

Baseline Personal Story Interviews from the Vancouver At Home Study

Prepared by:

Michelle Patterson, PhD

Melinda Markey, MPH

Faith Eiboff, BA

Julian Somers, PhD

Simon Fraser University

Faculty of Health Sciences

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Table of Contents

Executive Summary (1 page)	3
Executive Summary (3 pages)	4
Introduction	7
Context	8
Vancouver, BC: Site Description	8
Vancouver’s Downtown Eastside Neighbourhood	8
Characteristics of the Homelessness Situation	10
Description of “Treatment as Usual”	10
Methodology	11
Description of the sample	11
Documentation of methodological steps	13
Coding/analysis process	14
Monitoring quality	14
Results	15
1. Pathways into Homelessness	15
<i>Life Before Homelessness</i>	15
<i>Precipitants of First-time Homelessness</i>	17
<i>Recurrent Experiences of Homelessness</i>	18
<i>Recent Experiences of Homelessness</i>	19
2. Life on the Streets and in Shelters	20
<i>A Typical Day</i>	20
<i>Experiences with Services, Supports and Community Organizations</i>	23
<i>Experiences with Housing</i>	23
<i>Vision for the Future</i>	24
3. Experience of Mental Illness and Related Services	25
<i>Initial Experiences of Mental Illness</i>	25
<i>Ongoing Experiences with the Mental Health System</i>	26
<i>Recovery and Healing</i>	28
4. High, Low and Turning Point Stories	28
<i>High Point Stories</i>	28
<i>Low Point Stories</i>	29
<i>Turning Point Stories</i>	30
5. Cross-Cutting Themes or Issues	31
Conclusion	32
Reflections and Lessons Learned	33

Executive Summary (1 page)

This report examines the key themes that emerged from “personal story” interviews conducted with 52 participants within one month of their enrollment in the Vancouver At Home Study. Criteria for inclusion in the Vancouver At Home Study include homelessness and mental illness, with randomization to one of five intervention arms (total n=490). Ten participants were randomly and purposively sampled from each study arm. The interview followed a semi-structured format and covered pathways into homelessness, life on the streets, experiences with mental illness and related services, and key life events.

Transcripts were analyzed line-by-line using a general thematic coding strategy. Key themes are reported based on the topic headings and key questions from the interview guide.

Participant narratives reflected the diversity and complexity of experiences leading to homelessness. Many participants described childhood as a turbulent time marked by poverty, alcoholism, abuse and violence in the family home. The majority of participants first experienced homelessness as young adults but several participants lived on the streets as young adolescents. A few participants described becoming homelessness well into their adult years, after many years of being stably housed. For most participants, first becoming homeless was one point in a long trajectory of abuse, neglect, loss, difficulties maintaining relationships, substance dependence, and residential and financial instability.

Participants frequently identified Vancouver’s Downtown Eastside as the primary neighbourhood in which they lived and slept; however, the majority stated that they wanted to avoid or leave this community, particularly the Hastings Corridor. Dealing with the exigencies of daily living and survival consumed much of participants’ time and energy on a typical day. Profound discouragement and disengagement from the system and active involvement in drug culture featured prominently in participants’ narratives.

Symptoms of mental illness were often traced back to childhood. Many participants reported that symptoms of mental illness gradually worsened over time as a result of accumulated stress and loss. Most participants described not knowing how to access the help they need and recounted negative experiences with the health care system. A number of gaps in the current system of care were identified, including supported housing, good quality psychotherapy, and peer mentorship. According to participants, recovery and healing entailed adequate housing, meaningful work, and reconnecting with family.

Participants’ stories related to “high,” “low” and “turning” points were primarily connected to experiences with family and meaningful relationships, housing and homelessness, mental health and recovery, spirituality and nature, and promise for the future.

A number of reflections and lessons are presented. For example, participants who had received housing through the Vancouver At Home Study were positively influenced by this experience and expressed more gratitude and hope for the future than did the comparison group. In addition, interviewers noted that the protocol placed considerably greater focus on challenges and difficulties than on strengths and resilience. Finally, our findings suggest that further research is needed to better understand how institutions, including those

responsible for health and social welfare, can contribute to homeless people's continued marginalization.

Executive Summary (3 pages)

This report examines the key themes that emerged from the baseline personal story interviews conducted with a sub-sample of 52 participants within one month of enrollment in the Vancouver At Home Study. Participants (total n=490) were selected on the basis of inclusion criteria addressing homelessness and the presence of mental illness. The goal of the interviews was to engage directly with study participants and to listen to and learn from their voices, experiences, and observations. Ten participants were randomly and purposively sampled from each of the study's five intervention arms. Whenever possible, interviews were conducted in pairs with one field research interviewer and one peer interviewer.

The interview followed a semi-structured format and covered pathways into homelessness, life on the streets and in shelters, experiences with mental illness and related services, and key life events. On average, the interviews took about one hour to complete and, with each participant's permission, they were audio recorded and transcribed. Two qualitative research team members coded all transcripts line-by-line using a general thematic coding strategy; an additional four team members coded a subset of the interviews. All team members met for a day-long retreat to review codes and emerging themes. After the meeting, a summary of the themes was distributed to all team members and further revisions of themes and definitions were made. In addition, five audio recordings and accompanying transcripts were reviewed by a member of the National Qualitative Working Group for accuracy and quality.

Key themes are reported based on the topic headings and key questions from the interview guide.

1. Pathways into Homelessness

This cross-section of narratives reflects the diversity and complexity of experiences leading to homelessness among individuals with mental illness in Vancouver. Several participants reported becoming homeless as young as the age of 12; the majority of participants lived with their parents or guardians until their late adolescence and first experienced homelessness in their late twenties. For most participants, becoming homeless was one point in a long trajectory of abuse, neglect, loss, difficulties maintaining relationships, substance dependence, and residential and financial instability. A minority of participants became homeless later in life after a period of residential and financial stability. For the majority of participants, childhood was described as a turbulent time marked by poverty, alcoholism, abuse and violence in the family home.

The duration and number of episodes of homelessness varied considerably among participants. The length of homelessness experienced by participants ranged from less than one month to more than several decades over the life course. However, few participants experienced a single episode of homelessness. As one participant

explained, he had been homeless “off and on, all my life.” All participants described specific challenges associated with becoming, being, and exiting homelessness.

2. Life on the Streets and in Shelters

Participants frequently identified Vancouver’s Downtown Eastside (DTES) as the primary neighbourhood in which they spent time during the day and slept at night. Participants’ narratives revealed that many had internalized a conflict between the ideal of distancing themselves from the DTES and a daily reality that pushes them toward entering unsafe spaces in the neighbourhood. Dealing with the exigencies of daily living and survival consumed much of participants’ time and energy on a typical day (e.g., finding food, shelter, waiting in line-ups, etc.) Most participants cycled between living rough on the street, in emergency shelters, and in single room occupancy hotels. According to many participants, repeated rejection, evictions, and loss of housing led to profound discouragement and disengagement from the system and contributed to mental health issues and substance use. Various levels of involvement in drug culture featured prominently in the majority of participants’ narratives. Despite the negative impact of homelessness on participants’ relationships with family and friends, many displayed numerous strengths and resourcefulness.

3. Experiences of Mental Illness and Related Services

Many participants traced symptoms of mental illness to middle childhood and difficult family and social environments they experienced at that time. Feelings of depression, anxiety, and anger were frequently reported, as well as problems with parents and school, which often resulted in early drug use, social withdrawal, and/or aggressive and antisocial behaviour. Several participants reported being hospitalized in psychiatric wards and/or spending time in juvenile detention centres during their childhoods and adolescence. Few participants described these early interventions as helpful; most recalled being told that they were trouble-makers and attention-seekers and internalizing a sense of being unwanted by society. Other participants reported that symptoms of mental illness “crept up on them” and gradually worsened over time as a result of accumulated stress and loss.

Most participants described not knowing how to get the help they need for their mental illness. The majority of participants described very negative experiences with hospitals, doctors and medications and were generally averse to taking psychiatric medications. Participants identified a number of gaps in the current system of care that, if in place, would help them cope with mental illness including affordable housing, good quality psychotherapy, substance abuse counseling, and peer mentorship. According to participants, recovery and healing entailed good quality housing, meaningful work, and reconnecting with family.

4. High, Low, and Turning Point Stories

The majority of high, low and turning point stories are connected to family and meaningful relationships, housing and homelessness, mental health and recovery, spirituality and nature, and promise for the future. Major themes emerging from

the low point stories are largely related to loss, particularly the death of loved ones. Prominent themes emerging from the high point stories often related to the birth of children, getting married, and success in employment. Several turning points (e.g., gaining housing through the Vancouver At Home Study, losing custody of children) overlap with identified high and low points among participants, suggesting a particular importance of these events in participants' lives.

Finally, a number of underlying themes permeated all participants' narratives. Key cross-cutting themes included exclusion from community and increasing marginalization; poor attachment relationships beginning in early childhood and cascading throughout adulthood; and the impact of homelessness and mental illness on identity and sense of self.

