Evaluation of the Mental Health Commission of Canada's At Home/Chez Soi Project: Consumer Narratives at Baseline and 18-month Follow-up

CROSS-SITE REPORT

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KEY MESSAGES

- A qualitative study undertaken at the five sites for the Mental Health Commission of Canada's At Home/Chez Soi project examined experiences and changes in the lives of participants between baseline and 18 months after study enrollment.
- This report focuses on changes ascertained through consumer narratives at baseline and 18-month follow-up interviews, and the reasons for those changes.
- A total of 195 participants completed both the baseline and 18-month follow-up consumer narrative interviews, with 119 Housing First (HF) participants and 76 Treatment as Usual (TAU) participants.
- The analysis of changes and contributors to changes were examined in a number of domains, including: housing stability, quality of life/typical day, social support/ community integration, and recovery from mental health/ addictions issues.
- The analysis also examined overall changes in life trajectories, and whether these trajectories were positive, mixed, or negative.
- Overall, HF participants showed superior housing stability, quality of life, and community integration.
- Factors facilitating housing stability included choice, positive social support, and the ability to reflect on setbacks, while social isolation and "bringing the wrong people in" often led to housing loss, particularly for those participants in both HF and TAU groups whose housing was in close proximity to substance-using social networks.
- Changes in quality of life included becoming less survival oriented ("feeling safer"), establishing a meaningful routine (vs. "killing time"), having more control over social interactions, and becoming future oriented (vs. "feeling stuck"). These changes were facilitated by recovery-oriented support and good quality housing.
- Improved social support and community integration were facilitated by good housing and positive relationships within the HF program. Housing provided a sense of control, a stable base, and the self-esteem necessary to establish or strengthen relationships, or distentangle from negative relationships. Positive relationships with service providers and peers within the program provided a base for developing social support and belonging outside of the program, and isolation from previous support networks, lack of social skill, and distrust were the main barriers to social support.
- Recovery was enabled by good housing, which catalyzed readiness for change and spurred engagement with mental health and addictions care. Positive, non-judgmental relationships with service-providers were also crucial to the recovery process.
- Proportionally more HF participants had positive change trajectories compared with TAU participants. Factors associated with positive trajectories included initial hopefulness upon being offered housing, having stable housing of good quality, having positive relationships (including an "advocate"), and gaining increased control over substance use issues.
- In line with the HF logic model, these findings affirm that providing housing gives a stable base for recovery, and for providing a full range of supports. Attention to social support is crucial, particularly during the early phase of transitioning into housing. Along with helping participants gain clinical and personal stability, support (e.g., supported employment, supported socialization) must be provided to help participants reclaim valued personal and social roles.

EXECUTIVE SUMMARY

The At Home/Chez Soi research demonstration project is a community mental health intervention funded by the Mental Health Commission of Canada (MHCC) that evaluates a Housing First (HF) approach to housing individuals with histories of homelessness and mental health challenges and illnesses with no prerequisites of sobriety or participation in treatment (Stefancic & Tsemberis, 2007). This report focuses on participants' experiences and changes in specific domains (housing stability, quality of life, community integration, and recovery from mental illness and addictions), ascertained through consumer narrative interviews at baseline and 18-month follow up.

In order to understand early trajectories into homelessness and experiences of mental health challenges and illnesses, as well as pathways out of homelessness and changes on these various outcome domains, a series of in-depth interviews were conducted with a sub-sample of participants from the larger clinical trial of 2,255 participants. At baseline, 219 interviews (9.7 per cent of the total sample) were conducted. Attrition rates were quite low, with from 80 per cent to 100 per cent of the sample at each site retained for an 18-month follow-up interview, and 90 per cent retained over all sites. A total of 195 participants completed both the baseline and 18-month follow-up consumer narrative interviews, with 119 HF participants and 76 Treatment as Usual (TAU) participants. We will refer to these two study groups throughout the report.

Each site completed a site report using a common template. To analyze the narrative interviews, site researchers completed a template similar to that developed by Deborah Padgett and her colleagues (e.g., Padgett, Stanhope, Henwood, & Stefancic, 2011) in their qualitative research on the Pathways to Housing program in New York City for each participant, which included more than 20 domains of change (e.g., life changes, typical day). Next, a matrix display was used to compare the HF and TAU participants on the domains (Miles, Huberman, & Saldana, 2013). The site researchers then identified factors that facilitated and hindered change in domain categories. Finally, matrix displays were developed that compared positive, mixed, and negative trajectories by HF and TAU and factors related to each of these types of trajectories.

For the cross-site analysis, members of the National Qualitative Research Team read the individual site reports and created matrix displays (Miles et al., 2013), highlighting the main topics covered in the site reports. Research questions guiding analyses included a comparison of HF and TAU groups with respect to changes experienced between baseline and 18-month follow-up, factors identified as helping or hindering changes, and factors related to positive, negative, and mixed trajectories of participants over time.

Participants in both HF and TAU experienced positive and negative changes in their lives, with those in the HF group being more likely to experience more positive than negative changes. Housed participants in both groups spoke about the benefits and challenges of becoming housed after experiencing homelessness. Although some reported that adapting to new neighbourhoods and feeling isolated from previous support networks was a challenge, many participants described housing as a catalyst for making positive life changes. Housing often enabled individuals to experience a sense of security and control in their lives, which in turn facilitated the process of reconnecting with family members, pursuing meaningful relationships, and working on recovery goals related to education, employment, and participation in other activities.

Particularly within the HF group, more participants were engaged in mental health and addictions supports, which was enabled by safe and stable housing and positive relationships with service providers. Individuals in the HF group were more likely to report improved finances since being housed, although individuals in both study groups were equally likely to report being connected to benefits or to programs that helped them move toward vocational goals. Participants in the HF group were also more likely to report improvements in quality of life (e.g., safety, sense of peacefulness,

and forming a stable routine); mental health (e.g., symptom management, reduced prescription medication misuse, psychological insight); and addictions (i.e., reduced dependence and consumption of drugs/alcohol), though sites reported mixed results in this area. With respect to mental health, feelings of depression, sadness, anger, and suicidality remained a problem for some across sites and study conditions. Hopes for the future were consistent across study groups, with stable housing, reconnecting with social support, forming romantic relationships, and going back to school or work being the most frequently reported recovery goals. While the nature of the identified goals was consistent across study groups, housed participants were more likely to report having goals, since becoming housed allowed participants to become more oriented towards the future. Furthermore, participants in the HF group reported actually being hopeful about their ability to achieve the goals that they identified.

For those participants who were doing well and experiencing positive changes between baseline and 18-month follow-up, factors facilitating these changes included housing, social support, supports from the health and mental health systems, positive relationships with support staff, reconnecting with friends/family/romantic partners, and increased self-efficacy. Two particularly important factors facilitating change were stable housing and having an advocate or positive, supportive relationship with someone (e.g., At Home/Chez Soi service provider, community mental health or social services staff, family member, romantic partner, or child). Finding a "good fit" between participants and new neighbourhoods was also an important facilitator of change across study groups, as was regaining a sense of belonging with Aboriginal heritage for HF participants from Winnipeg. Factors that hindered positive changes included social isolation in new environments, continued involvement in substance using social networks, and difficulty developing and achieving recovery goals related to going back to school, finding work, and reconnecting with social support.

Proportionally more HF participants had positive change trajectories after being housed compared with TAU participants. Across study groups, many of those participants who expressed mixed or neutral trajectories were still in a learning mode or "holding pattern." Some had made significant gains in housing stability but were still struggling with addictions, mental health challenges or illnesses, and isolation from supportive social networks. For others, relationships, mental health, and addictions had improved, but housing stability was still an area of concern, particularly for participants in the TAU group.

Participants in both the HF and TAU study groups reflected deeply on the changes that occurred in their lives in the 18 months since the baseline interviews. Their experiences and insights point to a number of lessons for planning and delivering services, and for developing policies to assist individuals who are homeless or newly housed and experiencing mental health challenges and illnesses.

In general, the findings affirmed the critical importance of integrating housing with mulifaceted support services. While housing enabled people to move from a mode of survival to a place of peace, security, and future orientation, the supportive role of mental health staff was essential to participants gaining greater control over their social relationships, mental health service utilization, and ability to remain successfully housed. Relationships with At Home/Chez Soi service providers and access to services such as personal and vocational counseling helped participants cultivate a sense of self-efficacy in securing volunteer opportunities, engaging in meaningful activities in the community, and finding paid employment.

A second learning related to the role of housing choice and location in facilitating social support and community integration. Limited housing choice in difficult social environments was noted as contributing to depression, isolation, and continued contact with negative acquaintances who reinforce addictions and impair recovery, particularly for participants in the TAU group. Living in neighbourhoods that fit their interests and experiences, developing more positive social contacts, and pursuing new social roles in their communities tended to facilitate a sense of community belonging in both study groups. Finally, providing opportunities to gain a sense of cultural belonging was an important facilitator to the healing process among Aboriginal participants in Winnipeg.

A third theme was the role of housing as a starting point in the recovery process. Recovery was discussed broadly, entailing not only progress in psychological insight and symptom management, but also the ability to develop independence and attain life goals related to volunteering, employment, education, and social relationships. Attaining housing catalyzed readiness for change in these life areas. However, services need to help people move beyond clinical and housing stability, towards helping people move on with their lives via employment and educational supports.

A final cross-cutting theme relates to pervasive structural and societal barriers that pose obstacles to housing, community integration, and recovery. Participants discussed financial struggles related to income supplements, stigma from traditional mental health service providers, and discrimination that resulted in participants having to live in inadequate housing in unsafe neighbourhoods (particularly in the TAU group). Moving forward, there is a need to utilize findings from the At Home/Chez Soi project to inform relevant advocacy efforts, policy initiatives, and population-based interventions.

// ACKNOWLEDGEMENTS

This cross-site report is based in part on the reports from qualitative researchers from the five sites. We want to acknowledge and thank these members of our Qualitative Research Team for their thorough work in putting together the individual site reports and for their help in planning and conceptualizing this research.

The five site reports are:

Personal Narratives from the Vancouver At Home Study: 18 Months Follow Up (April, 2013) by Michelle Patterson, Faculty of Health Sciences, Simon Fraser University.

Rapport sur les récits de vie - 18ième mois (juin, 2013) par Danielle Nolin, Université de Moncton.

At Home/Chez Soi 18 Month Consumer Narrative Report (June, 2013) by Eleanor Edgar, Erin Plenert, Maritt Kirst, Jeyagobi Jeyaratnam, Bonnie Kirsh, Patricia O'Campo, Vicky Stergiopoulos, and Stephen Hwang, Centre for Research on Inner City Health, St. Michael's Hospital.

At Home/Chez Soi Research Demonstration Project Winnipeg 18-month Follow-up Consumer Narratives Report (August, 2013), by Corinne Isaak and Eric Macnaughton, Institute of Urban Studies, University of Winnipeg and Faculty of Medicine, University of Manitoba.

Montreal Report on 18-month Narrative Interviews (September, 2013), by Chris McAll, Pierre-Luc Lupien, Marcio Guttierez, Aimée Fleury, Amélie Robert, and Antoine Rode, Montréal: CREMIS/CAU-CSSS Jeanne-Mance.

Thanks also to each of the sites for reviewing and providing feedback on an earlier draft of this report.

INTRODUCTION

This report presents findings regarding the outcomes of the At Home/Chez Soi project.[1] This pan-Canadian project was funded by the Mental Health Commission of Canada (MHCC),[2] through a grant provided by Health Canada. It was a four-year research demonstration project exploring ways to help the growing number of people who are homeless and have a mental illness. At Home/Chez Soi built on existing evidence and knowledge and applied it in Canadian settings to learn about what housing, service, and system interventions can best help people across Canada who are living with mental health issues and who have been homeless. The At Home/Chez Soi project was implemented in five cities across Canada: Moncton, Montréal, Toronto, Winnipeg, and Vancouver. A more detailed description of the project's structure and the five sites is provided in Appendix 1.

This report focuses on changes ascertained through consumer narrative interviews at baseline and 18-month follow-up interviews. A previous report focused on consumer narratives at baseline (Piat et al., 2013). The At Home/Chez Soi project was a randomized controlled trial (RCT) of Housing First (HF) vs. Treatment as Usual (TAU) (Goering et al., 2011; Nelson, Goering, &Tsemberis, 2012; Tsemberis, Gulcur, & Nakae, 2004). Nested within each of these two experimental conditions are two study groups of participants: those with high needs, who receive support from Assertive Community Treatment (ACT) teams in the HF group, and those with moderate needs, who receive support from Intensive Case Management (ICM) programs in the HF group. Additionally, sites had the option of developing a "third arm," or an intervention group that was tailor-made to local conditions and needs, and most sites developed a third arm. More information on the principles of HF can be found in Appendix 2, and a visual depiction of the HF theory of change is provided in Appendix 3. Interim findings on one-year outcomes have been described in a previous report (Goering et al., 2012).

The purpose of this part of the research is to understand changes in the *lived experiences of consumers by study condition* through life story interviews. This component of the research is intended to complement the analysis of quantitative outcome measures, as well as provide an understanding of process factors that help or hinder recovery and factors that are related to positive, negative, and mixed outcome trajectories for participants. The specific research questions that are addressed are:

1. **Do consumers in the HF interventions (HF/ACT, HF/ICM, and other site-specific interventions) show more positive changes in their narratives (e.g., life changes, relationships and belonging, recovery, etc.) than those in the TAU control conditions?**
2. **What are the factors (e.g., housing, mental health services) that consumers identify as helping or hindering the changes that they experience?**
3. **What are the important factors or qualities that are related to positive trajectories, mixed trajectories, and negative trajectories of participants over time?**

[1]The origins of the At Home/Chez Soi project and the selection of the five demonstration sites are detailed in the Qualitative Research Team's report, *Conception of the Mental Health Commission of Canada's At Home/Chez Soi Project* (Macnaughton, Nelson, Piat, Eckerle Curwood, & Egalité, 2010). The planning process for the sites is described in the cross-site report, *Planning and proposal development of the Mental Health Commission of Canada's At Home/Chez Soi Project* (Nelson, Macnaughton, Eckerle Curwood, Egalité, Piat, & Goering, 2011). Implementation of At Home/Chez Soi is described in two reports, *Implementation evaluation of the Mental Health Commission of Canada's At Home/Chez Soi project: Cross-site report* (Nelson, Rae, Townley, Goering, Macnaughton, Piat, Égalité, Stefancic & Tsemberis, 2012) and *Follow-up implementation evaluation of the Mental Health Commission of Canada's At Home/Chez Soi project: Cross-site report* (Nelson, Macnaughton, Caplan, Macleod, Townley, Piat, Stefancic, Tsemberis, & Goering, 2013).

