I notice now how beautifully decorated this room is now" (after meditation)	No suggestion made at this time.	Appropriate	Appropriate	
6	7/24/2017 (Mon.) 9:30-10:15am	2	0	2	2	Breathcape and Bodyscape CD1-3 (Less guidance) With Japanese flute background sound (Length 20:38)	"I felt the gentle energy moving through my body" (Male participant #1) "It was wonderful" (Male participant #2) "I also felt gentle energy in my eyes when I closed my eyes. I saw something like light, I don't know how to explain it." (Male participant #1)	"I really liked the music." (both participants)	"I want the mediation to be 5 minutes longer, I wanted to sit for a bit longer." (Male participant #1)	Appropriate Except that one participant was very restless today, and he stood up to go to the bathroom in the middle, then came back.	Appropriate	

7	7/28/2017 (Fri.) 11:00-11:45am	4	1	3	3	Breathcape and Bodyscape CD1-3 (Less guidance) With Japanese flute background sound (Length 20:38)	"I had some very productive thoughts. The thoughts came to me. " (Female participant #3) "It was a good practice" (Male participant) "I have fibromyalgia, and whenever I meditate, it helps with pain. I feel relaxed now." (Female participant #2)	"I liked the music" (Female participant #1) "I liked the guidance. I was able to flow in the guidance" (Male participant)	"His voice [in the recording] is very directive. It's too cut and clean, and I feel like I am given a direction, not guidance" (Female participant #3) "I want you to record your voice instead of his voice" (2 female participants) "I think female voice might be better if there are more women in the room" (female participant #3)	Appropriate	Language was appropriate, but some participants found his tone of voice slightly too directive.	After the group meeting, one of the peer counselors approached and asked about when this group is offered. He says he has a very stressful job, and that he would like to join next time.