In summary, many homeless individuals in Vancouver experience a confluence of poverty, mental illness, substance use, and social exclusion. With few trustworthy friends or family to confide in, drug use and a marginalized lifestyle serve as a form of social currency. Participants expressed strong dissatisfaction and frustration with "the system," the degree of choice they have over their lives, and distrust of others' intentions. The majority of our participants expressed a desire to exit homelessness and many described multiple attempts to achieve independence from public assistance. However, these attempts at independence are often not supported by the larger system. Once this cycle repeats itself a number of times in different areas such as housing, employment, welfare, child protection, and health, individuals' sense of self-efficacy and hope for the future is eroded. Even once people are managing their substance use or mental illness on an individual level, often with the assistance of service providers in the community, it is very difficult for them to reintegrate into the wider community. Community groups are frequently vocal in their opposition of homeless shelters, supported housing, and other services for marginalized individuals. People who are homeless with mental health and addiction problems therefore remain marginalized and many of the same risk factors (i.e., loneliness, disconnection from community, emotional struggles) that precipitate their substance use are unresolved.

A number of reflections and lessons are presented. For example, although all participants were interviewed within one month of enrollment in the project, there were noticeable differences between the accounts given by participants who were assigned to Housing First compared to those assigned to Treatment as Usual. Those participants who had received housing through the study were strongly and positively influenced by this experience and expressed more gratitude and hope for the future than did the control group. In addition, research team members noted that the interview guide had a greater focus on challenges and difficulties than on strengths and resilience. Finally, we discuss how the environment can exacerbate marginalization. Our findings suggest that further research is needed to better understand how institutions, including those responsible for health and social welfare, can contribute to homeless people's continued marginalization.

Introduction

Over the past 20 years, researchers have paid more attention to understanding the subjective experiences of homeless people. A number of qualitative studies have examined homeless people's perceptions and experiences of life on the streets and in shelters (see Hopper, 2003 for a review), mental illness (Forchuk et al, 2006), substance use (McNaughton, 2008; Tyler & Johnston, 2006; Wiseman, 1979), health care (Daiski, 2007), various social services (Lipsky, 1980; Tischler et al., 2007), and different types of housing (Nelson et al, 2005; Kirkpatrick & Byrne, 2009). In addition, researchers have begun to explore homeless people's psychological experiences of social exclusion and marginalization (e.g., Boydell et al, 2000; Hopper, 2003; Runquist & Reed, 2007).

Many studies allude to a combination of systemic and individual factors that make it difficult for marginalized individuals to exit homelessness and integrate into the community. For example, Daiski (2007) interviewed 24 homeless adults about the adequacy of their health care. Participants reported multiple and complex chronic health conditions, which were reinforced by poverty and life on the streets. A desire to be housed and employed was widely expressed; however, many participants reported feeling trapped in a dehumanizing system of institutions and expressed emotional distress and depersonalization related to exclusion from the community. Padgett and colleagues (2008) interviewed 41 homeless adults with concurrent disorders about their housing preferences and needs before they entered a residential treatment program. Participants expressed discomfort around people and a desire for privacy, but also a need for more social support in their lives. Participants also noted that their experience of choice was frequently constrained by program restrictions and larger social forces, such as stigma and discrimination, which impact one's ability to change. Thus, questions directed at people's experience of substance use, health care and housing elicited broader themes related to psychological needs and complex systemic barriers.

Homelessness is a multi-layered, complex, and heterogeneous phenomenon involving overlapping economic, political, social and psychological deprivation. However, policy instruments tend to neglect the larger, more complex social and political dimensions of homelessness, as well as the aspirations of people living on the streets or in precarious living situations (Shinn, 2007; Wright, Rubin, & Devine, 1998). Qualitative research methods can contribute in several ways to the development and evaluation of both complex and other health interventions (see Lewin, Glenton, & Oxman, 2009 for a review). The use of multiple, integrated approaches may be particularly useful in the evaluation of the effects of complex health and social care interventions as these involve social or behavioural processes that are difficult to explore or capture using quantitative methods alone. Conventional statistical methods are often unequal to the challenge of capturing the subjective, fluid and complex realities of people's lives, particularly concerning phenomena related to homelessness like social exclusion and discrimination (Mander, 2010).

The Vancouver At Home Study was designed as a mixed-methods randomized controlled trial to examine the effectiveness of Housing First interventions, Congregate Housing, and existing services ("usual care") with homeless adults who have serious mental illness. The Vancouver At Home Study includes core components that have been incorporated in

concurrent studies in five Canadian cities (Moncton, Toronto, Montreal, Winnipeg, Vancouver). Qualitative methods that are used across sites include the selection of a subset of study participants to engage in a Personal Story Interview at enrollment and again near the end of the study. This report focuses on the first wave of interviews conducted with approximately 10 participants from each study arm (n=52) within one month of enrollment in the Vancouver project. The goal of the personal story interviews was to speak at length with study participants in order to learn from their experiences, ideas, and observations. Qualitative methods such as life stories can augment other sources of information (e.g., questionnaires) to provide a more complete and nuanced understanding of the social, cultural, political, and psychological dimensions of the experience of homelessness. We hope this report reflects the complexity of individual experience, the reality of everyday life, hidden spheres of experience such as resilience and coping, and the meaning people give to their experiences.

Context

Vancouver, BC: Site Description

Vancouver is a harbour city located on the southwest coast of British Columbia. Greater Vancouver is the third-largest metropolitan area in the country and the most populous in Western Canada with 2,116,581 residents at the 2006 census. In 2010, the population of the city of Vancouver was estimated at 642,843, and the metropolitan population estimated at just over 2.37 million, making it the most densely populated Canadian city. Vancouver has a moderate oceanic climate with summer months that are typically dry and frequent rain throughout the rest of the year. It has the second warmest overall climate of Canada's major cities.

Like all Canadian cities, Vancouver has been greatly affected by the federal reduction in affordable housing. Between 1980 and 2000, the number of affordable housing units created by the Government of Canada dropped from 24,000 to 940 (Canadian Mental Health Association, April 2005). In addition, there has been a sharp decline in private-market single room occupancy (SRO) accommodation across BC. In Vancouver, for example, there are now just over 6,000 SROs, compared to 13,300 25 years ago. Existing buildings will decline at an even steeper rate due to redevelopment and the demolition of increasingly dilapidated SRO stock. Moreover, in many communities, adequate and affordable housing is beyond the means of people who rely on income support. Even with the recent increases to income assistance rates in BC, people on disability benefits or social assistance receive \$375 per month for shelter (the support portion is \$235 per month for regular assistance and \$531 per month for persons with disabilities); however, average market rents in many of BC's urban centers are well over \$600 per month. Even a poor quality SRO hotel room costs, on average, \$380 per month. Producing new affordable rental housing and preserving existing low-cost rental housing are frequently cited as key factors in preventing and reducing homelessness (e.g., Golden et al., 1999).

Vancouver's Downtown Eastside Neighbourhood

One of Vancouver's oldest neighbourhoods, the Downtown Eastside (DTES) is home to 18,000 people and consists of eight distinct communities. Socio-historical events that have shaped the area set the stage for the personal narratives discussed in this report, as most

participants moved to the DTES (particularly the Hastings Corridor) after becoming increasingly marginalized from mainstream society. While a thorough history of the DTES is beyond the scope of this report, we summarize a number of social and structural determinants of health as they relate to this neighbourhood and people's experience of homelessness within it (see Campbell, Boyd & Culbert, 2009 for a more detailed history of the DTES).

Vancouver first became a city in 1886 and what is today known as the DTES was the original town site. The area contained the early retail core, including the city library, banks, theatres, transportation hubs, and several large department stores. In the 1950s, the retail and transportation core moved west and a visible "skid row" developed as the labour force and resource industries such as fishing and logging were restructured. The most striking changes occurred in the 1980s with rapid gentrification leading up to Expo '86 and the advent of more potent forms of heroin and crack cocaine (Campbell, Boyd & Culbert, 2009). During this time, increasing numbers of psychiatric patients were moved from long-stay institutions into the community (City of Vancouver, 2008). Many relocated psychiatric patients were drawn to the DTES as it was one of few neighbourhoods in the city that had affordable housing, mostly in the form of rooming houses. However, beginning in 1984, the federal government cut support for social housing initiatives and it became increasingly difficult for individuals on fixed welfare or disability incomes to keep or find adequate and affordable shelter.

Incomes throughout the city of Vancouver have not kept pace with housing prices. For example, from 1979 to 2008, median incomes increased by 9% in the Vancouver Census Metropolitan Area. In contrast, the median sale price of a single family home in the east side of Vancouver increased by 360% (City of Vancouver, 2011). Recently, the City of Vancouver (2011) reported that less than 35% of Single Room Occupant (SRO) hotel rooms rent at the current shelter assistance rate of \$375 per month. Thus, efforts to prevent and reduce homelessness are situated within the context of escalating rents, an acute shortage of social housing, and income inequality.