[2] The MHCC is a national not-for-profit organization that was established to focus national attention on mental health. While it is funded by the federal government, it operates at arm's length from it. The work of the MHCC is currently focused on a number of key initiatives including housing and homelessness, as well as efforts to end stigma and discrimination faced by Canadians with mental health issues and illnesses, and has developed a Mental Health Strategy for Canada and a Knowledge Exchange Centre.

BRIEF METHODOLOGY[3]

MIXED METHODS

The inclusion of qualitative consumer narrative interviews complements the analysis of quantitative outcome measures. Mixed methods approaches are increasingly used to provide breadth, depth, and triangulation in the understanding of social and health programs (Macnaughton, Goering, & Nelson, 2012; Padgett, 2012). While the present report focuses on qualitive findings, these will be be integrated into the final mixed methods study report.

SAMPLING AND SAMPLE

Sub-sample. The sampling method for the larger clinical sample is described in a previous article (Goering et al., 2011). A total of 2,255 participants were recruited into the clinical trial and randomly assigned to study conditions in each of the five sites. We decided to use a sub-sample of 10 per cent of the participants from the larger clinical trial. Sub-sample selection was conducted as follows. For the first few interviews, site researchers selected one out of every 10 participants per study condition from each site to be interviewed. The sites began with whatever number they wished (e.g., participant number 6, 16, etc.). However, as sub-sample selection progressed, sites shifted to more purposeful selection to ensure that they were obtaining a diverse sub-sample for the narrative interviews that was representative of the larger sample of participants at each site.
For example, each site selected at least two women to be interviewed per condition. Other criteria were used (e.g., age, ethnoracial background) to ensure representativeness of the sample unique to each site. Each site strived to conduct the narrative interviews within two weeks of the baseline quantitative interviews. At baseline, we obtained 219 interviews in total (9.7 per cent of the total sample).

Comparisons with the larger sample. We compared the narrative sub-sample (n=219) with those participants who were not selected to participate in a narrative interview (n=2036) at baseline on more than 50 demographic, clinical diagnostic, and outcome measures. The groups differed significantly on only three of these variables. There was a significantly higher proportion of persons who identified themselves as female or other (e.g., transgender) in the consumer narrative sub-sample (32.0 per cent, n=219) compared with the larger sample (28.4 per cent, n=2,036), $\chi^2(2)=7.47$, $p < .05$. Also, significantly fewer participants in the consumer narrative sub-sample (31.6 per cent, n=214) had three or symptoms on a measure of substance use than those in the larger sample (35.8 per cent, n=1940), $\chi^2(2)=9.80$, $p < .002$. Finally, those in the consumer narrative sub-sample had a significantly higher level of income in the last month (mean = $781.00, SD = 839.7) than those in the larger sample (mean = $681.20, SD = 660.30), $t(2253)=2.07$, $p < .05$. There were no significant differences between Treatment as Usual (TAU) and Housing First (HF) group participants on all variables investigated.

Attrition rates. Overall, the attrition rates were quite low, with from 80 per cent to 100 per cent of the sample at the sites retained for an 18-month follow-up interview (see Appendix 4). Only 11 per cent of the sample was lost to attrition. Reasons for attrition included not being able to locate the participant, incarceration (since recording devices were not allowed), refusal, and death.

[3] A more detailed description of the methodology can be found in Appendix 4.

Sample characteristics. A total of 195 participants completed both the baseline and 18-month follow-up consumer narrative interviews, with 119 HF participants and 76 TAU participants. The HF and TAU groups were compared on a number of demographic and diagnostic variables and, with randomization, there were no significant differences between the groups on any of these variables. Characteristics of this sample include the following: per centage of men (62.6 per cent), per centage of Aboriginal people (22.9 per cent), per centage of ethnoracial minorities (22.9 per cent), per centage unemployed (93.8 per cent), per centage not obtaining a high school diploma (56.4 per cent), per centage married or cohabiting (1.4 per cent), per centage major depressive disorder (52.6 per cent), per centage psychotic disorder (31.8 per cent), per centage alcohol dependence (34.1 per cent), per centage substance dependence (50.2 per cent), average age (41.3), last month's income ($781), and lifetime months of homelessness (68) (see Appendix 4).

DATA COLLECTION

Baseline consumer narrative interviews focused on life before enrolment in the programs. Follow-up interviews focused on changes in a number of life domains since enrolment. See Appendix 5 for a model information letter/consent form, Appendix 6 for the baseline consumer narrative interview guide, Appendix 7 for the 18-month follow-up interview guide, and Appendix 8 for the post-interview observations by the interviewer. All interviews were digitally recorded and transcribed (see Appendix 9 for the transcription protocol for the consumer narrative interviews). All the audio files and transcripts for the interviews are stored on a Virtual Machine at St. Michael's Hospital in Toronto.

DATA ANALYSIS

At each site, researchers completed a template similar to that developed by Deborah Padgett and her colleagues in their qualitative research on the Pathways to Housing program in New York (e.g., Padgett, Stanhope, Henwood, & Stefancic, 2011) for each participant. The template included more than 20 domains of change (e.g., life changes, typical day) for the baseline interview, follow-up interview, changes, and causes for changes. Additionally, a short summary for each participant was completed. Next, a matrix display was used to compare the HF and TAU participants on the domains (Miles & Huberman, 1994). The site researchers then developed themes from the interviews about factors that facilitated and hindered change. Finally, matrix displays were developed that compared positive, mixed, and negative trajectories by HF and TAU, and factors related to each of these types of trajectories were examined. Positive trajectories were coded as 1, mixed or neutral trajectories as 2, and negative trajectories as 3. Regarding the trajectory coding, one rater who was blind to the participants' study conditions independently coded the trajectories of a sample of 20 participants (four per site), using both the baseline and follow-up interview transcripts. Inter-rater reliability was determined using the Pearson correlation between the site ratings and the independent reliability rater and was found to be .77, which is considered to be reasonably strong.

Qualitative researchers at each of the sites produced site reports (Edgar, Plenert, Kirst, Jeyaratnam, Kirsh, O'Campo, Stergiopoulos, & Hwang, 2013; Isaak & Macnaughton, 2013; McAll, Lupien, Guttierez, Fleury, Robert, & Rode, 2013; Nolin, 2013; Patterson, 2013). More information about the methods of analysis can be found in Appendix 4. For the cross-site analysis, members of the National Qualitative Research Team read the five qualitative consumer narrative site reports. Matrix displays were constructed using the main topics covered in the site reports and were populated with data from each site report for each of the three main research questions (see Appendix 4).

QUALITY CONTROL

Quality control. It is important to verify the quality of qualitative data collected through interviews (Meyrick, 2006). All interviewers at the sites were trained in qualitative interviewing and how to use the baseline and follow-up consumer

narrative interview guides. Members of the site research teams conducted ongoing checks of the initial interviews and provided feedback to the interviewers regarding interview length, listening skills, building report, and respecting the integrity of participants.

Members of the National Qualitative Research Team developed a checklist that was used as a quality control measure (see Appendices 10 and 11). The checklist included both interview domains and interviewer skill. The baseline checklist was composed of 15 questions regarding interview domains and 10 items regarding interviewer skill, while the follow-up checklist was composed of 13 common interview domain items (with an additional three items specifically asked of Assertive Community Treatment (ACT) participants, three specifically for Intensive Case Management (ICM) participants, and one for TAU participants) and 10 interviewer skill items. One site researcher and one member of the National Qualitative Research Team independently reviewed two to five interviews per site, listened to the audio recording of the interviews, reviewed the transcripts, and completed the checklist for each interview. For the quality control review, each site randomly selected roughly one consumer narrative interview from each experimental condition: 1 - HF High Needs; 2 - HF Moderate Needs; 3 - Treatment as Usual High Needs; 4 - Treatment as Usual Moderate Needs; 5 - Site-Specific Third Arm. The total sample at baseline included 23 interviews. There were only two reviews for Moncton since it had only one treatment and one control condition. The total sample size was 18 for baseline and 22 for the follow-up. Each item was either checked or not checked, depending on whether the interviewer asked questions about the domain and did so with skill.

As can be seen in tables in Appendix 4, both site raters and National Team raters gave high levels of endorsement that the domains were covered at baseline (95 per cent and 88 per cent averages across all items) and follow-up (97 per cent and 93 per cent averages across all items). Simlarly, both raters endorsed a high level of interviewer skill at baseline (87 per cent and 86 per cent averages across all items) and follow-up (97 per cent and 94 per cent averages across all items). As well, there was improvement from baseline to follow-up with higher ratings of endorsement from both raters on both domain and skill items.

FINDINGS

This section on findings is organized by the three research questions.

Changes by study condition and outcome domains

1. **Typical day/quality of life**. At baseline, participants described their typical days as being dominated by survival concerns, and talked about how their activities were very much focused on immediate preoccupations, such as weather, food, physical safety, and navigating an environment of social chaos. As one person said, *"I was just in survival now mode."* When interviewed later, participants in both Housing First (HF) and Treatment as Usual (TAU) who had become housed typically talked about coming out of survival mode, and gaining a sense of *"peace"* and *"safety"* in their daily lives, and also a sense of freedom that one person described as the *"lifting (of) a giant weight from my shoulders."* This was particularly true of participants in the intervention group, whose housing tended to be in neighbourhoods that were experienced as safe and secure. For example, a Moncton HF participant shared, *"What do I like the most about my place? Just the fact that I'm (not) downtown where freaks can't come and visit me, idiots that got out of jail."*

   Another feature of daily life at baseline, especially in some sites, was for participants to describe their routines as dictated by rules of shelters or other services, and talk about their days outside of the shelter as *"making the rounds."* As one person put it, *"I've got to get up and out of there and wander around until the evening."* In the 18-month interviews, however, people typically talked about *"establishing their own rhythm,"* or *"finding a nice routine"* of regular activities they could *"look forward to."* For instance, one Winnipeg participant talked about how he'd get up, have a coffee, and then go downtown to a restaurant where he was *"becoming a regular."* Another change was that participants' daily lives and quality of life in general, rather than being in the here and now, also tended to become more purposeful and future-oriented. One Toronto HF participant referred to this as *"doing stuff that matter(s)."* In addition to looking forward to daily routines, participants also began talking about their future hopes, for things such as reconnecting with significant others, and going back to school or past vocations. As one person said *"I used to be an ice maker (with the parks and recreation department) ...maybe I could go back to doing that."*

   A final change was that housed participants' daily lives tended to become less dominated by illness and addictions, and the activities necessary for sustaining their habits. For instance, at baseline, one participant described his daily routine as *"getting up, meeting up with friends, going on a robbing spree, getting high, and going to sleep, and then next day, waking up in the afternoon and repeating the whole thing."* In illustration of the change, a housed Winnipeg participant talked about living a similar life when he came into the project. At 18 months, he said *"my days are different now; instead of just going out for the beer, I like drinking coffee too."*

   In summary, housed participants' daily lives were more peaceful, secure, and more likely to feature a routine of participants' own choosing, and which was less likely to be dominated by illness or addictions. Also, their daily activities and lives tended to have become more purposeful and future-oriented. In general, housed participants from both HF and TAU groups conveyed a sense that they had moved away from a previous life where they had felt *"trapped"* or *"stuck"* and towards a life that was more secure and purposeful. This change was more pronounced in participants from the HF group, where it was more likely that housing choices allowed participants to live in more positive, hopeful, and safe social environments.

2. **Relationships/connections/belonging**. At baseline, participants described a kind of social chaos that they had to navigate and were sometimes caught up with. They also talked about not having *"true friends."* As a Moncton HF participant put it: *"I don't have any friends ... just people I know."* At follow up, housed participants had more control over how they related to others, a phenomenon that was particularly notable in the HF group. For instance, one person who had previously lived in Single Room Occupancy (SRO) housing talked about how he *"didn't have to worry about other people coming over with a bottle in their hand,"* since he now had the sanctuary of his own place, to which he could safely retreat. As another person put it, with housing, he now lived in a more *"normal"* social environment. Other participants talked about being more able to *"set boundaries"* and distinguish between *"true friends"* and those who were merely *"acquaintances"* who didn't have have their best interests at heart.

   Along with this sense of control over their social environment, participants began strengthening relationships with individuals of their choice. First of all, HF participants often developed relationships with staff and peers from the At Home/Chez Soi program. As one person from the Winnipeg site said *"the girls (i.e., staff) are always there for me."* Another person talked about wanting to *"give back"* and help others in the program who were also *"from the wrong side of the tracks."* Forming reciprocal relationships with peers and then wanting to develop helping relationships in a peer support role was a common sentiment expressed by HF participants. It should be noted, however, that not all participants who talked about such relationships were in the HF group. Some TAU participants also talked about forming supportive relationships with others who lived in the same shelter.

   Across the sites, there were numerous examples of housed people reconnecting with significant others outside the program, such as friends, offspring, siblings, and parents. While homeless, people often lost all sense of dignity. As one person said about his life before the project, *"I thought I was nothing."* Once they were housed, however, people often felt better about themselves, more worthy of others, and thus more motivated to reconnect with family members, or to pursue other meaningful relationships. One man from Vancouver described the difficulty of having to tell his son prior to the project that *"I was homeless and an addict"* and how one of the high points of the project was his pride at being able to email his son to tell him he *"ha(d) a place in Kitsilano."* Participants also talked about this increase in motivation to reconnect as having to do with the stability of having a place. One person, for instance, talked about how housing enabled her to be a more *"consistent"* parent, because she had a place to have her daughter visit. Many others talked about how having a place enabled them to *"invite people over"* to their homes and be more part of their lives.