The DTES has an extensive history of positive community action (Culhane, 2003; Pederson & Swanson, 2010) and is home to many families as well as over 2,000 businesses. Nevertheless, recent years have seen increased attention directed toward the negative attributes of the Hastings Corridor and certain sub-populations of residents. Today, the DTES is well known throughout much of North America for its high rates of poverty, mental illness, unemployment, homelessness, infectious disease, addiction, and for its murdered and missing women (Salmon, 2009; Schatz, 2010). Although many neighborhoods in the DTES are vibrant and healthy communities, the Hastings Corridor continues to garner attention due to the concentration of individuals experiencing material poverty and deprivation. Residents of the DTES must accept facilities that are often rejected by the rest of the city, including homeless shelters, methadone clinics, and a supervised injection site, which further reinforce the stigma associated with the community (Permentier, van Ham & Bolt, 2007). Over the last several decades a number of not-for-profit societies have developed and have both advocated for and created more social housing in the DTES. In summary, inequities in health and other social indicators for

people experiencing homelessness in Vancouver's DTES are shaped by a complex interplay of social, political, economic and historical factors.

Characteristics of the Homelessness Situation

The 2011 Metro Vancouver Homeless Count enumerated homeless people living in shelters and on the streets over the course of a 24-hour period on March 16, 2011. Results from the count indicated that, since 2010, the total number of street homeless in the City of Vancouver has decreased by 276 people to 145 (a 65% decrease); and the number of people living in shelters increased by 13% between 2010 and 2011. Full descriptive data are not yet available from the 2011 count but a preliminary report states that 27% of the homeless population reported being Aboriginal (City of Vancouver, 2011).

Women comprise a significant part of the 'hidden homeless' population and continue to be under-counted in homeless enumerations and under-represented in research on homelessness. There are currently few shelter spaces or services designated for homeless women in Vancouver. Women often avoid accessing existing homeless shelters and services for safety reasons, and temporarily stay with friends, family or, more often, in exploitative relationships to obtain shelter. Many homeless women are engaged in the survival sex trade industry. Their relationships with men are often exploitive and involve a gross imbalance of power, frequently putting them at great risk of physical harm and injury. The 2008 Metro Vancouver Homelessness Count found that the number of homeless women increased disproportionately to homeless men since 2005, and represented 27% of the homeless population (SPARC BC, 2008).

Preliminary analysis by City Hall cites several reasons for the apparent decrease in homelessness. However, it must be noted that homeless counts are widely known to be gross underestimates of the actual population and should be compared across years with caution due to the inconsistent methodologies used. According to City Hall, key factors contributing to the decline in homelessness include:

- The shift in shelter policy in 2008 to open several low-barrier homeless shelters that offer 24/7 access and accept pets and carts. This has helped transition people into permanent housing;
- The provincial purchase of 23 SROs, providing approximately 1,400 units; and
- The Vancouver At Home Study, which is providing two years of housing and support for 290 people with serious mental illness and recruited the majority of participants during 2010.

In addition, up to 1,400 new supportive housing units have been forecast to open in the next two years through a partnership between the City of Vancouver and the Province, through BC Housing. City Council has also approved several new housing projects, including the renovation of the former remand centre to provide 90 new units of housing, and a partnership with the YWCA to build housing for women and children above a new library in Strathcona.

Description of "Treatment as Usual"

No research has examined the effectiveness of existing services for people who are

homeless and experiencing mental illness in Vancouver. The Vancouver At Home study has randomly assigned 200 participants to existing services (i.e., “treatment as usual”), in order to address this important gap, and to compare different service models for individuals in need of housing and support. Several recent initiatives have focused attention on planning and the reform of resources addressing homelessness in Vancouver. The City of Vancouver created the *Homeless Action Plan* (HAP) in 2005, which was updated in 2008. The BC provincial government introduced *Housing Matters BC* in 2007, which offered recommendations for province-wide housing policy. This document addresses many items recommended in the HAP, including the development of a Supportive Housing Strategy; a pilot project to facilitate access to Income Assistance; the Provincial Outreach Program; improvements to the provincial Emergency Shelter Program; and increased funding for the development of social and supportive housing. However, only modest improvements and funding increases were made for support services for people experiencing addiction and mental illness, and income assistance rates and the shelter allowance continue to fall far short of average rents for bachelor suites.

As of January 2010, Vancouver’s downtown core had 13,694 low-income housing units, comprised of 8,181 non-market units, 4,401 single room occupancy (SRO) hotel rooms, and 1,112 community care facility and group residence beds (COV Housing Policy & Community Services Group, 2010). Vancouver Coastal Health Authority (VCHA, personal communication, April 2011) funds 974 units of supported housing which are specifically designated for individuals with mental illness. These units include Supported Independent Living, block apartments, enhanced apartments, and unlicensed group homes. There are 1,080 units of low barrier housing, predominantly located in the DTES, which have few requirements around substance use or disruptive behaviours. Approximately 200 units of supported housing are specifically designated for people in recovery from substance use. In addition to the SRO and low-income housing stock, the downtown core has 15 licensed care facilities and group residences consisting of 334 beds; however, these beds are generally not available to people who have been homeless for long periods of time and/or who have substance use problems. Finally, there are also 12 year-round shelters, with a capacity of 481 beds, and three temporary winter response shelters with a total of 280 beds.

Methodology

Description of the sample

Demographic characteristics of those participants who took part in the personal story interviews are presented in Table 1. Age ranged from 21 to 66 years (mean=42 years). The sample included 28 males (54%), 21 females (40%), and three transgender participants. Over half of the participants were White (60%) and 23% identified as Aboriginal. Most participants were single, never married (60%) or divorced/separated/widowed (35%). The vast majority (81%) of participants experienced absolute homelessness, while the remaining participants were precariously housed. At the time of the interview, 40% had attended but not completed high school. The demographic characteristics of the subsample selected for the qualitative interview are largely representative of the full study sample (n=490). Compared to the full sample, the qualitative interview sample contained

more women (40% vs. 27%), more Aboriginal people (23% vs. 16%), more participants with children under the age of 18 (33% vs. 25%), and more participants who met criteria for Mood Disorder with Psychotic Features (29% vs. 17%).

The categories of mental disorders that were most frequently identified in the sample, according to the MINI Neuropsychiatric Interview, were Psychotic Disorder (48%), Major Depressive Episode (46%), Mood Disorder with Psychotic Features (29%), and Post-Traumatic Stress Disorder (29%). In addition, 63% of participants met criteria for current Substance Dependence on the MINI and 21% met criteria for Alcohol Dependence. Participants' main source of income was social assistance, with 50% of participants receiving basic income assistance and another 46% receiving support associated with a disability.

Table. Demographic characteristics for baseline personal story sample (n=52)

	Mean (years)	
Age (range, median)	42 (21-66, 42.5)	
Lifetime duration homeless (range, median)	5.5 (0.2-33, 3)	
	n	%
Gender		
Male	28	54
Female	21	40
Transgender	3	6
Race/Ethnicity		
White	31	60
Aboriginal	12	23
Mixed	6	12
Black	3	6
Housing Status		
Absolutely homeless	42	81
Precariously housed (SRO)	10	19
Marital Status		
Single, never married	31	60
Divorced/separated/widowed	18	35
Married/co-habiting	2	4
Unsure	1	2
Have Children under 18 years	17	33

Education		
Grade 8 or less	10	20
Incomplete high school	21	40
Completed high school	9	17
Attended or completed post-secondary institution	12	23
Mental Disorders		
Psychotic Disorder	25	48
Major Depressive Episode	24	46
Mood Disorder with Psychotic Features	15	29
Post-Traumatic Stress Disorder	15	29
Panic Disorder	14	27
Manic or Hypomanic Episode	10	19
Substance Dependence	33	63
Alcohol Dependence	11	21
Main Source of Income		
Basic income assistance	26	50
Disability	24	46
Pension*	3	6

*Of these three participants, two also had disability status and one also received basic income assistance.

Documentation of methodological steps

A local team of qualitative researchers and interviewers was established, consisting of two PhD-level university researchers, one PhD student, one post-doctoral fellow, one person with lived experience, and one field interviewer. Two graduate student research assistants who were arms-length from the project transcribed most of the interviews, however, three additional people assisted with a small number of transcripts. Four members of the qualitative team were involved in conducting interviews. Whenever possible, interviews were conducted in pairs that included a peer interviewer. In 25 cases, the interview was conducted by one interviewer without the presence of a peer interviewer.

The interview guide was jointly created by qualitative investigators from each participating research centre, and contained key questions and probes. Interviewers were encouraged to use the interview guide to provide structure to a conversation with the participant. Interviews were conducted at a private location that was comfortable for the participant. The most common locations included the project field office and small rooms in service agencies.

Initially, participants for the personal narratives were chosen randomly; however, the team soon moved to a purposive sampling method in order to ensure a diverse representation of participants (e.g., gender, ethnicity, age, sexuality, etc.). Participants were either invited to participate at the end of their baseline quantitative interview or were contacted by a qualitative interviewer by telephone a few weeks after their quantitative baseline interview. Informed consent was obtained from all participants and they received a cash honorarium (\$30) at the end of the personal story interview.

Coding/analysis process

Beginning in December 2009, the local qualitative team met monthly to review interviews conducted to date. As each interview was transcribed, two members of the qualitative team read and coded all interviews. At each monthly meeting of the qualitative team, two transcripts were reviewed and discussed for both quality and emerging themes. In August 2010, the qualitative team developed a list of key themes that had emerged from the interviews conducted to date (n=23). From that point forward, the team met every four to six weeks to discuss key themes that were emerging from the interviews.

A sense of dislocation and feeling trapped in Vancouver's DTES neighbourhood were prominent themes and spurred an interest in participants' sense of community. Therefore, in June 2010, the team decided to add two questions related to sense of community: "What does community mean to you?" and "Do you feel like you belong in your community? Why or why not?"

In January 2011, the qualitative team met for a day-long retreat to co-code transcripts using a general thematic approach. Prior to the meeting, each team member was assigned six transcripts and coded the transcripts line-by-line focusing on an assigned topic (e.g., pathways to homelessness, life on the streets, experience with mental health services, and key life events). At the retreat, the team broke into pairs to identify emerging themes, define the themes, and identify key examples of each theme. These themes were then presented to the large group who discussed and agreed upon key themes. After the meeting, a summary of the themes was distributed to all team members and further revisions of themes and definitions were made over email.

Monitoring quality

Before interviewing commenced in December 2009, all interviewers were trained on qualitative interviewing in general and how to use the interview guide. The first two interviews that each interviewer conducted were reviewed in detail by the team and feedback was provided to the interviewers. The qualitative team met as a group every month to review transcripts of interviews. From December 2009 through to July 2010, these meetings predominantly focused on improving the quality of interviewing (e.g., posing open ended questions, probing adequately, dealing with negative emotion and difficult situations, avoiding leading questions, and not providing too much personal information or "cheerleading").

Five audio files were reviewed by one of the local university researchers on the team as well as by the post-doctoral fellow (who is also on the National Qualitative Working Group). The audio files were checked against their respective transcripts and a checklist, which assessed coverage of key topics and probes, was completed.

Results

Results are presented by key topic headings and questions from the interview guide: pathways into homelessness; life on the streets or in shelters; experiences of mental health issues and services; and key life events.

1. Pathways into Homelessness

This cross-section of narratives reflects the diversity and complexity of experiences leading to homelessness among individuals with mental illness in Vancouver. Participants' places of birth represent all regions of Canada, both urban and rural. Several participants reported becoming homeless as young as the age of 12; however, most participants first experienced homelessness in early adulthood. For most participants, homelessness occurred after cumulative experiences of loss; but for others, homelessness happened relatively suddenly. The duration and number of times homeless varied considerably among participants. The length of homelessness experienced by participants ranged from less than one month to more than several decades over the life course. However, few participants experienced a single episode of homelessness. As one participant explained, he had been homeless "off and on, all my life." All participants described challenges associated with becoming, being, and exiting homelessness.

Life Before Homelessness

For the majority of participants, childhood was described as a turbulent time marked by poverty, alcoholism, abuse and violence in the family home. A few participants reported happy childhoods, describing positive relationships with family members. However, family conflict was prominent across the narratives, particularly among participants having multiple step-parents and/or foster-parents, and within adoptive families. Conflict with parents and guardians escalated in the teenage years, often resulting in being kicked out of the home or initiating a cycle of running away. Some participants attributed conflict with parents as normal teenage rebelliousness. Others indicated they were escaping from serious family violence and abuse:

My father was an alcoholic, truck driver, very cruel, very mean... I mean he broke my arms, he broke my collar bone, he fractured my skull, he locked me in foot lockers, he beat me with my own guitar... just crazy. ... I started running away from home when I was probably nine... By the time I was 13, I was on my own.

My childhood would be being abused by both parents, physically, mentally and sexually. Uh, my first assault charge was with my dad. I'd seen him hit my mom and I hit him with a two-by-four in the back of the head. And that was when I was 12.

Participants frequently described having troubled siblings, and often reported that their parents suffered from serious mental illness, and/or alcohol and drug abuse. Further, several participants experienced severe childhood neglect by their biological parents and were adopted as infants by other family members or into foster families. The family histories described by many participants highlight an intergenerational cycle of poverty, abuse, mental illness, alcohol and drug use. For example:

But I think my mom had trouble with housing too, because she was in foster homes as a little girl and I did a lot of foster homes, an orphanage, up north.

I was born addicted to heroin. My aunt's a drug dealer, my mum's a junkie, so... I tried it and I liked it.

As children and teenagers, many participants were apprehended by social services and placed in foster care, group homes and other juvenile detention settings. Many participants described frequent moves among multiple institutional settings, as well as among different family members (i.e., grandparents, aunts and uncles). Some Aboriginal participants also reported moving on and off reserve. Several participants described experiencing periodic psychiatric hospitalizations as youth, but with little, if any, positive impact.

When I was a kid, they sent me to ... a psych hospital in Montreal and I saw a psychiatrist there and he ended up asking me to have my mother come in. When my mother came in he ended up doing more visits with her than he did with me. And again, I slipped through the cracks.

Difficulties in school were also commonly reported by participants, with many either dropping out or being expelled. School disruption was often accompanied by negative peer associations, experimentation with hard drugs, and involvement in criminal activity and the law. For example:

That [using drugs and alcohol] was the beginning, and sort of gambling with friends, you know, playing cards, and, uh, it just led down to a spiral from 16 to 18, I guess...in and out of prison every day, like every, the shortest period I was out, I think I was out for 12 hours.

Participants often described feeling as though they never fit in with others socially. They described feeling 'different,' having poor social skills, and often labeled themselves as a 'badass,' a 'shit-disturber,' or 'not very bright.' Many participants described being bullied and teased at school.

Kids used to tease me at school. I got tired of it and I left home when I was 13. So I only had a grade 7 education for the longest time until I went to college here in BC.

When participants left home for the first time, some became immediately homeless, some were provided with housing through social services, and some moved into suites or apartments with friends, roommates or romantic partners. Many women described exploitative relationships with men as a means of finding shelter.

I was homeless. I stayed from place to place. I stayed at dates' places, I stayed in washrooms at the McDonald's, I slept in washrooms sometimes. Um, when I didn't have a place to stay, slept in the park sometimes... I was homeless when I was 13. From about 13 to about 16 years old, I was homeless.

Several participants reported moving into hotels and apartments once eligible to collect welfare. Others expressed enjoying their first jobs working as cooks, in retail, in construction, or taking college courses. A small minority of participants continued their education and completed undergraduate or technical degrees. Prior to becoming

homeless, several participants reported having successful careers, good marriages with children, and a stable family home life.

Precipitants of First-time Homelessness

Family Relationships: In general, participants' ties to family and the circumstances around their leaving the family home impacted future housing stability. Some participants became homeless immediately upon leaving their parents' home as a result of being kicked out, running away, or otherwise escaping family conflict. For others, the death of parent(s) or guardian(s) was a loss of unconditional support and contributed to the onset of homelessness. For example:

I lived in a house with my parents until they died. Then I became homeless.

I've been homeless a couple times. Just over the years, started drifting in and out of jails and stuff. Like, I could always go home to my mom when she was alive. Anytime, morning, noon and night, I was always welcome home...

Cumulative Loss: For others, homelessness occurred over time as a culmination of life experiences. Some participants had difficulty identifying the exact cause of their homelessness, but often described the process as life going 'downhill fast' or that it 'came out of nowhere':

Um, it's been difficult; I've been on my own since I was 17, so it's been hard at times. I've had employment, and things that had been going good and then it's like the carpet's been swept out from underneath me.

Substance Use: Many participants pointed to involvement with drugs as a major contributing factor to homelessness. Some blamed themselves for 'messing up' with drugs, and, in turn, 'blowing it' with money and interpersonal relationships (i.e., family members, romantic partners, roommates and landlords). For others, a traumatic loss such as divorce or a death in the family triggered a 'downward spiral' of drug use and eventual homelessness. For example:

Something happened 10 years ago that sent me on a downward spiral, so uh... It's taken me 10 years to get here... My daughter died. She was killed by a drunk driver. And it just sent me over the deep end and I ended up blowing a million and a half dollars on drugs over the last 10 years. ... I totally lost it. I didn't care about anything. Total depression, uh... I was doing up to an ounce a day of blow, so... I didn't care about having a house or not, I lived in my truck until they re-possessed it..."

Social Skills and Support: Compromised social functioning associated with mental illness such as anxiety (e.g., claustrophobia, agoraphobia, flashbacks), severe depression, and paranoia was also identified as contributing to homelessness. For some, being unable to take public transit or to be around other people prohibited them from gaining employment or accessing welfare. Some participants admitted to having poor frustration tolerance and conflict resolutions skills which make interacting with others very difficult.

Participants also pointed to social factors and a lack of supportive social networks as contributing to homelessness. For example, lack of education, little or no family support, and having few life skills were frequently cited as contributors to homelessness. Several participants voiced concern over the lack of transition and support services for individuals released from institutional settings such as psychiatric hospitals, juvenile detention centres and prison. Many participants not only suffered a loss of housing due to hospitalization and imprisonment, but when released were left essentially homeless without supports or social services to negotiate the system. For example:

'Cause when you get out, after, like, you do more than five years, you don't know how to live out here... You know, I didn't know how to go to the Welfare Office and fill out a form.

When my time was up, they just kicked you out. And they didn't tell you to set up anything or go anywhere. They just said, 'Your time's up and you gotta go.'

Other factors identified by participants included the lack of available affordable housing, rent increases, evictions, loss of employment, inadequate welfare, poverty, childhood abuse, identifying as homosexual, divorce and broken relationships. Amongst female participants with children, long and expensive custody battles was specified as taking both a financial and emotional toll that left them vulnerable to homelessness.