   Participants also reported an increased sense of community belonging, both in terms of concrete examples of participation and in terms of their feeling of belonging. For instance, one person in the HF group in Vancouver talked about participating in an environmental rally in his neighbourhood and noted the significance of how *"the guy who hated binners is now standing beside me, to help save a tree."* Another person at the same site talked about how he now walks freely in his new neighbourhood, whereas he used to *"stick to a three-block radius, like a turtle in his shell."*

   A final change, particularly in Winnipeg, was the significant number of people in HF who had gained a sense of connection with their Aboriginal culture. At this site, all three HF teams provided opportunities for learning about and participating in cultural activities. As the Winnipeg site report states:*"Through these experiences, many participants established a connection with their Aboriginal culture and teachings, some for the first time in their lives. This learning and involvement played a critical role in the healing journey for a number of participants.*"

   While the HF participants were typically more likely than the TAU group to report these relationship changes, there were some exceptions. In a minority of instances, some people expressed concern about being more isolated after coming inside, especially those who were *"not good with relationships,"* as one participant put it. Others remained caught up with people and relationships they acknowledged as unhealthy, and often talked about "*bringing the*

wrong people" into their places. Some who had made attempts to reconnect with family members learned that their initial hopes may have been misplaced, such as the man who had a reunion with his aunts, had tried to follow up later, but was disappointed that they *"hadn't returned his call."* With respect to community integration, some participants talked about not feeling they belonged in their new neighbourhood, or that this feeling of belonging can take some time. For instance, one person talked about how it was only after several months he finally felt worthy of *"walking on the sidewalks, instead of in the back alleys,"* as he used to do. Finally, there were some participants who continued to distance themselves from peers in the program, and thus may have missed out on an opportunity for connection.

3. **Finances/material situation.** For the most part, HF participants experienced an improvement in their financial situation compared with TAU participants. This was either from their increased access to the vocational sphere (as discussed above), or from being connected to income assistance or disability benefits to which they were entitled but had previously not received. This increase in income had subsidiary benefits. For instance, one participant, expressing the sentiment of others, talked about how having more money meant that she could *"shop for good food and make a nice meal."* Some also talked about a general increase in food security; for instance, being more able to make healthy choices about what they ate, rather than eating food of low quality, or not eating much at all. Others talked about how they could now *"enjoy some nice things"* and thus about the link between income and overall quality of life. Some Moncton HF participants mentioned the importance of becoming self-sufficient by learning how to save money and how to manage a budget. For example, one participant said, *"You're able to manage your budget with my social worker you know ... I hold on to this so I don't spend it all you know."* Another Monction HF participant shared: *"... I paid my dentist everything ... I had my teeth fixed there ... I was approved. But it took me a long time to save the money."*

   While HF participants more typically improved on finances and their material situation, others in the TAU group talked about being connected to benefits or to programs that helped them move towards vocational goals (and thus income). Some site reports in particular (i.e., Toronto's) noted that participants continued to experience systemic barriers that hindered their financial and material situation, such as discrimination in the job market, and problematic income assistance policies (i.e., having earned income clawed back).

4. **Education/work/meaningful activity**. Changes in the domain of education/work/meaningful activity could be looked at as a continuum. At the very least, housed participants often talked about *"establishing their own routine"* of activities which they could *"look forward to."* These routines consisted not only of pleasant activities like having one's morning coffee or listening to music, but also included things that in the words of one person entailed *"being productive,"* like making repairs, or engaging in creative activities like music or painting.

   Upon becoming housed, out of *"crisis mode"* and into a "*normal routine,"* people also talked about being free to make future plans for significant activities like going back to school, finding jobs, or more generally for *"getting back on track"* in their vocational lives. By the 18-month mark of the project, some participants had actually resumed school or found jobs, either on a part-time or a volunteer basis. For example, in Moncton, a HF participant said: "*I work in my spare time at the bottle exchange on Steadman Street ... Yesterday I collected bottles for five hours."*

   While the participants who talked about engaging in this type of meaningful activity were typically in the HF group, there were some TAU participants who had also moved in this direction. For instance, it appeared that in Toronto, some participants living in shelters had gained access to educational or vocational supports. In Winnipeg, a man talked about gaining access to this sort of programming through a social worker.

   A minority of HF participants expressed a *"what now?"* sentiment, identifying a lack of purpose and a need to *"move forward"* in their lives now that they were housed. For instance, the Vancouver report talks about how some

housed participants struggled with *"killing time"* because their daily routines still lacked meaning. There were also some participants who, after initial hope, had experienced a significant setback to their vocational plans. One man in Toronto, for instance, had completed pre-educational planning for a childcare program only to find that the community college had disqualified him from consideration because of a past criminal record. Another HF participant in Moncton shared that she also experienced setbacks in finding employment due to the state of her health: *"I would like to do things but it depends on my health ... I would like to find a job, but I'm not ready ... I know I'm not ready."*

5. **Housing.** Across sites, participants in HF were more likely to talk about being housed, and thus appeared to experience considerably more access to housing than did the TAU group. These participants also talked about the stability of their housing tenure, as many of them spoke about living in their units since the beginning of the project. The TAU group, particularly in Toronto, also talked about gaining access to housing, but as this site report notes, many of the housed TAU participants expressed discontent with their housing situation, associated with feelings of *"wanting to move"* and with safety concerns.

   Regarding housing choice, while there were some problems in the HF group (e.g., participants feeling that they *"had to take the first choice"* offered to them, people feeling that choices offered to them were not adequate), these challenges were nonetheless more prevalent in the housed TAU group than in the HF group. For instance, one person talked about being *"trapped"* in his housing situation in an unsafe neighbourhood, an experience that, while not specific to the TAU group, appeared to happen more in this group. In Moncton, some participants in the TAU group stated that their privacy was non-existent because of the constant coming and going of the other residents. *"You don't know how many people have been moping and coming and going. Every time I walk past there's another moving truck and I just, you know. Everybody is gossiping about who is doing what."*

   Thus, because of better choice, housed participants from the HF group were more likely to live in an environment that not only provided safety, but also privacy and a sense of distance from their previous social world. As a participant from Winnipeg who lived outside the downtown core explained: *"my inebriated friends ... don't wanna take the time to come over and rather stay in town and drink."* Finally, housed participants in the HF group often expressed a feeling of stability and permanence about their housing, often describing in positive terms how much they appreciated *"having (their) own place,"* which they sometimes described as a "base" that could help them address their problems and then move forward.

   While participants in the HF group were more likely to be stably housed, there were some exceptions. First, some participants identified the issue of project sustainability (especially whether the money for housing subsidies would continue) as something that negatively impacted the sense that their housing was stable and permanent. There also appeared to be minority of housed participants in the HF group who were having trouble maintaining housing stability. This challenge to maintain housing impacted some sites more than others, appeared to be related to housing quality, and was associated with certain types of participant challenges (e.g., visitors, substance use). All of these issues will be discussed later in the report, when we examine the contributors and barriers to stable housing. Finally, many TAU participants who hadn't been housed maintained the hope that they would in fact access housing in the future, and remained hopeful that this housing would help them get their lives back on track.

6. **Health.** Across sites, there were two common themes regarding changes in participant health, which differed between HF and TAU groups: *feelings of peace and stability, and engagement in health-related activities.*

   Feelings of peace and stability were essential aspects of the changes reported in participant health for HF participants across sites. In Winnipeg, several participants in the HF study condition reported feeling safer, more relaxed, and better about their overall life situation. In Montréal, HF participants were much more likely to report

a “new sense of peace” and feeling less stressed than those in the TAU study group. In contrast, those in the TAU group in Montréal were much more likely to report living in continual fear of violence and feeling more stressed than those in the HF condition. As the Montréal report states:

> *“Whatever the condition, the mere fact of having access to stable housing (with the rent supplement provided by the project) tends to be seen as having an impact in terms of security, tranquility (“peace”), and having a space of one’s own in which one can do whatever one feels like doing, including behaving in strange ways – without being constantly in the public eye.”*

Changes were also reported with regards to *engagement in health-related activities* for many participants in the HF study group. Multiple participants from Winnipeg reported that they engaged in more health-related activities and appointments to improve their wellbeing. They found that having a steady income was paramount to improving their eating and personal hygiene patterns, since they could finally purchase food and supplies for themselves. In Vancouver, several HF participants reported that they felt healthier and more energized since being stably housed, and housed participants in Toronto from both the HF and TAU groups reported many positive (and some negative) changes in their physical health with respect to nutrition, diet, and exercise. Participants attributed these positive changes to their increased ability to make better choices and decisions with regard to their physical activity and nutrition, as opposed to just eating what was available in shelters and drop-ins when living on the streets. While many participants in Toronto reported positive changes in their nutritional status, some reported negative changes. This subgroup found that living alone resulted in poorer nutrition, because of their lack of ability to cook for themselves, and the high cost of nutritional foods. One participant with diabetes stated: *“I said well, I had told him I can’t afford to go on a diet, I am a poor woman I cannot afford to buy different food for me and different food for my son.”* This brings to light a more systemic barrier for even those who have acquired stable housing, but cannot afford the very high cost of nutritional food.

7. **Mental health.** Generally across sites, participants in the HF group were more likely to report improvements in their mental health over the last 18 months than those in the TAU condition. Across sites, there were three common themes regarding changes in participant mental health in the HF groups: *reduced prescription medication misuse and increased medication management; increased insight; and increased sense of autonomy, voice, and purpose*. Additionally, symptoms such as *feelings of depression, sadness, and anger,* as well as *suicidality* did not appear to differentiate between TAU and HF groups.

   Numerous participants in the HF groups described *reductions in prescription medication misuse and increased medication management* across sites. Participants in Montréal’s HF condition were much more likely to report reduced prescription medication (mis)consumption than those in Montréal’s TAU group. In Moncton, one of the factors associated with influencing positive changes in mental health outcomes for HF participants was more stable medication management than at the beginning of the project. For example, one HF participant at that site stated : *“When I wasn’t on my meds I thought I was secretly married to a (girl) from Australia ... and she would meet me on Vancouver Island, so I hitchhiked from here to Vancouver Island with a backpack for her and backpack for me ... so after I got back on my medication I realized that her boat wasn’t there so ... whatever, I figured out that I was maybe ok but a little bit off in my head.”* Additionally, numerous Winnipeg participants in the HF group who were under the care of a psychiatrist or psychologist at 18 months reported improved illness and medication management, as well as decreased mental health-related symptoms.

   Across the sites, many HF participants reported significant gains in psychological insight and curiosity into their mental health. HF participants from Moncton stated that through insight into themselves, they learned to develop more constructive behaviors to deal and cope with their mental health issues. For example, a Moncton HF participant shared that: *“Their advice helped me enormously ... First step was to assume, second step was to*

accept it." Insight in another sense was especially evident in a group of Aboriginal participants in the HF condition of the Winnipeg site. Participants spoke about the positive relationships they developed with the At Home/Chez Soi service providers, which facilitated their learning and insight into how to constructively cope with anger, frustration, and past trauma. One participant stated:

> *"But then coming into the program is when I realized that I was living with depression and anxiety and traumatic stress syndrome. And once I was able to realize that was part of what was going on with me because I seem to have like a, cycle, I believe, I mean I'm great, if you push me down, I'm great. I can get myself back up wonderfully, but it's maintaining once I get back up there."*

A greater sense of *autonomy, voice, and purpose* was developed in numerous participants in the HF group across sites, as well as in many of the housed TAU participants in Toronto. In Montréal, many HF participants reported a newfound feeling of autonomy, liberty, and ability to make decisions. This was partly attributed to the degree of responsibility that was required of participants in the project in order to maintain their housing and live independently. However, TAU participants reported opposite sentiments, feeling that they were often subject to arbitrary rules and other controlling mechanisms that regulated their lives. In Moncton, numerous HF participants reported feeling a sense of autonomy and pride in being able to hold a job, manage their finances, and rely on themselves, rather than on others. In Winnipeg, Toronto, and Montréal, HF participants (and TAU participants in Toronto) reported improved self-confidence, self-worth, positivity, hopefulness, and purpose, as well as feeling as though they have a voice that is recognized as valuable. One HF participant from Toronto said: *"I am really proud of myself. With a lot of help I was ... able to ... not really get back to where I used to be, but in a better place."*

Feelings of depression, sadness, anger, as well as *suicidality* were a common preoccupation at baseline and tended to remain so at the 18-month follow-up for both study groups. One exception was in the Montréal site, where participants in the TAU qualitative sample were more likely to report suicidal contemplation over the last 18 months than those in the HF condition. While a number of participants reported feeling less depressed and suicidal in the HF condition in Vancouver, the majority of participants acknowledged continued mental health issues related to feelings of intense sadness, loss, loneliness, and anger. These were mainly attributed to past trauma, such as early emotional deprivation, neglect, and abuse, which participants felt needed to be dealt with through more creative means than just taking medication. Furthermore, living alone allows for more time and space to think about and feel psychological pain and suffering. One participant in Vancouver said: *"Deep down, I'm still hurting like hell. I'm still screwed up and I need a lot of help. I need one-on-one counseling, but it's hard to find."*

In Toronto, a few of the housed participants in the HF and TAU conditions experienced deterioration of their mental health and increased feelings of hopelessness, anger, and depression, which were sometimes accompanied by suicidal thoughts or attempts. These feelings and behaviors were usually linked to emotional challenges, feelings of uncertainty about living independently, death of a loved one, or challenges around romantic relationships. This was reaffirmed by a Moncton TAU group participant, who shared: *"It's hard to do anything like your daily things [...] and it's hard to have relationships with people. Depression. That's really really the problem, makes me want to just lay in bed all day."*

8. **Substance use/addiction.** In some sites, there was a tendency for participants in the HF condition to reduce their dependence and consumption of drugs/alcohol over the last 18 months. In Montréal, HF participants were more likely to report reduced consumption of drugs/alcohol, while participants in the TAU group were more likely to report dependency on drugs or alcohol. In Vancouver, many participants in the HF group had reduced frequency and amount of substance use, while many participants in the TAU group spoke of their daily routine consisting of using drugs. In Winnipeg, HF participants made significant progress with recovery, mental health, and addictions issues, and many participants reported reduced drug and alcohol use 18 months after their baseline interviews.

Finally, many of Toronto's HF participants described significantly positive changes in substance use, which ranged from adoption of harm reduction strategies, to decreasing substance use, to complete sobriety. In Moncton, however, substance use and addiction were still very present among some participants, whether in the HF group or the TAU group. However, participants in both groups recognized ways to manage their substance use and their addiction. Examples of these include distancing oneself from friends who consume and acknowledging the negative consequences of addiction (i.e., losing custody of children and jail time). One Moncton TAU group participant said: *"... it's just all the drugs and stuff so I've been staying away from everybody cause everybody is into the drugs; it doesn't matter who it is it, could be family, friends, they're all into dope."*

Across sites, there were two common themes regarding substance use and addiction. The first was addiction as coping, and the second related to *attempts at exiting the cycle of addiction* or *"revolving door."* Across all five sites and study conditions, and regardless of substance use reduction or increase over time, participants described similar motivations for using drugs or alcohol. It is clear that for many people, the use of drugs and alcohol is a means of coping with life. For example, the Montréal report talks about a participant in the TAU group who *"has to consume a given amount of marijuana every day (carefully budgeted) just in order to cope with the stress of being homeless."* This is in contrast to a HF participant who explains that he no longer has to consume as much alcohol as he had in order to get through the night, because he is no longer sleeping on the streets. Furthermore, for the majority of participants in Vancouver (regardless of study condition), reducing or controlling substance use was a significant challenge, hence they struggled to exit the revolving door of addiction. While many were aware of the negative effects drug use had on them, they found drugs to be a helpful coping mechanism in dealing with issues related to their mental health (e.g. feelings of low self-worth) and psychological pain; for some, being alone in one's home could cause painful emotions to resurface. Participants in Moncton's TAU group and Toronto's HF and TAU groups all showed similar findings with respect to drug and alcohol use being means of coping with life. One Toronto participant stated: *"I use it (drugs) to not think, not to feel."*

Some participants in the Moncton and Toronto TAU groups commonly described sex work as a means by which they acquired drugs/alcohol to help them cope with life. Drug/alcohol use and sex work often led to trouble with the law, which then led to worse psychological health, poor mental illness management, and a further dependency on drugs/alcohol. In Vancouver, many participants described increased self-esteem and confidence as helping them to improve their social interactions and reduce their substance use over the 18 months since baseline. The Vancouver report also emphasizes the need for an increased focus on trauma-informed care as a way of helping participants deal with the issues that may be underlying their addictions.

9. **Use of services.** Rather than including information about frequency of service use (as reported in the quantitative findings), experiences in using services were described within site reports. Across sites, two common themes emerged from the data regarding participant use of services: *supportive, non-judgemental support available through At Home/Chez Soi and stigma/discrimination experienced through traditional services and society.*

   Participants in all HF groups reported extremely positive experiences and constancy in working with the supportive service teams available through the At Home/Chez Soi project over the 18 months since baseline. In Moncton, participants reported increased involvement in external activities over the 18 months since baseline, partially attributed to the inspirational and non-judgmental support they received through their Assertive Community Treatment (ACT) and Intensive Case Management (ICM) teams. A Moncton HF participant felt supported by his ACT team, to the point of referring to his support workers as *"family:" "They've been a good source of support for you. My new family now ... I'm gonna miss it once it's finished you know."* Similarly, in Vancouver, many HF participants said that the help and support of the At Home/Chez Soi service teams was instrumental in their increased stability, and in Winnipeg, having a supportive relationship with an At Home/Chez Soi service team member was linked to

significant improvements in health and wellness, housing stability, and reduced drug and alcohol use. One participant in Winnipeg's ICM group said:

> *"Well I think it was partly 'cause I really wanted to change my life and I think it was also because of this program, and the people that I've met, had some great counselors and I don't know I think it's done a lot of good for my life right, at the time."*

In Montréal, support and recognition from the ACT and ICM teams was a consistent theme for HF participants. Some participants even expressed surprise that service providers did not judge them. These sentiment are reflected by HF and TAU participants in Toronto, many of whom demonstrated that feeling supported and not judged by their healthcare providers led to significant improvements in their perception of services. Authors of the Moncton report attributed four main reasons for the positive reputation of their ACT team amongst participants. These include: *centralization of services* (participants can access different service providers in the same place); *diversification* (participants can learn a variety of skills from the team members); *regularity* (standard meetings create a consistent schedule for life management); and *anchor for stability* (constant, stable support for participants). One Moncton HF participant stated that the services offered in the project were so good that he hadn't been to the hospital or detoxification even once since his baseline interview.

Stigma and discrimination experienced through traditional services and society was consistently reported across sites and study conditions. Many participants in Vancouver reported continued stigma and discrimination related to their mental health issues and substance use, particularly within the traditional healthcare system. Even over time, distrust for those involved in "the system" was commonly reported, especially in relation to psychiatric treatment. This may be why participants in Vancouver continued to struggle with symptoms of mental illness and preferred to self-medicate with drugs than trust the traditional healthcare system. As one participant stated:

> *"The only reason they treat me like shit [in the hospital] is because, in my twenties... I was in withdrawal and had a psychotic break ... and now I have this schizo-affective diagnosis on my file. It carries with you. I get depressed but I'm not crazy. All they [doctors] want to give me are anti-psychotics."*

A few participants from Toronto's TAU group explained that some of the mainstream services they had accessed caused more harm than help, and one participant described his experience with a psychiatrist who refused to alter his medication, despite his requests. Similar comments were expressed by participants in the TAU group in Vancouver, who described their loss of faith in the medical system for a variety of reasons, including a lack of service availability and being consistently put on a waitlist, even with a court order for services, and negative experiences of psychiatry.

Housed participants in Toronto also reported continued stigma and discrimination with respect to sexual orientation, race, ethnicity, and mental illness over the 18-month study period. This brings to light another deeply embedded systemic barrier for those without (and even with) stable housing, because they were still discriminated against due to personal characteristics and socially constructed expectations. These barriers were clearly recognized by numerous participants, whether they were in the HF or TAU condition. A TAU participant in Vancouver said: *"I want to get up and move on. But, you know what? The forces in this world seem to keep you where you are, for whatever reason."*

One HF participant in Vancouver powerfully stated that he didn't want to kill himself because he was sad or hopeless, but because he didn't want to be in a world with the rules and cultural norms that dominate our society.

10. **Hopes for the future/recovery.** It is clear that HF participants showed consistent improvements in terms of hopes for the future and recovery since the beginning of the project. Across sites, three common themes emerged from

the data regarding participant recovery and hopes for the future over the 18 months since baseline for HF (and many housed Toronto TAU) participants, including *definitions of recovery, feelings of hopefulness,* and *goals for the future*.

The similar ways that HF participants spoke about recovery across sites lead to a theme of a *broad definition of recovery*. It was clear that this definition was broad because it encompassed managing illness, managing stress, dealing with trauma and emotions, establishing supportive relationships, and finding meaningful activities. Participants spoke of recovery with respect to their ability to take their medications regularly; avoid hospitalization; manage drug use effectively; manage finances; maintain a healthy lifestyle; recognize, accept, and react better to life issues; establish normal daily routines; engage in meaningful activities (not related to substance use); as well as develop boundaries or separate from detrimental relationships. Importantly, many Aboriginal participants from the HF groups in Winnipeg described the importance of connecting to and learning about their Aboriginal culture (often with elders available through the At Home/Chez Soi service teams), as an integral part of their healing and recovery process. Many HF participants in Winnipeg also expressed that knowing they had someone (often referring to service providers) to rely on for support and positivity was imperative in their recovery journey. A significant barrier that Toronto's HF participants felt stood in their way of recovery and achieving future goals was physical limitations, such as chronic injuries or illnesses.

Feelings of hopefulness was a consistent theme across sites over the 18 months since baseline, which was integrally related to the recovery process. Most of Vancouver and Winnipeg's HF participants reported feeling more hopeful about the future and positive about being themselves, while some of Moncton's TAU participants reported either non-existent or close to non-existent hopes for the future. For example, a Moncton TAU participant shared, *"I'm a waste being here, cause I'm doing nothing with my life—right? All I want to do is sleep, and (do) drugs ... that's a waste, it's not a life."* In Toronto, many HF and some TAU participants seemed to have strengthened their hopes for the future over time and in various ways, including increasing their number of goals, becoming more confident in planning and achieving their goals, and in having maintained their most important goals over the 18-month study period.

Over the last 18-months, the nature of participants' *goals for the future* was consistent across sites and study groups as well. For TAU participants who had not acquired housing, finding a home was usually their primary goal for the future. Many participants in the HF and TAU groups with housing stated that stable housing allowed them to focus more on themselves, and had given them more time to make decisions and formulate future goals. Goals included: reconnecting with family and other relationships, engaging in paid or volunteer work, going back to school, travelling, and forming romantic relationships that are supportive and positive. A number of Aboriginal participants in Winnipeg had established goals of reconnecting with children and family members. Many found that learning to deal with anger, confusion, and emotions associated with historical trauma (i.e., Residential Schools, Sixties Scoop) was an integral part of the healing process that allowed them to be closer to achieving these goals. One Aboriginal participant in the HF/ICM group who had been impacted by Residential Schools said:

> *"Being able to, being able to say 'I love you' and 'I'm sorry' to my kids ... I've never said that to them you know, those types of things come out; that's what I mean, those types of fatherly qualities, manly qualities I should have had were always blocked by this anger in me."*

A participant from Toronto, reflecting the sentiment of participants from other sites, expressed one of her future goals in terms of giving back to her community. She described how her educational goals and decision to go back to school was a means to helping her give back, stating: *"Whatever I can learn from there I can use it to help other women in abuse, who is in an ... abusive relationship or whatever, you know?"* Wanting to become a peer support worker was another common goal reflecting the desire to "give back."

Factors that Helped or Hindered Changes in Outcome Domains

The following section describes the factors that impacted several broad categories of outcomes, including changes in participants' housing situation, changes in the nature and quality of their daily lives, improvements in social integration and belonging, and positive movement in their recovery processes in relation to mental health and addictions issues. We discuss factors that either facilitate or hinder each type of outcome. In some cases, the same factor (e.g., social networks) can act as facilitator or hindrance, depending on the context.

1. **Changes in housing situation.** Above, we mentioned that compared to Treatment as Usual (TAU) participants, more people in the Housing First (HF) group had gained access to housing, and had remained in their places for longer periods of time. As explained below, the main factors influencing housing stability were: motivation to *"get back on track,"* quality of housing, quality of social support (related to living in proximity to substance-using social networks), *"bringing the wrong people in,"* and an ability to learn from mistakes.

   According to many HF participants, a prominent reason for their housing stability was that housing catalyzed hope that they could *"get back on track,"* which provided them with the motivation to *"do what it takes,"* including addressing their mental health and addictions issues. In other words, housing itself was intrinsically motivating to participants, since it represented a chance to get their lives back. In contrast, a minority of HF participants expressed continued demoralization about their life prospects upon entry into the study and appeared unmotivated to keep their housing.

   Another main contributor to housing stability was having good quality housing, in a good neighbourhood, where there was a good *"fit."* According to the Toronto site report, where a relatively high number of TAU participants accessed housing, without a housing subsidy, these participants often found themselves in housing where they felt *"trapped"* and unsafe, a situation that made housing tenure more difficult.

   Participants' comments also pointed to the relationship between housing stability and the quality of social support. What appeared most saliently was when participants talked about how poor social support hindered housing stability (one can also infer that healthy social support would be a positive contributor). In particular, these participants talked about either social isolation, or entanglement in substance-using networks, with participants expressing some variation on the theme that the problem was *"bringing the wrong people into their places."* In other words, because they were isolated in their places, and/or still involved with substance-using street networks, some participants' homes became centres of drug-related social activity, which jeopardized their tenancy. These individuals may have ended up living in worse (even less stable) housing as a result, which could make it even harder to achieve housing stability.

   On the positive side, the ability to *"reflect"* on mistakes such as these and their potential consequences helped some participants become more stably housed as time passed. As one woman from Vancouver acknowledged, *"… I invited the wrong people into my place."* Also, the ability to *"set boundaries"* with others helped participants maintain their places over time, since they started to be able to distinguish *"true friends"* from those who didn't have their interests at heart, and then begin to stay away from these relationships.

   Finally, there was a relationship between the quality of social support, the quality of housing, and housing stability. That is, having good quality housing in a safe environment could make a difference to housing stability for people who identified their social networks as unhealthy, because it could help participants distance themselves from their previous lifestyles. An example of this was mentioned above, which was the Winnipeg participant who described how living away from the downtown core meant that he was left alone by his *"inebriated friends,"* who previously tempted him to drink.

2. **Changes in typical day/quality of life.** As will be explained, becoming housed was instrumental in changing participants' daily lives. By distancing them from their previous milieu, housing catalyzed a series of changes to the nature and quality of participants' daily lives, where participants gradually oriented themselves towards the future. On the other hand, some participants may still have felt trapped in their life situation by limited choice over where they lived. Further, they may still have lacked the motivation, opportunity, and support to change their lives in a more significant way.

   As mentioned, housed participants from both HF and TAU groups, but more often the former, conveyed a sense that they had moved away from a previous life where they had felt *"trapped"* or *"stuck"* and towards a life that was more secure, free, and purposeful. Perhaps not surprisingly, the main contributor to this change was having good quality housing. As participants said, having a roof over their heads freed them from survival concerns, which meant that they could feel more *"safe"* and *"at peace."* It also freed them from a socially chaotic environment, and offered more control over their day-to-day interactions with others.