Recurrent Experiences of Homelessness

The majority of participants reported recurrent periods of homelessness, temporarily finding shelter with friends or family, couch-surfing, accessing shelters, etc., but having difficulty locating and keeping permanent housing.

I was homeless for almost three years. I did get kicked out of my place for no reason, but I said, "Ok, I'm going to try to figure out, like what is it to be homeless? ... How can we get out of homelessness?" It's not an easy thing to do. As soon as you get outside and you get kicked out, you turn around and there's nothing! There's nothing around! It took me two years to find a place. I passed through two winters. There was some shelters and everything, But the system makes it very hard to get back on your feet.

I don't want to be homeless. Nobody wants to be homeless. There's not enough housing in this area. You go looking for minimum 375 and all you're going to find is cockroaches and bedbugs and all that kind of stuff so...I've tried it.

Participants frequently discussed arbitrary rules and evictions practiced by landlords as contributing to their recurrent homelessness (e.g., the practice of demanding guest fees and being kicked out for bringing people into their units). Moreover, many participants complained that much of the available housing stock is in very poor condition, very insecure and so unsafe that several participants fled their housing for their own safety and comfort. Female participants expressed that it is much harder to feel safe as a homeless woman.

Uh, my room was getting broken into and all my stuff was getting stolen...and uh, people – there was drug dealers that lived above me, and they were assaulting girls upstairs and I could hear it perfectly, you know? I just left whatever I had there and I

never went back... 'Cause I was too scared. I was like, "What if they know that I can hear?" You know what I mean? If they want to fuckin', you know? So I was just like, "Fuck this."

Many participants also expressed frustrations with the 'years-long' waiting lists to secure housing units with BC Housing and other housing agencies, making it difficult to be re-housed. It was further indicated that some BC Housing units are in as poor a condition as the worst 'slumlord' units. Several participants admitted to ultimately giving up and not making the effort to find housing.

Participants also reported feeling demoralized by rules of 'the system' and service providers. Participants with children expressed feeling scrutinized by service providers, leaving them fearful of having their children apprehended and/or their housing taken away at any time. Others expressed frustration with having social workers control their incomes as a prerequisite for social housing. Several participants reported losing their housing due to conflicts with social workers over handling their money.

Having personal identification and a bank account were also recognized as important prerequisites for accessing welfare and housing. Further, several participants, particularly those new to Vancouver, reported being unsure of where and how to access services such as welfare and replacing identification.

Participants also commonly reported being taken advantage of by roommates, partners and family members for housing, food, drugs and money – placing them at risk of eviction. Many participants often described the expectation and pressure by roommates and partners to both supply and use drugs when they had money.

Recent Experiences of Homelessness

Participants described finding their most recent housing through a variety of community resources and networks, as well as by individual resourcefulness. Participants reported receiving support through income and employment programs, community centres, non-profit housing societies, BC Housing, outreach workers, word-of-mouth referrals, and doing their own searches on Craigslist. Many participants expressed frustration at the lengthy waitlists for social housing, with some sitting on waitlists for several years. Several participants described strategies that accelerated their placement into BC Housing units, for example, by purposely living homeless on the street for a period of time to gain priority status, or by holding an address at an SRO to ensure they were in 'the system.'

Maintaining housing was a challenge for many participants. Participants often attributed staying away from drugs as the key to remaining housed. For example, according to one participant:

I ended up using and they've got a no using policy, so they ended up kicking me out. So that put me back on the street again, right back to square one. My fault – yes, I used – but ... you got to find out why the guy used. You just don't send them to a treatment centre. I already know all that stuff. It's why I'm using that I need to know. I get depressed, I get off my meds. I start thinking about my daughter too much. There's

something I need to go through- uh, grief counseling with somebody for my daughter. Because that's one of my major steps – it hurts me the worst.

Other factors identified as contributing to maintaining housing included having employment, participating in volunteer activities, following rules, 'being good,' adhering to medication regimens, and paying rent on time.

Although access to good quality, subsidized housing was identified as a primary factor that assists individuals to stay housed, programs with strict abstinence policies or limits on length of stay were cited as barriers. For example, one participant who lived in youth housing first became homeless when he reached the youth age ceiling of 25.

A few participants reported that in the past they had good apartments and supportive landlords who had assisted them with keeping their housing. However, the majority of participants expressed frustration with the discriminatory practices of landlords, arbitrary evictions, and a lack of tenant rights which prevented them from accessing and keeping housing.

Well, I know some places, they just pick whoever they want, or they just tell you that there is no place. But, I found that there is places, there was rooms, but they pick and choose who they wanted...

Other common barriers identified by participants in finding and keeping housing included landlords that do not accept pets and smoking, problems with the condition of housing units (i.e., bed bugs, noise, drugs, theft, poor building repair), safety of the neighbourhood, and difficult tenants and roommates.

2. Life on the Streets and in Shelters

Participants frequently identified Vancouver's DTES (specifically the Hastings Corridor) as the primary neighbourhood in which they spent time during the day and slept at night. A small proportion of participants stated that they avoided the area as much as possible and entered only to access essential services. Given the concentration of homeless individuals in the Hastings Corridor, participants' experiences of life on the streets and in shelters and SROs was strongly influenced by both the physical and social characteristics of the Hastings Corridor.

A Typical Day

Exigencies of Daily Living: While experiencing homelessness, dealing with the exigencies of daily living and survival consumed much of participants' time and energy. For example, carrying belongings all day, attending appointments, waiting in line-ups for long periods of time, and looking for ways to obtain money and food took a physical and emotional toll on most participants. Keeping oneself and one's possessions dry, including sleeping material (e.g. cardboard), posed a unique challenge for participants living outside due to the rainy local climate, as described below:

I'd sometimes get into those lines at 9:00 at night just to guarantee for when they open up at 11:00... If it's raining, you're getting wet. When you're in line,

you're soaked. You go to bed, you're soaked. You wake up and you're wet... I hated it.

For participants not willing to use or wait in line for emergency shelters, there were additional challenges related to finding a safe place to sleep. Participants reported sleeping in stairwells, doorways, under trucks, in forests and parks, at the beach, and in parkades. Given the poor condition of many of the local shelters (e.g., hygiene, noise, safety, privacy), several participants mentioned 'choosing' to sleep outside. At times, participants stayed awake all night:

If I can sit up somewhere in the night, like an all-night coffee shop or sometimes at the airport like I do, I stay there. I read my book. People see you – they think you're travelling. I'll do that before I go to a shelter... To me, [staying at a shelter] is one step from the grave.

With regard to obtaining food, many participants reported using soup kitchens and food line-ups. Participants reported that free food is easy to find in Vancouver, although they noted that the quality of the food is very poor. Some participants foraged in dumpsters or bought food from grocery stores or fast food restaurants.

Emotional and Social Disengagement: Participants also described experiencing significant personal loss, which affected them on a daily basis. The most common losses included the privacy and safety that comes with adequate housing; dignity and respect; possessions; relationships with children, family, and romantic partners; employment; and physical and emotional health. For many participants, the loss of housing included the loss of the opportunity to *access* additional housing. Several participants described being evicted or kicked out of housing they had secured, often for the very behaviours that they needed help with at the outset (e.g. symptoms related to mental illness and addictions). In addition, many participants reported pervasive stigma and discrimination when trying to secure housing in the rental market. According to many participants, repeated rejection, evictions and loss of housing led to profound discouragement and disengagement from the system.

Substance Use as Coping: Various degrees of involvement in drug culture featured prominently in many participants' descriptions of a typical day. Many participants described relying on daily drug use to cope with the circumstances of their environment or as a response to boredom, as described below:

It's a crutch or a blocker. So, you block out that you're bad or that you're not having a good day. Take some heroin. Your day ain't gonna get anything but better... You can stay high all day and not give a shit if you're dead or have nothing going for you.

Participants engaged in regular substance use described spending large portions of their day looking for and using drugs and recovering from their effects. For many participants, the majority of their social interactions revolved around drug use. Some participants described spending their days on a street corner working for different dealers, waking up

dope-sick, and turning to crime to support their habit. For some individuals, drug use was described as unavoidable:

People get into a trap. You know, welfare – they only pay so much, right? And what are you going to do? If you're stuck downtown, and that's the only place you can afford, and what's around you? Drugs. So what do you do? Your next-door neighbour does it. You're just in a trap and you can't really get out.

For others, the prevalence of drug use in the Hastings Corridor keeps them from going back to the neighbourhood unless absolutely necessary.

I won't go there [Main and Hastings] if I don't have to.... It's not good. It makes me aggressive. Like, one look makes me want to start drugs. I think, "Oh my god, I can't wait, I cant' wait to get out of this."

Resilience and Resourcefulness: Overall, participants' descriptions of their daily existence contained examples of considerable resourcefulness. For instance, numerous participants described income-generating activities to supplement their social assistance, including collecting bottles and scrap metal, binning, selling drugs, panhandling, soliciting, and busking. A few participants described their use of local community centres to meet basic needs, such as staying healthy through activities like using the weight room or swimming, and taking a shower. In order to stay warm and gain reprieve from the chaos of the streets, several participants reported spending time at the library. The library was described as a safe place where individuals could spend time without being bothered.