   This freedom in turn helped participants to live *"life at their own rhythm,"* rather than having their routine dictated by shelter services or by others, and establish their own daily routine that they could *"look forward to."* Being freed from here-and-now survival concerns also enabled them to reflect and *"make better decisions"* about their lives and *"think about the future"* and how they might achieve their future plans.

   Another change in daily life that housing catalyzed was having their routines less dominated by illness or addictions. As mentioned above, this was partly because participants were motivated to *"do what it (took)"* to keep their place, and this often involved working on their mental health and addictions issues. The relationship between housing and recovery from mental health problems and addictions will be discussed in more detail.

   In general, housing allows people to *"become unstuck"* from a life preoccupied with survival, establish a routine of their own choosing, and become more oriented to the future. The freedom from survival concerns thus opens up possibilities for positive freedom to pursue vocational pursuits or meaningful relationships.

   On the other hand, some participants, particularly those in TAU, who experienced limited housing choice, talked about how they still felt *"trapped"* in their life situation. Still others expressed a profound sense of hopelessness about their abilty to change their lives. Finally, there were some participants who still lacked the opportunity or support necessary to change the quality of their lives. Although they acknowledged that their lives had changed and were no longer preoccupied with survival concerns, they spent their days *"killing time"* and wondered *"what now?"*

3. **Changes in relationships/sense of belonging.** As mentioned, HF participants experienced an increased sense of control over day-to-day social relationships, as well as in increase in their degree of social engagement. As discussed below, the contributors to social integration included having a protective "sanctuary," having a "stable base," gaining the self-esteem necessary for seeking out relationships, and forming positive relationships with service providers and peers within the program. The barriers included living at a distance from previous supportive relationships, lack of social ability around making friends or setting boundaries, and lack of trust. Stigma surrounding other people who were previously homeless could also play a hindering role to forming social relationships. Finally, some participants had experienced relationship setbacks during the course of the project, and felt vulnerable to further rejection or failure. Community integration was facilitated by living in a neighbourhood with a good "fit" and by tolerance for diversity. Regardless of fit, participants could take a while before they felt a true sense of belonging in a new neighbourhood. In Winnipeg, in particular, participating in At Home/Chez Soi-related activities facilitated a sense of cultural belonging for people of Aboriginal heritage.

   With respect to the increased sense of control over their interactions, participants suggested that housing in a good neighbourhood provided an environment of normalcy, and a *"sanctuary"* or refuge from social chaos, that

enabled them greater choice about with whom they spent time. With respect to increased social engagement, participants' comments suggested that this could also be attributed to both the material and meaning aspects of good housing. In other words, the material fact of having housing provides people with a stable base for carrying out relationships; with respect to its meaning, participants' comments suggest that becoming housed signifies to them that their lives are important and they are valued as persons. This increased sense of dignity or self-esteem makes them more motivated to pursue relationships that may have fallen by the wayside because they now feel more worthy of these connections.

Participants also suggested that this greater social engagement could be attributed to the supportive environment provided by the At Home/Chez Soi teams. This was because participants formed supportive, trusting relationships with team members, and also because the program provided an opportunity to develop friendship with other people who had been homeless and experienced mental illness. As the Winnipeg report suggests, increased social engagement can be viewed as a *"continuum,"* where people may first of all develop *"encouraging and trusting"* relationships with team members, before reaching out to *"re-establish a web of family relationships,"* and also *"reach out to others,"* such as peers within the program, to whom they could relate"based on their common lived experience."

Participants' comments also suggested some negative relationship themes. For some, moving inside may have alienated them from their previously supportive social networks. Some individuals also made comments indicating they were not *"good at relationships."* There was also a tendency for some participants to distance themselves from others, including mental health professionals for whom they had never developed a sense of trust, and other people who were homeless and living with mental illness, whom they may have seen as people to be avoided. Becoming alienated from previous social contacts, and also reluctant to associate with peers in the program, could leave some participants isolated. The Vancouver report also found that *"keeping to themselves"* was a social strategy that many participants had adopted for many years prior to the project, which they tended to carry into the project. A final negative theme mentioned by participants was *"experiencing setbacks."* This characterizes the experience of the participants who had become motivated to reconnect but had their initial hopes dashed by a negative experience, and who, as a result, had pulled back from any sort of social engagement.

A main contributor to community integration mentioned by participants was having a *"good fit"* between the participant and the new neighbourhood. It could take a while, however, before this fit could be found. A case in point was a Vancouver participant who initially lived in an area of the city he perceived as affluent and *"cold,"* but then moved to the Commercial Drive area of the city, where the neighbours are *"used to all sorts of people"* and the participant felt he belonged. As the Vancouver report mentions, however, some participants remained ambivalent about their old milieu, being both relieved to be away from it, but possibly missing its inclusiveness. Given that finding a sense of belonging in a new neighbourhood can be challenging, some participants thus still expressed some uncertainty about *"where they belong."*

In Winnipeg, in particular, HF participants gained a sense of belonging with their Aboriginal heritage, because of the explicit attention paid to cultural reconnection by all of the At Home/Chez Soi teams at that site. For instance, participants mentioned the value of participating in cultural ceremonies, and how this helped them regain a lost sense of cultural identity. They also mentioned being supported to work through issues of anger, distrust, and trauma that were associated with the residential school experience of the participant or their parents or grandparents. Being able to work through these issues helped with their mental health (as discussed later), but also helped them regain a sense of cultural connection that may have been weakened by the residential school experience.

4. **Changes in recovery (from mental health problems/addictions)**. As mentioned previously, participants from both HF and TAU conditions thought of recovery in broad terms. They saw recovery as entailing not only being able to manage symptoms, or substance use, but as also related to being able to work through stressors and problems, and to being able to live a healthy and meaningful life. They also talked about the process of recovery, which included gaining knowledge and *"insight"* into their problems, confidence in their ability to solve them, and hope for the future. Given the comprehensiveness of the recovery concept, it is unclear whether the HFgroup was actually further along in their recovery trajectories. It is apparent, however, that the experience of participants sheds insight into the recovery process and the factors that either faciliated or hindered it. As discussed later, good housing played a key role in catalyzing readiness for change, in helping participants develop a sense of efficacy in their lives, and in helping participants replace drug-related daily routines with meaningful activity. Housing alone was not sufficient to promote recovery, which also required non-judgmental and positive relationships with members of informal and formal support networks. One significant barrier to recovery in its broad sense was a lack of support for helping participants pursue educational and vocational pursuits.

   With respect to housing, it appears that housing provides contributions to recovery both in terms of material wellbeing and meaning. In terms of material wellbeing, housing provides a *"stable base"* for recovery, (i.e., a sense of stability and security). This in itself offers participants a sense of *"wellbeing,"* but also provides them an opportunity to "work on themselves" and on issues that stand in their way. In terms of meaning-making, housing contributes to recovery because it catalyzes hope that participants can possibly reclaim lost aspects of their identity, motivating them to *"do what it takes"* to keep that housing. This could entail working on the issues standing in the way of their aspirations with respect to vocational pursuits or to one's relationships or connections. For participants, *"doing what it takes"* could entail addressing long-standing illness or addictions issues, adopting the responsibilities required to be a *"good tenant,"* and learning from setbacks. Being a good tenant also entailed learning to take responsibility and control over one's life, and gaining a sense of efficacy that has been associated with the recovery process. Some participants also mentioned that the more meaningful and peaceful daily routines they established once housed helped their addictions in the sense that these offered a replacement to previous routines dominated by addictions.

   With respect to the relationship between recovery and support, the primary contributor mentioned by participants was the value of a *"trusting"* and *"non-judgmental"* relationship. Having such a relationship allowed participants to disclose personal problems, or tell support workers when they might have *"slipped up."* It also enabled them to *"open up"* about issues of trauma, and deal with "anger," loss, or interpersonal trust issues that may have hindered their lives and stood in the way of their recovery. The other main support-related factor was having support proactively delivered by the team. While for many people, this support signified the *"care"* of the team, for others, home visits may have been perceived as being *"checked up on."* Still others may have felt that they didn't have as much support as they needed, so the issue of titrating the amount of support to the needs and perceptions of the individual is an issue that needs consideration in the future.

   As mentioned, participants spoke about barriers to recovery in the broad sense of identifying and achieving personal goals (vocational or relational). While some participants went back to school or work or reconnected (or made plans for doing so), others had still not developed a sense of purpose and wondered *"what now?"* Still others had suffered setbacks, and at least at the time of the 18-month interview were demoralized. A few people appeared demoralized upon entry into the study and were people for whom the prospect of housing did not catalyze hopes for regaining their life.

Factors Related to Positive, Mixed and Negative Trajectories

1. **Trajectories of Housing First (HF) and Treatment as Usual (TAU) participants.** In Table 1, we show the life trajectories of HF and TAU participants. This summarizes whether the participants' lives had improved, stayed the same, or deteriorated over the course of the project, based on a holistic assessment made by the research team. Proportionately more of the HF participants had positive trajectories compared with TAU participants, with the per centage of participants in HF reporting positive trajectories more than double that for TAU participants, $\chi^2(2)=29.1$, $p < .0001$.

Table 1

Number of Participants with Positive, Mixed, and Negative Trajectories by Housing Condition for Each of the Sites

	HF – TYPE OF TRAJECTORY			TAU – TYPE OF TRAJECTORY		
SITE	POSITIVE	MIXED	NEGATIVE	POSITIVE	MIXED	NEGATIVE
Moncton	6	2	0	1	3	4
Montréal	19	2	6	5	1	12
Toronto	20	8	3	7	5	7
Winnipeg	12	12	1	6	9	3
Vancouver	15	13	0	3	10	2
Total	72 (61%)	37 (31%)	10 (8%)	22 (28%)	28 (36%)	28 (36%)

We were interested in understanding the factors related to positive, mixed, and negative trajectories. Across sites, there were clear differences between the factors associated with positive and negative trajectories. The factors associated with mixed trajectories were similar to negative but differed largely in terms of the magnitude of factors, and also with respect to experiencing setbacks in their recovery process. The factors presented in the next sections incorporate participants in both the HF and TAU conditions. The final section looks at the factors that differentiate HF and TAU group participants.

2. **Factors associated with positive trajectories.** *Stable housing*, together with the hopefulness it catalyzed in most participants, was an important factor associated with individuals who had positive trajectories. In other words, the acquisition of stable housing gave most (but not all) participants both hope and confidence, and provided opportunity for them to take on or reclaim valued social roles. A second factor was *positive social contacts*, which was multifaceted and varied across sites. In Toronto, participants who had positive or improving relationships with family tended towards positive trajectories; the same was true in Winnipeg of Aboriginal participants who connected with their cultural traditions and supportive communities. Across sites, it was the support garnered from *positive social contacts* that was key to understanding how this factor contributed to positive trajectories. Supportive social contacts were associated with reduced substance use. It is difficult to ascertain the direction of the relationship between these factors, whether decreased substance use caused or resulted from changes in social support, or whether the two things reinforced each other in a positive feedback loop. It was clear, however, that *reductions in substance use* were associated with positive life trajectories. Finally, *new social roles* were an important factor in positive trajectories across sites. In Vancouver, Toronto, and Moncton many participants changed their daily activities to include things like volunteering, coaching softball, working, attending school, or becoming peer support workers. In Winnipeg, Aboriginal participants reconnected with their traditional cultural communities, in addition to pursuing the activities mentioned in the other sites. All of these endeavours gave participants opportunities to take on new and valued social roles that expressed a positive social identity.

3. **Factors associated with negative trajectories.** *Precarious housing* — losing housing; living in shelters, housing of poor quality, or unstable housing; or negative experiences with housing — was associated across sites with negative trajectories for participants. It should be noted that precarious housing might represent uneven implementation of the model in sites where decent housing is more difficult to access and is of more variable quality (e.g., Winnipeg). Housing is central to the Housing First model and recovery, so it is unsurprising that *precarious housing* is a crucial factor associated with negative trajectories. *Negative social contacts and isolation* were also associated with negative trajectories. While negative social contacts affected both housed and unhoused participants, isolation was typically — although not exclusively — associated with housed participants. In both instances, participants lacked the supportive social contacts that are important in helping to make difficult life changes. *Increased or continued heavy substance use* was associated with negative trajectories and likely associated with individuals remaining involved in social groups that use substances. Finally, *hopelessness* was an important factor associated with negative trajectories. Hopelessness was presented across sites as the pervasive belief that things would not improve for the individual, and was often associated with a long history of social marginalization. In some cases, participants remained hopeless despite being offered housing. For others, their prevailing sense of hopelessness was rekindled after losing the housing they'd initially been offered by the project. One participant in Vancouver who faced an eviction presented her circumstances in the following terms: *"I'm an addict. I screwed up. I was clean for eight months and then I relapsed ... Maybe I'm not good enough to have an apartment. I'm thinking that now."*

4. **Factors associated with mixed trajectories.** Mixed trajectories were associated with *substance* use as well as *perceived failures and disappointments*. In this trajectory, participants made uneven progress with a split of roughly equal positive and negative gains. Similar to negative trajectories, participants with mixed experiences showed sustained *substance use* and setbacks due to relapse. *Perceived failures and disappointments* is the most salient factor associated with mixed trajectories. Similar to *hopelessness* for those individuals with negative trajectories, participants with mixed trajectories often made attempts to make life changes but had difficulty following through when faced with setbacks. The subsequent cycle of hope and disappointment was emblematic of mixed trajectories. One salient example of a mixed trajectory was a participant from Vancouver who attempted to return to school and resume contact with their family. Both pursuits did not go well from their perspective, leaving the participant feeling depressed and hopeless and, subsequently, self-isolating.

5. **HF groups vs. TAU**. Between the HF intervention group and the TAU group, there were both similarities and differences. In this section, we will present only important comparisons between groups in relation to trajectory. The two most striking differences between groups were *experiences with housing* and *substance use*.

   There were marked differences across study conditions with regard to *experiences with housing*. Across sites, participants having positive trajectories were housed, with the majority having received the HF program. Put another way, positive trajectories were associated with housing stability and HF produced housing stability significantly better than TAU. Inversely, negative trajectories across sites were associated with precarious housing and negative experiences of housing, which were more common for TAU participants.