A few participants described using computers at libraries and community centres to look for housing and employment, or for low-cost items in the online classified ads. Others described looking for work on street corners where casual day labour is sought and, on occasion, doing casual jobs. Many participants drew strength from their own creativity and expressed their enjoyment of playing guitar, reading, creating art and going to church.

Relationships and Identity: According to participants, the impact of homelessness on both their personal relationships and identity is immense. Participants often described keeping their circumstances hidden from family members, feeling profound shame, suicidal ideation, and doubt about what they should be doing on any given day. Monotony, boredom, and a lack of opportunity to engage in meaningful activity made it difficult for many participants to engage in the community and to feel good about themselves. In addition, participants with children expressed fears related to seeing them or keeping in touch, and felt scrutiny from service providers surrounding their circumstances. While a small number of participants described spending time with a significant other, many participants described spending their days alone, with limited social interaction:

I felt so awful...so transient. I didn't really talk to people. You're just concerned about what you're going to eat, where you're going to eat, and where you're going to sleep that being relaxed enough just to go hang out with somebody just...it's not really possible.

When asked how life had changed since becoming homeless, a few participants either didn't know or indicated that life had not changed. Most participants commented on the impact of homelessness on their relationships, and their feelings of isolation and loneliness. Some participants mentioned that becoming homeless had negatively affected their families and they had stopped communicating with family members for long periods of time. Other participants expressed absolute devastation as a result of the experience, noting marked deterioration in their mental and physical health; several participants described having to sell everything – including themselves – to survive, and a complete sense of being lost in the world. Many participants described the effect of homelessness on their self-respect and having to do things they never contemplated in order to survive. According to one participant, the hardest thing about being homeless was:

Swallowing my pride. If you're digging in a dumpster, you know, and someone comes by and sees you doing that – I used to be, like, embarrassed or whatever about doing that, or picking up butts or whatever I had to do. It kind of sucked. I hated that. I hated that feeling.

Experiences with Services, Supports and Community Organizations

Services, supports, and community organizations were described both positively and negatively. According to participants, characteristics of helpful organizations included offering a safe, comfortable space to relax where people felt accepted for who they are. In addition, helpful services employed staff who were proactive, respectful and offered meaningful assistance. Other positive attributes of helpful services included the ability to store personal belongings during the day, access to computers and concrete help with housing and job searches, access to good family doctors, and advocacy around basic needs (e.g., enrolling in income assistance, obtaining identification). Finally, agencies that provided opportunities for social interaction were also considered to be helpful, and a small number of participants had positive experiences in the hospital or at the emergency ward because they felt nurtured and sheltered while they received care.

According to participants, unhelpful organizations were characterized primarily by the lack of training or disposition of employees. For example, some staff members were perceived to be judgmental, rude or discriminating, and had little respect for participants' personal belongings. In addition, participants reported frequent interactions with service providers who did not listen or provide useful services or assistance. In addition, some participants objected to shelter staff having control over access to their medication. Other participants described being excluded from particular shelters or services due to their substance use. A few participants described being banned from shelters and other services and felt that staff often lacked the training necessary to deal with people experiencing mental illness and addiction.

Experiences with Housing

Since first experiencing homelessness, participants overwhelmingly described negative encounters and experiences with the housing system. Oftentimes, the only housing available to people was extremely poor quality (often SROs which lack private bathrooms and cooking facilities) and was described as dirty and infested with pests.

When I was homeless, the places were run-down, bed bug infested. There were cockroaches and mice and rats that were the size of my cat. Or, going into squats...an old abandoned warehouse or storefronts where you can sneak in and there's no alarms or hydro or nothing, but there's no heat or nothing... It's just out of the rain.

In addition, participants described the limited housing and shelter options available to them as unsafe, whether due to disrepair, violence and abuse, or frequent theft. Personal security was a daily challenge, as highlighted in the following passage:

Being in these shelters where everything is ripped off...it's just not worth it... And on top of that, the last shelter I stayed at, I had bed bug marks all over my legs. I stopped staying there and started staying in my tent. Way better.

While several participants noted that they had no conflict with their neighbours or landlords, many participants described landlords and building managers who ignored major building disrepair (e.g., toilets that don't work, major ceiling leaks) and contributed to the drug trade, and being kicked out or evicted for no apparent reason. Exposure to stigma and discrimination was commonplace for most participants, particularly when looking for housing. For example, the following participant described an interaction he had with a landlord while searching for housing:

He [the landlord] said, "Oh, you're on a junkies pay plan." He was all, "...Buddy, if you're on welfare, you're on some sort of fucking dope and I don't want that in this house, or your friends."

While looking for housing, participants stated that they were often told all units were occupied or openly denied housing because of their welfare status, ethnicity, sexual orientation, or appearance. In addition, several participants reported being evicted following a hospital stay. If housing was located, participants were often not able to secure it due to lack of telephone access or references. Finally, when able to rent short-term, some participants described being kicked out after a short period, with no return of the damage deposit.

Positive experiences with housing were rarely reported. Characteristics associated with a positive housing experience included subsidized housing that was family oriented, good relationships with neighbours, living harmoniously with friends or family, a place that was clean with secure locks, and experiencing some stability in the same housing unit over time. Unfortunately, several participants indicated that the At Home project was the first positive experience they have ever had with housing.

Vision for the Future

Meaning of Home: When asked what "home" means, most participants described a place where they could be themselves, safety and security, comfort, and ultimately peace of mind. For several participants, the concept of "home" meant living a "normal" existence consisting of work, friends, family, neighbours, and living in a community that is not dominated by drugs.

Ideal housing situations varied from person to person, based on whether individuals preferred to live alone or with others. The majority of participants expressed the desire to live away from the drug scene of the Hastings Corridor; a sense of permanency, privacy, and security (e.g., a door that locks); space (larger than an SRO); and quality (e.g., a place they could invite family and friends). The majority of participants described their ideal housing situation as one that they could call their own, with either a formal or informal support system, including having family or others to care about. Participants identified a number of barriers that might jeopardize their ideal housing situation, including returning to the Hastings Corridor, drug use or relapse, relapsing into mental illness, boredom and loneliness, financial problems, and lack of support.

Participation in the At Home Project: With respect to participation in the At Home project to date, the majority of participants greatly appreciated the receipt of good quality housing and being treated with respect by project staff. Several participants expressed thanks for the support services and stated that they feel hopeful about the future. A minority of participants expressed confusion and/or skepticism around what will be done with the information collected through the project.

Many participants described their drive to keep going either as an internal motivation or something drawn from others. Internal motivation included strength of character and hope that things would eventually change. Some participants were motivated by doing things they enjoyed such as playing chess, reading, helping others, volunteering, and trying to keep healthy through proper nutrition and exercise. External motivation was often drawn from services such as clubhouses that participants could visit on a daily basis, treatment and recovery-oriented programs, or from looking forward to spending time with pets. For participants who had children, the thought of reuniting in the future was a powerful motivator to keep going.

3. Experience of Mental Illness and Related Services

Initial Experiences of Mental Illness

Many participants were able to trace symptoms of mental illness to middle childhood (ages 10-14) and difficult family and social environments they experienced at that time. Many participants stated that they were aware that “something was wrong” and that they were not like other kids. Feelings of depression, anxiety, and anger were frequently reported, as well as problems with parents and school, which often resulted in early drug use, social withdrawal, and/or aggressive and antisocial behaviour. Several participants reported being hospitalized in psychiatric wards and/or spending time in juvenile detention centres during their childhoods and adolescence. Few participants described these early interventions as helpful; most recalled being told that they were troublemakers and attention-seekers and developed a sense of being unwanted by society.

Other participants reported that symptoms of mental illness “crept up on them” and gradually worsened over time as a result of accumulated stress and loss. Many participants described key stressors and life events that precipitated a “break” in their mental health, including the loss of key roles and relationships (e.g., death of a loved one, divorce, loss of

custody of one's children, job loss), poverty (e.g., being evicted, not being able to pay one's bills), and being homeless. For example:

A lot of stuff contributed to my mental health problems: relationships, kids, people passing away when you're not there, other things. Stuff that you weren't there for when you could've been. There are lots of things. I can't really pin-point each one. It just builds up and builds up, right? And then you've got your own thing to handle that you're not letting anyone know about, so it all just builds up and comes out.

I had no sense of this [psychosis] happening... This just kind of hit me smack in the face and everything just kind of blew up to the point where I just didn't give a shit anymore. That was it. I was ready to check out of here.

For many participants, early signs of mental illness were intimately tied to symptoms of heavy substance use. For example:

I didn't know until after that it was psychosis. ... I thought it was normal but, after, I'd get really depressed. I thought it was because of drugs...the drugs didn't help. It was part of it, but I would get really depressed for six months.

I felt like there was something wrong with me because the first time I did cocaine – I was 14 – it felt like the missing part of me, and it made my thoughts and feelings clearer.

Participants told numerous stories of feeling marginalized and discriminated against in their attempts to get help for their mental illness. Oftentimes, participants were diagnosed and given a prescription for medication without having the chance to ask questions and talk about their feelings, thoughts, and experiences. In other cases, participants felt that something was wrong for many years, but were too ashamed to seek help or were told by health and social service providers that nothing was wrong. In many of these cases, participants felt increasingly depressed and often attempted suicide as a means to escape their suffering. Of note, many participants first reported receiving a diagnosis for their mental disorder as adults while incarcerated or when hospitalized after their first suicide attempt.

Ongoing Experiences with the Mental Health System

Most participants described not knowing how to get the help they needed for their mental health symptoms. Many participants reported that they periodically “wind up” in hospital because they could not find a mental health professional to consult with in the community. A few participants described finding a psychiatrist who prescribed medications that have been helpful and connecting with helpful mental health support services. Most participants described very negative experiences with hospitals, doctors, and medications. Several participants expressed anger that medications were administered or changed without their permission. The majority of participants did not find psychiatric medication to be helpful and expressed a desire to address the underlying issues via individual counseling or support groups.

I just stay away from doctors. I hate hospitals. I hate doctors. Every time you go see a doctor, you end up getting strapped down and filled with a bunch of medication. I hate taking medications. Every time I see a doctor, they're trying to push it on me.

Several participants stated that they could only see doctors in the DTES but often miss their appointment because they want to avoid entering that neighbourhood for various reasons or because their lives are too chaotic to remember appointments. While most participants acknowledged the negative impact of substance use on their mental illness, many stated that they prefer to manage their symptoms with street drugs rather than psychiatric medications.

Relationships with service providers¹: Positive experiences involved service providers who were compassionate, good listeners, and respectful. Participants described a number of positive experiences with the mental health system, characterized by being treated with respect, staff follow-through on recommendations, and consistency. However, negative experiences with service providers outnumbered positive experiences. Negative interactions often involved stigma and discrimination, rude and dismissive behaviour, and not being listened to. A number of participants stated that mental health professionals in the community are poorly skilled to deal with complex and concurrent issues and often fail to follow-up on a course of action. As a result, the majority of participants felt that they have to deal with their problems on their own and many expressed disengagement from the system.

I felt rebuffed and treated, in my situation, most of the time, like brain jelly in the Animal Zoo that everyone gets to have fun with. I don't get any integrity as a human being anymore. And this has gone on so long that I care less and sometimes would rather be dead.

They [mental health services] aren't really a lot of help unless you do the footwork. And, of course, when you are a drug addict, the footwork just doesn't get done. You just keep sliding, sliding, sliding.

Most participants were coping with symptoms of substance use as well as other mental disorders and reported that they often get shuffled between mental health and addictions services or face stigma and discrimination around using substances. For example:

I'll drink sometimes when I start to go manic and that'll make it [Bipolar Disorder] worse. And once I start that, psychiatrists don't even want to talk to me. Drinking and being Bipolar, the combination of the two, it's a nasty one.

Participants identified a number of gaps in mental health services. Only a few participants had regular access to a psychiatrist, and many did not have a family doctor. The majority

¹ Given that interviews were conducted shortly after participants' enrollment in the study, this section refers to participants' experiences with service providers in general and is not specific to service providers involved in the Vancouver At Home Study.

of participants emphasized the need for good quality psychotherapy in addition to or instead of medication management. A number of participants stated a need for mentorship from someone who had gone through similar experiences (e.g., a peer support worker). Many participants described having frequent contact with various services (e.g., detox, recovery homes, mental health teams, forensics, emergency rooms) without any meaningful benefit. Those who did receive good quality services noted that they were very fragmented and stated that they would like coordinated care instead of having multiple workers for each area of one's life. For example:

I'd rather have a smaller, more committed group of people rather than have to jump around to 10 different meetings. Because it just becomes overwhelming with different people and you're going over the same ground....it's almost like a waste of time.

I think the system really needs an overhaul, you know? ... people don't need to be dependent on services. They need to be empowered so they can be the services themselves too, you know? Like you're strengthening someone, not pushing them down.

Recovery and Healing

When asked what recovery or healing means to them, most participants described re-engaging in work, family, and the community. The majority of participants stated the need for good quality, safe housing outside of the Hastings Corridor and connection with some support services. Many participants expressed wanting to reduce or stop their substance use. Several participants acknowledged the need to take psychiatric medication regularly and to learn better coping skills. A few participants described broader attitudes they would like to adopt. For example:

I think it's a lot of awareness and a lot of self-love and a non-judgmental attitude for myself and acceptance and commitment, I guess, to myself to, I don't know, keep trying.

Forgiveness, quietness, gentleness, harmony, insight, meditation, faith, hope, trust, carrying on...

4. High, Low and Turning Point Stories

The majority of high, low and turning point stories are connected to family and meaningful relationships, housing and homelessness, mental health and recovery, spirituality and nature, and promise for the future. Low points were readily identified by participants, although some participants expressed difficulty identifying high points and turning points in their lives. Several turning points overlap with a few of the identified high and low points among participants, suggesting a particular importance of these events in participants' lives.

High Point Stories

Prominent themes emerging from the high point stories often related to the birth of children, getting married, and success in employment and career. For example:

The birth of my son. When I looked him in the eyes, I told him, "Buddy, I'm going to be backing you up from now on. I'm a dad now! I'm a man, buddy!" It changed me. It was amazing. I lost a whole lot of violence when he was born. It just went – whoosh!

Spending quality time with family or re-connecting with distant family members – children, siblings, extended family and biological family – was also frequently considered an important high point in participants' lives. Other themes included spirituality and making a connection with God, and finding peace and a connection with nature. Some participants described memorable events as high points, such as a particular birthday celebration or Christmas with friends and family. Accomplishing a specific goal was also identified as a highly rewarding and proud point in participants' lives (e.g., a successful choir audition, getting a Class 1 Driver's License). For example:

Well, I remember auditioning for my choir. ... I'd just been kicked out. I was homeless. I was staying with a cocaine addict who was trying to peer pressure me into doing drugs too...and, you know, feeling like everyone had betrayed me and, you know, everything was a mess...and uh, I thought, "I need choir. I need music in my life." So I auditioned ... and I remember the phone call from the director the next day that just said, "We have room for you in the choir." And it was the most exciting day of my whole life and since then it's been the most rewarding thing for me.

It would have been when I was young, probably around the age of 15. I used to like to ski... and I guess that...was probably one of the happier times in my life. Uh, just my state of mind at the time was happy. I had a lot of friends. I felt...like a normal functioning human, you know?

In contrast, a few participants expressed difficulty identifying high points in their lives, did not believe they had any high points, or hoped that a high point was on the horizon:

I haven't gotten there yet. Nope. Gotta be just around the corner though.

Several participants stated that receiving housing through the At Home study was not only a high point but the 'best moment' of their lives, and expressed feeling happy and positive about the future. Others discussed being in recovery as a high point and expressed enjoying improvements in the quality of their lives: feeling normal, getting into a routine, staying clean from drug use, and setting an example for others.

Low Point Stories

Major themes emerging from the low point stories are largely related to loss. The death of loved ones featured prominently, particularly the death of close family members: grandparents, parents, spouses, children and siblings. The end of significant relationships through separation or divorce, and the loss of custody of children also due to divorce or by apprehension by social services, was another prominent low point reported by participants. The loss of housing and becoming homeless, and the further loss of dignity and self-respect accompanying street survival activities were also frequently reported:

Like feeling degraded. Degrading yourself sometimes. Doing things that you never thought would be possible, you know, that you end up doing, you know. Feeling like

that. It takes a toll, having done things like that. Even to this day, like whenever I think about it, it's like, "Why?" It's hard, it's affected me, it's kicked me... Like, you feel that you can't recover from. I'll compare it to a soldier when they come back from active duty. You know, having those flashbacks...

When I was shooting drugs and I went out to work on the streets to get money for drugs. That was the lowest point of my life.

For some participants, first experiences with mental health symptoms were considered a devastating low point:

So, the realization that - I didn't think it was mental illness at the time, I thought it was communication with people and the fear that that created...I thought perhaps it was related to Vancouver, but I got to Calgary and they were still there. The voices were still there. So that was...really, really devastating... I was the object of all this ridicule and anger and negative input that was coming at me.

Other low points reported by participants included intimidating experiences with mental health professionals and medications; first time incarceration and the subsequent loss of freedom; hard core drug use and associated harms; childhood abuse; fear associated with intimate partner violence and death threats; and distressing events such as car accidents. Many participants indicated that they had experienced multiple low points simultaneously.

Turning Point Stories

Several key themes that emerged from the turning point stories were also considered as high or low points by a number of participants. Receiving housing through the Vancouver At Home study was considered a high point and a turning point for several participants, with many describing positive changes in their lives. For example, by gaining a healthy weight, quitting and/or reducing alcohol and drug use, and ceasing to participate in sex work. Several participants also described the importance of entering a recovery program and accessing treatment as both a high point and turning point by helping participants shift behaviours, improve their health, and understand oneself better.

The turning point was three years ago when I finally got fed up and decided I gotta get help and I went out and busted my balls trying to find the people that I needed. ... And in the last three years, I've been steadily climbing up. A couple falls back and climb a little higher and fall back, climb a little higher... so I'm still gaining. I'm not losing ground anymore.