   Substance use was a crucial factor that differed between the HF group and the TAU group with regard to trajectory. Where individuals receiving HF and having a positive trajectory decreased use, TAU participants with positive trajectories often did not. Similarly, where individuals receiving HF had negative trajectories, these individuals reported relapse or continued use whereas TAU participants reported continued heavy or increased use. Social relationships are likely an important part of understanding substance use and it is likely that good quality housing, or lack thereof, influences participants' social contacts, which in turn influences their substance use.

LESSONS LEARNED AND IMPLICATIONS

While acknowledging the complexity of living with mental health challenges and negotiating the stresses of one's physical and social environments, sites consistently reported that being housed helped participants establish a stable routine, focus on their mental and physical health, and actively work toward the development and attainment of future-oriented goals. Participants in both the Housing First (HF) and treatment as usual (TAU) conditions reflected deeply on the changes that occurred in their lives in the 18 months since the baseline interviews. Analysis and reflection about their experiences and insights point to a number of lessons with implications for planning and delivering services, and for developing policies to assist individuals who are homeless or newly housed and experiencing mental health challenges.

Housing as a Stable Base for Providing Support

Very much in line with the HF logic model, the most commonly reported lesson learned across sites by report authors was that offering housing with no readiness-oriented pre-conditions provides a stable base for participants to benefit from multifaceted support services. While housing enabled people to move from a mode of survival to a place of peace, security, and future orientation, the supportive role of housing and mental health staff helped participants to gain greater control over their social relationships, their mental health service utilization, and their ability to remain successfully housed. Particularly for those individuals whose identities were most entrenched in lifestyles and routines developed while homeless, providing housing alone was insufficient for facilitating an exit from homelessness.

Sites noted that intensive services that focus on linking individuals with their communities are particularly important in the early stages of housing. These services can help individuals adjust to being housed and counteract feelings of loneliness and isolation that many experience as they leave behind the support from social networks created while living on the streets. As noted by the Toronto site, a diverse array of services and supports may be useful in this early phase, including frequent, intense support from outreach workers, volunteer visiting, and peer support. Relationships developed between participants and support staff members were also noted as being of central importance. According to the Toronto site, those participants who reported feeling supported and accepted by staff experienced self-efficacy and satisfaction with their accomplishments, while those who did not feel supported described frustration and more difficulties managing their mental health. Their results suggest that "service providers working with people with complex needs must be able to find the opportunity to exhibit active listening, empathy, and positive regard for their clients" (Toronto report, p. 34). These findings are worthy of attention in the development of content and approaches to staff training and supervision.

The Role of Housing Choice and Support in Facilitating Community Integration and Belonging

Also in line with the HF logic model, the importance of housing choice and location was also commonly noted in the site reports. Limited housing choice in difficult social environments was recognized as contributing to depression, isolation, and continued contact with negative acquaintances who reinforce addictions and impair recovery, particularly among participants in the TAU group. Finding housing in new neighbourhoods with less social chaos was often experienced as empowering by participants, enabling them to move past a sense of being stuck in place. Overall, there was some ambivalence about old and new neighbourhoods: some participants in both study conditions reported that the change in neighbourhoods or routine had disconnected them from their familiar spots in the community, and from services and people that they had come to know while living on the streets. Feeling a low sense of connection to their new

communities and experiencing decreased levels of social interaction may have contributed to negative trajectories among some participants, at least initially. Developing more positive social contacts and pursuing new social roles in their communities tended to result in more positive trajectories, but becoming integrated in a new neighbourhood takes time.

Given the important role of housing choice and location in facilitating community integration and belonging, services should be structured around actively helping participants locate homes in neighbourhoods that fit their needs, interests, and experiences. Despite the important role that supportive services can play in the community integration process, it is also important to encourage independence and choice among consumers as they navigate new settings, develop diverse social relationships, and work toward achieving recovery goals. As stated in the Vancouver site report, "community participation and belonging cannot be engineered but are built and rebuilt in small increments by individuals stepping out of isolation, enjoying connectedness, and taking responsibility for their actions" (Vancouver Report, p. 30). Cultural belonging was also an important issue to address. Among HF participants at the Winnipeg site, opportunities for cultural healing and connection to Aboriginal heritage were noted as very significant for facilitating recovery from mental health challenges and addictions.

Housing Stability and Beyond: Moving Towards Supported Education and Employment

Participants from both HF and TAU conditions spoke of the powerful role of housing in the recovery process. Recovery was discussed broadly, entailing not only progress in terms of stability, insight, and management of symptoms or substance use, but also the ability to work through stressors and problems, developing independence from support staff, and attaining life goals. Further, participants were clear in their assessment of stable housing as the starting point of their recovery process — restoring dignity and selfhood, while also providing the stability needed to pursue school, work, or volunteering — but not sufficient in and of itself. In line with this suggestion, sites noted that services should move beyond focusing on clinical and housing stability, and towards helping people move on with their lives by emphasizing employment and educational support, as was done in the Montréal site, which implemented the supported employment model (Bond, 2004). In addition to supported employment, the Toronto site report recommends implementing supported education (Mueser & Cook, 2012) and social enterprises (Warner & Mandiberg, 2006). The Moncton site noted that services should be offered regularly, in a centralized manner, and focused on a variety of individual and group-based supports related to housing, employment, addictions, and mental health.

While acknowledging that many participants' narratives were very much impacted by recent and past traumatic experiences, sites also noted participants' strengths, optimism, and ability to maintain hope for the future in spite of their challenges. Breaking out of the cycle of poverty, gaining education and employment, giving back to the community, reconnecting with family or friends, pursing romantic relationships, and becoming mentally and physically healthy were all recovery goals stated by participants. This information is a testament to the strength of the human spirit and serves as a powerful reminder that individuals with lived experience of homelessness and mental health problems want and deserve opportunities to contribute to the social fabric and live rich, fulfilling, and productive lives in the community.

Sturctural and Societal Barriers to Community Integreation and Recovery

A final lesson learned relates to pervasive structural and societal barriers that pose obstacles to participants' community integration and recovery. For example, while many participants at the Toronto site reported being grateful for earnings provided by the Ontario Disability Support Program (ODSP), some found them insufficient for reaching

goals related to housing and recovery. They also felt the system disincentivizes work because, beyond the $200 mark, they lose 50 cents from their ODSP payment for every dollar they earn working. This is unfortunate given that employment can help individuals escape poverty, improves mental health, and benefits society. Policies guiding ODSP administration and similar financial assistance programs are in need of restructuring so that recipients are able to work without fearing future loss of benefits.

Findings regarding stigma and discrimination also hold implications for structural change. Numerous participants across sites reported ongoing experiences with discrimination based on their race/ethnicity, sexual orientation, and mental health. For example, in Moncton, some participants in the TAU group spoke of housing discrimination that resulted in them having to live in inadequate housing in unsafe neighbourhoods, while some participants in the HF group experienced stigma from landlords that made it difficult to establish a sense of ownership and responsibility over their living environments. Participants in Vancouver and Toronto reported discrimination, mistreatment, and poorly delivered services within the traditional healthcare system, particularly from individuals involved in psychiatric care and dealing with medications. Aboriginal participants in Winnipeg and elsewhere talked about discrimination and the continuing impact of intergenerational trauma on their own lives. Given the pernicious effects that stigma and discrimination can have on recovery, there is a need for increased advocacy, policy initiatives, and population-based interventions that eliminate barriers to community integration, address abuses of the traditional healthcare system, improve community attitudes about mental illness, and support individuals as they move out of homelessness and into places of their own.

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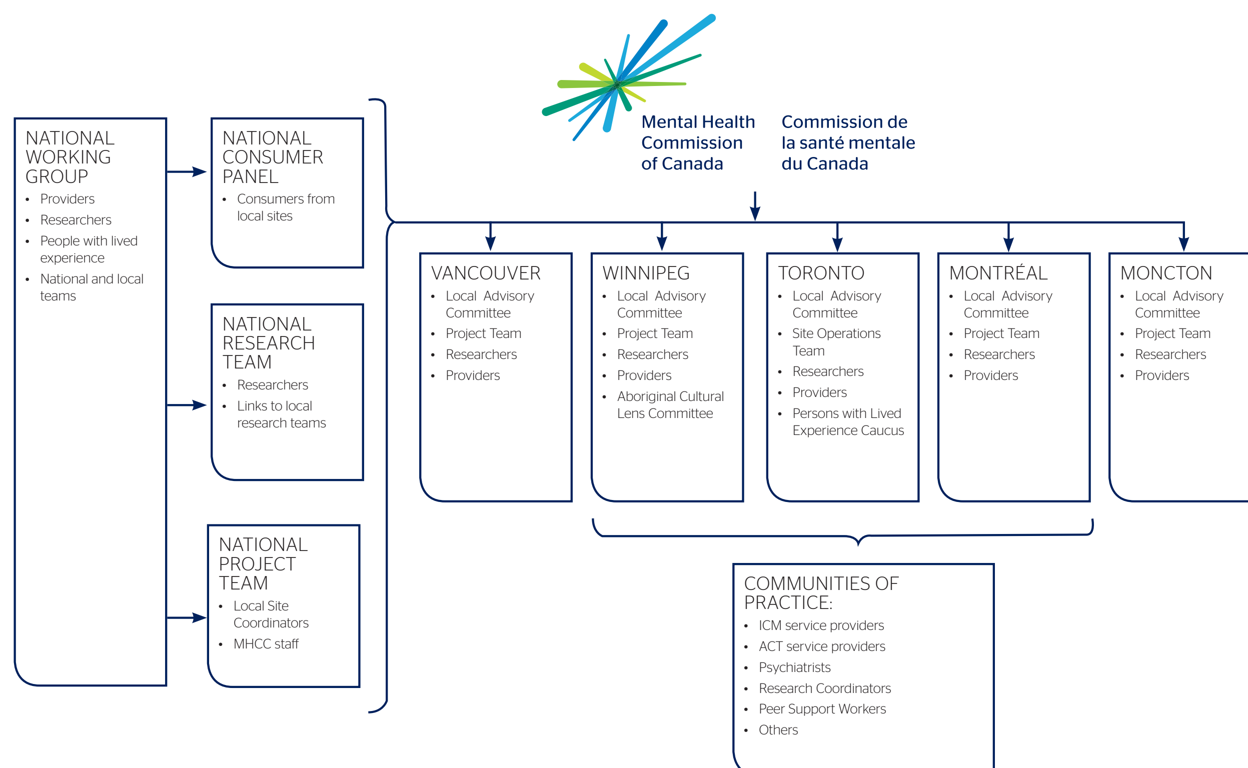
PROJECT STRUCTURE AND DESCRIPTION OF THE FIVE AT HOME/CHEZ SOI PROJECT SITES



VANCOUVER

Located on Canada's west coast, Metropolitan Vancouver is Canada's third largest urban area with a population of roughly two million. While Vancouver boasts a reputation as one of the most livable cities in the world, the overlap between mental disorders, substance use, and homelessness has become a civic crisis. When compared to the rest of British Columbia and Canada, the city is unique in terms of the heterogeneity, multi-morbidity and concentration of its homeless population. The extent of chronic medical conditions, including infectious disease, has been well-documented among Vancouver's homeless population (Acorn, 1993; Wood, Kerr et al., 2003). Furthermore, many individuals who are homeless in Vancouver are not connected to the formal healthcare system, and are thus at elevated risk of adverse medical outcomes, including drug overdose (Kerr et al., 2005).

The 2008 Metro Vancouver Homeless Count found 1,372 people who were homeless in the City of Vancouver. This number represents a 23 per cent increase since the previous count in 2005. Notably, between 2005 and 2008, the per centage of people who experienced homelessness for one year or more increased by 65 per cent, representing 48 per cent of people counted in 2008. In addition to the significant increase in the rate of homelessness, self-reported rates of mental illness and addictions have also increased significantly, by 86 per cent and 63 per cent, respectively.

Vancouver is home to the Downtown East Side (DTES) community (approximately 16,000 individuals), where homelessness, drug addiction, and other health and psychosocial problems are rampant and highly visible. Many individuals in the DTES are homeless or live in unstable housing conditions, resulting in high rates of health and social service needs. Vancouver Coastal Health (n.d.a) estimated that 3,200 individuals in the DTES have significant health problems and an additional 2,100 have more substantive disturbances that require intensive support and services. Other estimates suggest an even greater level of need. For example, Eby and Misura (2006) estimated that 5,000 injection drug users in the DTES are infected with Hepatitis C or HIV/AIDS.In response to the growing levels of homelessness in Vancouver and related issues in health and social problems, several not-for-profit organizations have established housing and other supportive services, many of which are located in the DTES.

Although estimates of the clinical, social, and housing service needs within the population of people who are homeless with mental disorders vary widely, it is clear that the variability and severity of need within the homeless population requires interventions that respond to individuals with both high and moderate levels of need. However, while Provincial ACT Standards have been developed and a Provincial Advisory Committee has been established to initiate ACT province-wide, there is currently only one ACT team in Vancouver (initiated within the past year), and only three province-wide. Thus, a critical element of context in Vancouver is the lack of basic service components (i.e., Housing First, ACT, ICM). This dearth of services may help explain the magnitude of complexity and tension in planning and implementing the At Home Project (i.e., not merely bringing people together around a common framework, but introducing key components of the framework at the same time).

The high concentration of Single Room Occupancy (SRO) hotels is also unique to downtown Vancouver. A high demand for low income housing is evidenced by the 0.5 per cent vacancy rate for bachelor suites in Vancouver. As a result, affordable housing is far beyond the shelter allowance of people receiving income assistance. The average rent for a bachelor apartment is $736/month, almost double the $375 monthly shelter allowance. In general, housing in Vancouver for people with multiple barriers due to substance use and other mental disorders has been in congregate settings, and this trend is continuing with the purchase and renovation of a number of SROs and the development of congregate housing on 12 city sites.