Hm, when I started going to treatment. ... I started learning about my addiction and what it does to me, what it can do to me and how it's affected my life, and where it's going to take me. Yeah, that's what changed my life - going to treatment, detox and all that stuff... That it's ok to ask for help. And it's ok to cry. It's ok to laugh. It's good to talk to people. Yeah, that's when I learned how to let myself talk, like I'm talking now. Just to let loose and be able to talk.

Some participants' low points such as the death of a parent, a car accident, or first time incarceration also served as turning points by motivating positive change in participants. For example, by motivating a reconnection with family, choosing recovery, and choosing to quit using drugs.

Being diagnosed with HIV and other traumatic events were also described as turning points that ultimately changed participants' lives positively by instilling hope for the future, the motivation to pursue interests, and to set an example for others.

Another turning point theme involved starting over again; starting fresh by making a new start in a new town with a new job. Other turning points, such as becoming pregnant, running away from home, turning 30, or accomplishing a goal were described as defining moments which provided a new perspective to participants' outlook about themselves.

Several participants struggled to identify a turning point, and for a few others it appeared too painful to discuss. Others were hopeful for a turning point, as described in urgent terms:

Could be now. Yeah, it's do or die right now.

5. Cross-Cutting Themes or Issues

A number of underlying themes emerged throughout participants' narratives. Key themes included exclusion from community and increasing marginalization; poor attachment relationships beginning in early childhood and cascading throughout adulthood; and the impact of homelessness and mental illness on identity and sense of self.

Exclusion from Community

Feelings of involvement in the community varied from non-existent (e.g. "I don't think about that") to past involvement in the community (prior to becoming homeless) to current community involvement. Many participants described the Hastings Corridor as an unsafe place (particularly for women) that they wanted to escape, but felt trapped because cheap housing, shelters, and other basic needs and services are located there. For some, being on welfare made it nearly impossible to develop a sense of community involvement. For example:

I'm an outcast. All the time, you're not part of the community. Even being on welfare and going to the bank, you don't feel a part of the community...people still look down on you and you can't do anything. You can't help friends, you know? I mean, the friends you get are the friends that are in your tax bracket basically... So how do you find normal, decent people? They want you to go do things and stuff, movies and that, and you can't afford to go and do anything. You can't afford to eat or live...

For others, not feeling involved in the community was described in relation to their lack of employment. Some participants described volunteering with service providers and the opportunity to gain a sense of connection to the community through being able to help others. Many participants described having several acquaintances but few meaningful

interactions. A few participants described feeling involved in their community because they were a part of a network of people working together towards a common goal (e.g., gardens, community projects). Positive feelings of community involvement were also derived through participation in informal activities with small groups of friends or acquaintances. Participants' narratives revealed that many experience a conflict between the goal of distancing themselves from the Hastings Corridor and a daily reality that pushes them toward entering unsafe spaces in the neighbourhood.

Identity

Many participants revealed conflicting ways of thinking about themselves and where they lived. Oftentimes, participants described themselves as "bad kids" and "troublemakers" in their youth and admitted that they made bad choices throughout their lives. Many participants had internalized a sense of worthlessness that began long before their first episode of homelessness, but crystallized after living in SROs, shelters, and on the streets. For example, according to one participant, "Down there [DTES], you're nothing." Nevertheless, many participants described themselves as strong and worthy of respect and understanding, despite their pasts. As one participant stated: "I have a big heart, so I volunteer and stuff like that." However, later in the interview, this same participant described himself as "cold" and "distant." Many participants evidenced a struggle between viewing themselves as survivors who deserve respect and as illegitimate citizens who are a burden on society and their families.

Sense of identity was closely related to interpersonal relationships and connection to others. Many people expressed conflicted thoughts and feeling around social interactions: most participants stated that they have no or few friends and that they purposefully keep to themselves and avoid contact with people. However, at the same time, most participants expressed deep feelings of loneliness, isolation, and pain related to disconnection from others.

Conclusion

Almost every homeless participant we interviewed described feeling trapped or stuck in "the system." As has been described in previous research, our homeless participants expressed the desire for a home, a place to live that is safe, clean, and affordable and where they feel they belong (Nelson et al., 2005). However, participants described aspects of the public system that significantly constrain and even undermine their efforts to achieve independence. Our participants reported multiple and repeated contacts with various public institutions over the years, however, their needs remained largely unmet. Whether the focus of the public institution was health care, mental health, addiction, corrections, income assistance or housing, the results were often the same: requirements and constraints along with repeated setbacks contribute to individuals feeling hopeless and ineffective. Constraints include eligibility criteria for services such as being abstinent from drugs for a period of time before being considered for housing, narrow diagnostic criteria for receiving mental health services, long waitlists and inflexible schedules for primary care and addictions treatment. Constraints also stem from substantial gaps in the system of care: affordable housing, inadequate discharge planning upon exiting the criminal

justice system, services for people with mental health and addictions, particularly treatment for concurrent disorders and psychological treatment related to trauma and loss. Finally, pervasive stigma was reported at all levels of analysis: within public institutions and agencies, within the community and social networks, and within families.

Many homeless individuals in Vancouver experience a confluence of poverty, mental illness, substance use, and social exclusion. With few trustworthy friends or family to confide in, drug use and marginalization serve as a form of social currency. Participants expressed strong dissatisfaction and frustration with “the system,” the degree of choice they have over their lives, and distrust of others’ intentions. The majority of our participants expressed a desire to exit homelessness and many described multiple attempts to achieve independence from government assistance. However, these attempts at independence were often not supported by the larger system. Once this cycle repeats itself a number of times in different areas such as housing, employment, welfare, child protection, and health, individuals’ sense of self-efficacy and hope for the future was often eroded. Even after people were managing their substance use or mental illness on an individual level, often with the assistance of service providers in the community, it was very difficult for them to reintegrate into the wider community. Community groups are frequently vocal in their opposition of homeless shelters, supported housing, and other services for marginalized individuals (Antos-Arens, 1993; Jason et al., 2005). People who are homeless with mental health and addiction problems therefore remain marginalized and many of the same risk factors (i.e., loneliness, disconnection from community, emotional struggles) that precipitate their substance use are unresolved.

The Hastings Corridor is an area of the DTES that has been the subject of a great deal of media attention, public outcry, and police surveillance. Individuals who experience homelessness are the recipients of ‘public shame’ from multiple sources including other homeless people, service providers, as well as the general public (Rhodes et al., 2007). With limited opportunities for escape, occupying a marginal position in social and geographical space powerfully informs individuals’ experiences (Fast et al., 2010). Therefore, the environment can exacerbate social marginalization (Rhodes et al., 2007). We encourage consideration of the complex social, political, economic, and historical factors that contribute to the experiences of homeless people who have mental illness and addictions.

Public health and policy efforts to address ‘the homeless problem’ have generally aimed to exclude, relocate, or forcibly remove people from public space (e.g., Caldeira, 2000; Sandberg & Pedersen, 2008; Moore, 2004). These strategies largely ignore contextual factors such as neighbourhood deprivation as well as longstanding socioeconomic disadvantage that operate to rapidly isolate and push people toward harmful practices (Rhodes et al., 2007). Our findings suggest that further research is needed to better understand how institutions, including those responsible for health and social welfare, can contribute to homeless people’s continued marginalization.

Reflections and Lessons Learned

Although all participants interviewed were recently enrolled in the Vancouver At Home project, there were noticeable differences between the ‘usual care’ and intervention

participants. Those participants who received housing through the study were very much positively influenced by that experience, and often expressed gratitude and hope for the future. In fact, involvement in the Vancouver At Home project was often cited as the participant's high point or turning point.

Given that the interview started by asking participants what life was like before they became homeless for the first time, many participants spoke about difficult childhood and early adulthood experiences. This focus on challenging and often traumatic memories may have set the tone for the rest of the interview. Furthermore, in general, questions tended to focus on challenges and difficulties rather than strengths and resilience. Despite this focus, a number of strengths were revealed in participants' narratives. Further research is needed in order to more thoroughly examine the presence and significance of personal strengths among similar samples.

Many participants shared deep personal pain in the interviews. A few interviews were very hard to interpret due to active symptoms of psychosis or a clear strategy on the part of the participant to end the interview as quickly as possible. However, the majority of participants was willing to share their experiences and appeared to enjoy the interview process. However, it is important to recognize that power relations are always embedded in the research process and this distribution of power ultimately favours the researchers' interpretation.

Overall, the researchers hope that the thoughts, feelings and experiences contained in participants' narratives will change some of the myths and perceptions associated with homelessness. The personal stories provided by participants afford rich insights concerning experiences such as deprivation, discrimination, and marginalization, and also emphasize the resourcefulness, optimism, and preferences of people who experience homelessness and mental illness. Far too often, the resources designed to help individuals are in conflict with their needs and their abilities to help themselves. The knowledge and insights derived from this research can be invaluable in efforts to secure the human rights of disadvantaged and oppressed people, and in the redesign and evaluation of public services and policies.

"It is significant and illuminating for poverty researchers to listen to people beyond statistics. But if we research people who live in conditions of destitution or violence which threatens their lives, or which render them vulnerable and hopeless, we cannot ethically only extract our research from them, and write and publish their life histories.

And then just walk away." (p. 269, Mander, 2010)

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