Growing civic commitment and public concern in Vancouver has been directed toward improving the health, autonomy, and quality of life among those who are homeless and have mental disorders. In November 2008, Vancouver's Mayor struck a Task Force to address the issue of homelessness. Numerous city- and province-led initiatives have recently addressed challenges related to homelessness, including reforms to the justice system (e.g., Community Court), expanded mental health services (e.g., Burnaby Centre for Mental Health & Addiction), access to income assistance (e.g., Homeless Outreach Teams), and investments to stabilize housing stock (e.g., purchase of SROs and development of additional supportive housing). If these activities and commitments fulfill their promise, they will significantly improve the standard of "usual care" for homeless people with mental disorders in Vancouver.

Sources:

The At Home/Chez Soi Project: A Review of the Proposal Development and Planning Phase in Vancouver, BC (September, 2010) by Michelle Patterson, Diane Schmidt, and Denise Zabkiewicz, Faculty of Health Sciences, Simon Fraser University.

The At Home/Chez Soi Project: Project Implementation at the Vancouver, BC Site (May, 2011) by Diane Schmidt and Michelle Patterson, Faculty of Health Sciences, Simon Fraser University.

WINNIPEG

Winnipeg is the capital and largest city (population of more than 600,000) in the province of Manitoba, which is in the prairies of Western Canada. Winnipeg is home to the largest urban Aboriginal population, with roughly 7,000 people of First Nations ancestry residing in Winnipeg.Estimates of the homeless population in Winnipeg range from a minimum of 350 livingon the streets, with a further 1,915 making use of shelters on a short-term or crisis basis (Ford 2009). One challenge associated with the Winnipeg demonstration project is thatthere has never been a comprehensive and coordinated homeless count. However, pastefforts and discussions with emergency shelter staff indicate that the average personwithout shelter in Winnipeg is most likely male (70%) and of Aboriginal descent (70%).

Low vacancyrates for rental property in Winnipeg - 1.1 per cent as of October 2009 - in both the public and private housing market have contributed to longwaiting lists for those seeking affordable shelter. Approximately 40 per cent of the rental housing stock is located within Winnipeg'sinner city where housing is older and increasingly in need of major repair.Winnipeg's housing rental stockis decreasing while rents increase, eroding both affordability and availability.As a result, prospective landowners andmanagers in the public market have the power to be particular in tenant selection. Someproperty owners and managers may avoid renting to tenants who are consideredmarginalized due to perceived drug and alcohol use and mental health issues, or as afunction of systemic discrimination.Racism and stigma are major obstacles to housing Aboriginal people with mental illness and/or addictions.

Accordingto a 2009 report from Canada Mortgage and Housing, the average rent for a bachelorapartment was $447, $615 for a one-bedroom and $809 for a two-bedroom.With the average rent this high, a single person on Employment and Income Assistance (EIA) with a budget of $320 per monthto rent an apartment (or $300 per month for accommodations in a rooming house) would have great difficulty obtaining shelter in Winnipeg. For a bachelor suite, this represents a shortfall of $147 per month for shelter costs, which must inevitably be taken from other household budget areas. A key issue in Winnipeg is the high demand for subsidized housing. The Manitoba Urban Native Housing Association reports that there is an overwhelming shortage of housing, with 2,300 persons on their wait lists (Distasio & Mulligan 2005). There are an estimated 5,000 tenants in 1,000 rooming houses (Distasio, Dudley & Maunder 2002). Meanwhile, close to 1,000 persons live in residential hotels along the Main Street area of downtown Winnipeg (Distasio & Mulligan 2005).

The standard form of shelter for the homeless in Winnipeg falls under the category of Crisis and Transitional Housing. In addition, there are emergency and transitional shelters geared towards providing services to particular populations, such as women or youth needing protection from dangerous home environments. Winnipeg currently has the capacity for 500 shelter beds during the winter months. Adult males represent a constituency of "high need" that are frequent users of emergency shelter, and who often have addictions issues. Moreover, Aboriginal males experiencing mental illness often seek emergency, transitional and supportive housing in contrast to permanent housing (2001 Community Plan on Homelessness and Housing). While overall shelter beds have increased over the past several years, there remains no Aboriginal-owned and operated shelter. The last shelter operated by the Aboriginal community was the Neeginan Emergency Shelter.

To some extent, housing is integrated into the delivery of mental health services in Winnipeg. But while there are general services, some supportive housing (with live-in staff) and supported housing (with case management) programs available for people with mental illness, the Housing First approach was not implemented on a widespread basis until the At Home/Chez Soi project. In terms of mental health services, Winnipeg has only recently developed its first ACT program. Moreover, there was little to no history of collaboration between mental health service-providers and organizations serving the Aboriginal population.

Although a large majority of project participants is of Aboriginal descent, it is a very diverse population of individuals with unique circumstances and needs. The existing housingsystem in the city has not dealt effectively with this population in the past. Many of the participants have had lengthy experience with the social services system, some not positive.

Sources:

Report on Proposal Development at the Winnipeg Site: The Mental Health Commission of Canada's At Home/Chez Soi Project (September, 2010) by Michael Dudley with the assistance of Fereshteh Moradzadeh, Institute of Urban Studies, University of Winnipeg.

Winnipeg Site Implementation Report (July, 2011) by Michael Dudley and Matthew Havens, Institute of Urban Studies, University of Winnipeg.

TORONTO

With a population of 2.7 million people, Toronto is the largest city in Canada and is known as one of the world's most multicultural centers. Half of the city's population was born outside of Canada and 47% of its residents describe themselves as belonging to a visible minority. Almost half of Toronto's population are immigrants (Statistics Canada, 2001), and this group has been identified as vulnerable to homelessness and in need of targeted support services (Toronto Shelter Support and Housing Administration, 2009; City of Toronto, 2000).

Homelessness in Toronto remains a significant social issue. Based on the Street Needs Assessment conducted by the City of Toronto in 2006, at any given night, there are more than 5,000 homeless people in Toronto. About 79% of them are living in shelters, 8% on the street, 4% in healthcare or treatment facilities, and 6% in correctional facilities (Toronto Shelter Support and Housing Administration, 2009). Between one forth to one third of homeless individuals in Toronto have a serious mental health problem such as schizophrenia, major depressive disorder, or bipolar affective disorder. A 2007 survey by Street Health found that about 35% of homeless people in Toronto reported a prior diagnosis of a mental health condition and 25% reported a combination of mental health and substance use problems (i.e. a concurrent disorder).

The unmet need for specialized mental health services among homeless individuals in the Toronto area is significant and a large proportion of homeless people with mental health problems do not receive the proper level of care. It is estimated that only twenty-five to fifty per cent of those eligible for services actually receive them. Furthermore, immigrants, who make up about one third of homeless people in Toronto, in particular face significant barriers (e.g. racism, language barriers and stigma) to accessing mental health services (Access Alliance Multicultural Community Health Centre, 2005).

There is a large pool of longstanding services available to individuals experiencing homelessness in Toronto, including supportive and alternative housing, emergency shelters, drop-ins, integrated street outreach services, housing help and eviction prevention services, and meal programs funded through threel evels of government and the charitable sector. Three downtown Community Health Centres – Parkdale in West Downtown, Queen West in Central Toronto and Regent Park in Southeast Toronto – are given $6 million dollars a year in addition to their annual funding to hire staff (doctors, nurses, nurse practitioners, social workers, outreach workers), to work specifically with people who are homeless, and to coordinate services for people who are homeless between CHCs in the city.

Also included in the homelessness service landscape is the City of Toronto's Streets to Homes program which began in 2005 and focuses on moving homeless individuals living outdoors into permanent housing (Toronto Shelter Support and Housing Administration, 2009). A sizeable mental health service network serves homeless and housed individuals

in Toronto; clients suffering from serious mental health problems and homelessness access the treatment system in Toronto through many different entry points.

Despite this, people who are homeless and living with mental health issues often face barriers to service access and end up using emergency room and inpatient hospitalizations for their care (Canadian Institutes of Health Research. Reducing Health Disparities & Promoting Equity for Vulnerable Populations. 2002). Existing mental health services often lack the resources or are unable to combine the basket of services and supports needed to address their needs, especially at higher levels of care (Stergiopoulos, Dewa, Durbin, Chau, Svoboda, 2010). A few larger drop-in centres in Toronto have the resources to provide more extensive medical and case management supports to their homeless clients living with serious mental health problems. However, most drop-ins have very limited resources for providing psychiatric or medical supports and those resources can be very precarious. Service fragmentation and lack of options for consumer choice often make it difficult to engage those with the most complex needs. There are ongoing efforts to develop a centralized access point for certain community services including case management, ACT, and supportive housing.

There are approximately 4405 supportive housing units in Toronto specifically designated for individuals with serious mental health problems. The great majority of these are permanent housing with anything from an hour a week to 24 hours a day of support. The supportive housing providers' tenants are diverse, with low incomes. They are predominantly single adults, have similar social or health issues affecting housing stability but must have a mental health diagnosis and may also live with addictions. In some instances supportive housing providers also house couples and families with children as long as one member of the household meets the mental health/diagnosis criterion. Additionally there are many units available through what is referred to as the "alternative housing providers," a group of providers who house individuals with a variety of health and social issues. The alternative housing providers' tenants are also diverse, but are predominately single adults with low incomes who may live with mental health problems or addictions, or other social or health issues which present barriers to finding and maintaining stable housing. Although several initiatives developed and funded by the Ministry of Health and Long-Term Carehave had an impact on homeless populations, the permanent nature of the housing creates capacity issues once the units are filled.

Sources:

At Home/Chez Soi Project Planning and Proposal Development Toronto Site Report (November, 2010) by Maritt Kirst, Erin Christine Plenert, Deborah Wise Harris, Bonnie Kirsh, Stephen Hwang, Patricia O'Campo, and Vicky Stergiopoulos, Centre for Inner City Health, St. Michael's Hospital.

At Home/Chez Soi Implementation Evaluation Toronto Site Report (August, 2011) by Vicky Stergiopoulos, Stephen Hwang, Patricia O'Campo, and Jeyagobi Jeyaratnam, Centre for Inner City Health, St. Michael's Hospital.

MONCTON

The Greater Moncton region of the Province of New Brunswick includes the Cities of Moncton, Dieppe and the Town of Riverview. The Greater Moncton area population is approximately 130,000 with it having experienced a growth of 6.5% between 2001 and 2006. The language composition of the population is approximately 62% Anglophone and 35% Francophone (City of Moncton, 2011). The location of the rural arm of the Moncton site study is in the Southeast region of the Province of New Brunswick. The Southeast region is within a 60 minute drive of Greater Moncton and covers a region stretching over 2000 square kilometers. The region is made up of a variety of small municipalities and service districts that range in population from a few hundred up to four or five thousand. There are approximately 40,000 people living in the Southeast region of the province.

Based on existing sources of data, the number of homeless individuals who received services from shelters in the

Greater Moncton area in 2006 is 946 (Human Resources and Social Development Canada, 2007). This outcome reflects the annual number of individuals served by the two largest shelters (in the City) (689 male adults; 177 female adults; and 80 children). In 2010, a total of 682 clients, representing 425 different individuals, had stays at the House of Nazareth shelter in Moncton (Greater Moncton Homelessness Steering Committee, 2011). In contrast, a total of 737 clients had stays at the House of Nazareth in 2009. The average length of stay for consumers at the House of Nazareth was a little over 6 days in both years. Overall, a total of 4,259 beds at the House of Nazareth were used in 2010 and 4,550 beds in 2009 representing a small drop in shelter use.

Approximately 70% of dwellings in the Greater Moncton region are owned with the remaining 30% being rental units. The Community Plan Assessment Framework (2007) identified approximately 15,500 individuals at potential risk of homelessness in the Greater Moncton area. These individuals were identified as living in substandard rental units (in "core housing needs"[4]), as well as experiencing significant financial demands related to covering their basic shelter and living costs. On average, approximately 30% of disposable income for renters is used to cover housing costs. In contrast, those living in rental situations identified as "in core housing need", spend approximately 45% - 50% of their income on housing related expenses. There is a relatively high vacancy rate in Moncton and a long waiting list for social housing. Nevertheless, there have been some small, incremental financial increases in income assistance and minimum wage. One of the significant gaps in policy that continues to affect the living conditions of many renters in New Brunswick is the absence of provincial standards to regulate the safety and suitability of rooming and boarding houses.

Services and supports available in the community include the range of longer-term services available through the community mental health centre (CMHCs) such as case management, community support, and rehabilitation as well as the community supports provided by other settings such as re-integration services, transitional and housing programs, and outreach services. CMHCs are the main source of services delivered in the community and these are organized under three core programs: (1) Acute services (i.e., 24-hour crisis intervention, short-term therapy prevention, consultation and service delivery coordination), (2) child and adolescent services (i.e., individualized assessment and treatment, service provision for all family members), and (3) adult long-term services (i.e., treatment, monitoring, psycho-social rehabilitation) (Health Systems Research and Consulting Unit, 2009). Publicly-funded mental health services are delivered in Moncton and in the adjoining rural region through CMHCs, tertiary and secondary facilities, and psychiatrists in private practice. The tertiary and secondary facilities and psychiatrists in private practice are located in Moncton. In addition, there are three rural service providers located out of the mental health clinic in Shediac. Addiction services available in Greater Moncton include a detoxification centre, outpatient counselling, health promotion, and wellness activities and school-based youth support services.

Relative to the other sites participating in the At Home / Chez Soi project, Moncton is the most resource deprived in terms of housing and community mental health services.There are two organizations in Moncton providing long-term supportive housing: (1) Alternative Residences Inc. which offers 30 units for mental health consumers that can accommodate up to 76 individuals; twenty-six of the 30 units are apartments and the other four are 24-hour supervised residences; the maximum stay is set at two years; and (2) Future Horizons Housing Inc. which has 12 units (3 two-bedrooms & 9 three-bedrooms) available for consumers of Headstart Inc. and offers a range of support services along with the housing (Greater Moncton Homelessness Steering Committee, 2008). The provincial Department of Social Development has 647 units of social housing available in Greater Moncton. As well, it provides rent supplements for another 669 units in the private housing market. There are no supports tied to any of these units.

[4] A household is said to be in core housing need if its housing falls below standards in terms of adequacy, suitability, or affordability and it would have to spend more than 30% of its before-tax income to pay the median rent of alternative local housing that meets all three standards. (Cooperative Housing Federation of Canada, 2007).

Sources:

Rapport de recherche: Phase I – Planification et développement du projet Chez-soi/At Home Moncton et volet rural (September, 2010) by Charles Gaucher, Linsay Flowers, Natasha Prévost, and WiebkeTinney.

Implementation Evaluation Report for the Mental Health Commission of Canada's At Home/Chez Soi Project: Moncton Site (June, 2011) by Tim Aubry, Rebecca Cherner, John Ecker, Jonathan Jetté, and Keith Philander.

MONTRÉAL

Located in the province of Québec, Montréal is Canada's second largest metropolitan area with roughly 3.8 million people. It also has the second largest Francophone population in the world, after Paris. Montréal has a significant problem of homelessness and mental illness.

At last count, carried out in 1998 by *Institut de la Statistique du Québec* (Québec institute of statistics), 28,214 people had at one time used a shelter, a soup kitchen or day centre. Of this number, 12,666 had been homeless over the course of the past year (MSSS, 2008). For 2005, the number of people in Montréal who were homeless at least part of the year, was estimated at 30,000 ("Cadre canadien en matière de logement 2005," in RAPSIM, 2008). The profile of homelessness has undergone a major transformation (Roy &Hurtubise, 2007).

There are more and more youths, women, seniors, and Natives living in the street. This population also faces major concurrent health problems. In particular, from 30 to 50% of homeless people have mental health problems, and 10% suffer from severe mental health problems. Over half of homeless adults with mental health problems may also have an addiction problem (Weinrebet al., 2005).In addition, an increasing number of homeless people have problems with the law (Bellot, 2008). The multiplicity of problems affecting this population makes it increasingly complex to implement adequate responses to homelessness.

Existing housing programs for people with mental illness include social housing (a congregate program for low income people living), hostels, foster families, group homes, supervised apartments, and rooming homes. Moreover, although since 2005 provincial policy has called for the implementation of ACT and ICM teams across the province, when the At Home/Chez Soi project started, access to such programs was still relatively limited. When the At Home/Chez Soi project started the At Home/Chez Soi project coincided with provincial initiatives to address the growing problem of homelessness in Québec.

[In 2008], the government of Québec established a parliamentary commission on homelessness. Over 145 submissions were made and 104 persons or groups provided testimonials. A document titled *L'itinérance au Québec – Cadre de reference* (Homelessness in Québec: A Reference Framework) was issued a few months later. It targeted four priority objectives at the provincial, regional, and local levels to respond to the needs of the homeless population: (1) enhance prevention; (2) respond to emergency situations; (3) intensify intervention and social reintegration; and (4) improve knowledge, research and training (MSSS, 2008). The reference framework is the basis for the Plan d'actioninterministériel en itinérance 2010-2013 (interministerial action plan on homelessness, 2010-2013) made public in December 2009, which recommends identifying best practices in the fight against homelessness.

It is worth noting that the action plan identifies the "Housing First" model as a promising avenue of exploration for persons facing chronic homelessness and mental health problems *(Plan d'action interministériel en itinérance 2010-2013, 2009). The Plan d'action en santé mentale 2005-2010* (mental healthcare action plan, 2005-2010), tabled in 2005, recommends consolidation of community services to help persons with mental health problems and to facilitate their social reintegration (MSSS, 2005). The action plan also presents specific targets for housing services with support from Assertive Community Treatment (ACT) teams and Intensive Case Management (ICM) teams.

APPENDIX 1

Source :

Projet Chez Soi Montréal - Projet de recherche et de démonstration sur la santé mentale et l'itinérance: Rapport d'évaluation de la planification et du développement du projet (été 2008 - automne 2009) (July, 2010) by Marie-Josée Fleury, Catherine Vallée, Roch Hurtubise, and Guy Grenier.

PRINCIPLES OF HOUSING FIRST

HOUSING FIRST MODEL

- Recovery-oriented culture
- Based on consumer choice for all services
- Only requirements: income paid directly as rent; visited at a minimum once a week for pre-determined periods of follow-up supports
- Rent supplements for clients in private market: participants pay 30 per cent or less of their income or the shelter portion of welfare
- Treatment and support services voluntary — clinicians/providers based off site
- Legal rights to tenancy (no head leases)
- No conditions on housing readiness
- Program facilitates access to housing stock
- Apartments are independent living settings primarily in scattered sites
- Services individualized, including cultural adaptations
- Reduce the negative consequences of substance use
- Availability of furniture and possibly maintenance services
- Tenancy not tied to engagement in treatment

Sources:

Tsemberis S. (1999). From streets to homes: An innovative approach to supported housing for homeless adults with psychiatric disabilities. *Journal of Community Psychology*, 27, 225-241.

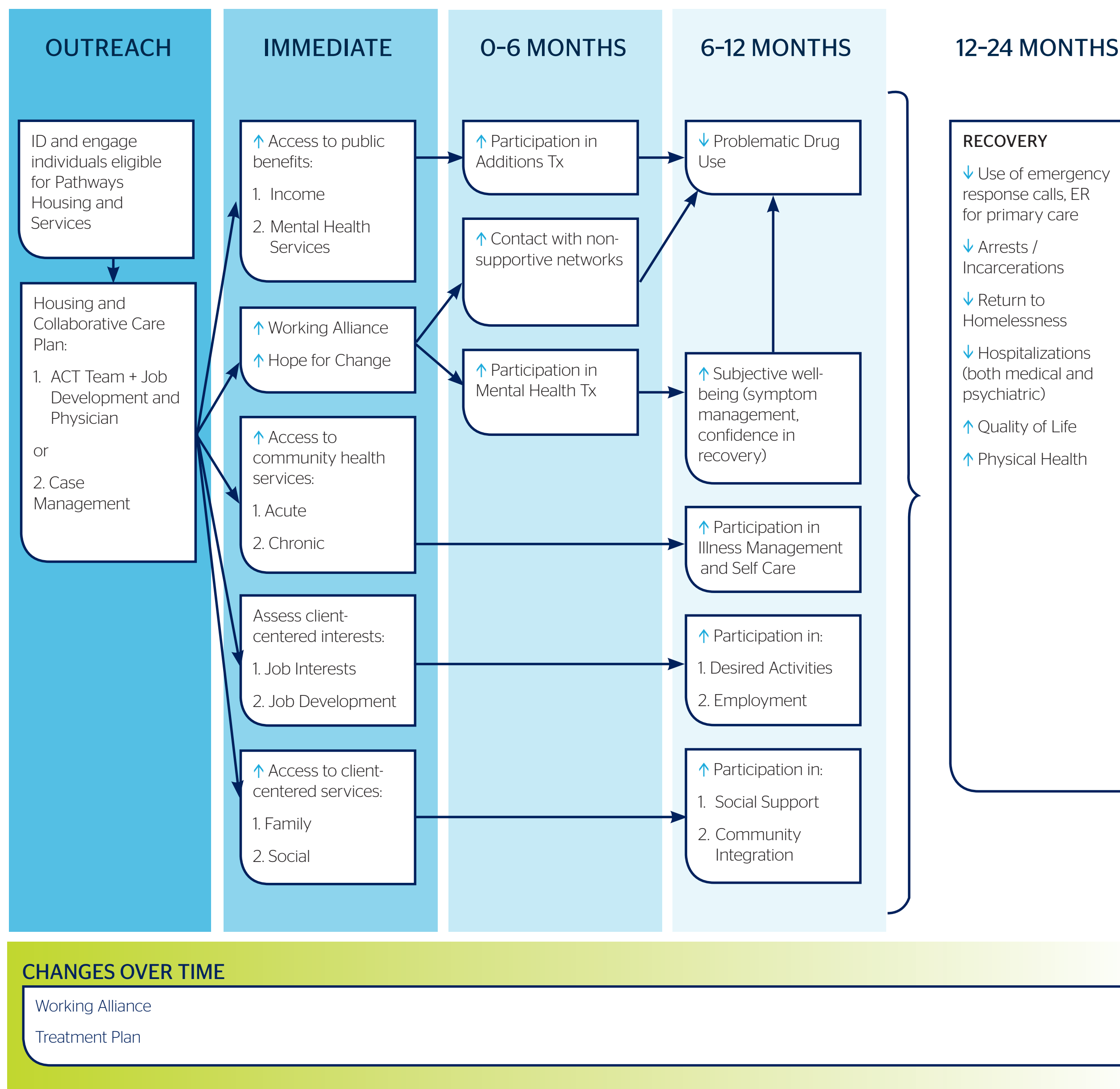
Tsemberis, S., & Eisenberg R.F. (2000). Pathways to housing: Supported housing for street-dwelling homeless individuals. *Psychiatric Services*, 51, 487-493

As outlined in *Request for Applications MHCC Research Demonstration Projects in Mental Health and Homelessness*, 2009.

HOUSING FIRST LOGIC MODEL

Figure 2 **Pathways Housing First Consumer Interventions and Outcomes**

DRAFT June 8, 2009



DETAILED METHODOLOGY

Mixed Methods Approach

A mixed methods approach was used (Macnaughton, Goering, & Nelson, 2012; Padgett, 2012). The consumer narrative interviews were used to complement the analysis of quantitative outcome measures.

Consumer Narrative Interviews

Sampling and sample. The sampling method for the larger clinical sample is described in a previous article (Goering et al., 2011). A total of 2,255 participants were recruited into the clinical trial and randomly assigned to treatment conditions in each of the five sites. We decided to use a subsample of 10 per cent of the participants from the larger clinical trial. Subsample selection was conducted as follows. For the first few interviews, site researchers selected one out of every 10 participants per treatment condition for each site to be interviewed. The sites began with whatever number they wished (e.g., participant number 6, 16, etc.). However, as subsample selection progressed, sites shifted to more purposeful selection to ensure that they were obtaining a subsample for the narrative interviews that was representative of the larger sample of participants at each site. For example, each site selected at least two women to be interviewed per condition. Other criteria were used (e.g., age, ethnoracial background) to ensure representativeness of the sample unique to each site. Each site strived to conduct the narrative interviews within two weeks of the baseline quantitative interviews. At baseline, we obtained 219 interviews in total (9.7 per cent of the total sample).

We compared the narrative subsample (n=219) with those participants who were not selected to participate in a narrative interview (n=2036) at baseline on more than 50 demographic, diagnostic, and outcome measures. The χ^2 test was used to examine differences on all categorical variables, and t-tests were used to examine differences on all continuous variables. The groups differed significantly on only three of more than 50 variables. There was a significantly higher proportion of persons who identified themselves as female or other (e.g., transgender) in the consumer narrative subsample (32.0%, n=219) compared with the larger sample (28.4%, n=2036), $\chi^2(2)=7.47$, $p < .05$. Also, significantly fewer participants in the consumer narrative subsample (31.6%, n=214) had three or symptoms on a measure of substance use than those in the larger sample (35.8%, n=1940), $\chi^2(2)=9.80$, $p < .002$. Finally, those in the consumer narrative subsample had a significantly higher level of income in the last month (mean = $781.00, SD = 839.7) than those in the larger sample (mean = $681.20, SD = 660.30), $t(2253)=2.07$, $p < .05$. However, given that there were significant differences on only three of more than 50 variables, the subsample appears to be representative of the larger sample.

Attrition rates. Overall, the attritions rates were quite low, with from 80 per cent to 100 per cent of the sample at the sites retained for an 18-month follow-up interview (see Table 1). Only 11 per cent of the sample was lost to attrition. Reasons for attrition included not being able to locate the participant, participant refusal, and death.

Table 4.1
Number of Participants Who Completed Baseline and Follow-up Interviews

SITE	TOTAL BASELINE INTERVIEWS	TOTAL 18-MONTH FOLLOW-UP INTERVIEWS
Moncton	20	16 (80%)
Montréal	45	45 (100%)
Toronto	60	50 (83%)
Winnipeg	45	43 (96%)
Vancouver	50	43 (86%)
All Sites/Total	219	195 (89%)

Sample characteristics. A total of 195 participants completed both the baseline and 18-month follow-up consumer narrative interviews, with 119 Housing First (HF) participants and 76 Treatment as Usual (TAU) participants (see Table 2).

Table 4.2
Number of Participants in HF and TAU

SITE	HF	TAU
Moncton	8	8
Montréal	27	18
Toronto	31	19
Winnipeg	25	18
Vancouver	28	15
All Sites/Total	119	76

The HF and TAU groups were compared on a number of demographic and diagnostic variables and, with randomization, there were no significant differences between the groups on any of these variables. Thus, the two groups were combined in Table 4.3 to show the overall characteristics of the sample at baseline.

Table 4.3

Demographic and Diagnostic Characteristics of the Consumer Narrative Sample at Baseline

VARIABLE	*n* (%) OR MEAN (SD)
Need Level	
High	92 (43.6%)
Moderate	119 (56.4%)
Gender	
Male	132 (62.6%)
Female	74 (35.1%)
Other	5 (2.3%)
Aboriginal (First Nations, Métis, Inuit)	
Yes	49 (22.9%)
Ethnoracial	
Yes	49 (22.9%)
Employment	
Unemployed	198 (93.8%)
Employed, volunteer, or in school	13 (6.2%)
Education	
Less than high school graduate	119 (56.4%)
High school graduate	34 (16.1%)
More than high school graduate	58 (27.5%)
Marital Status	
Single, never married	140 (66.4%)
Separated/divorced/widowed	68 (32.2%)
Married/cohabiting	3 (1.4%)
Disorders	
Major depressive episode	111 (52.6%)
Manic/hypomanic episode	34 (16.1%)
PTSD	58 (27.5%)
Panic	53 (25.1%)
Mood disorder with psychotic features	48 (22.7%)
Psychotic disorder	67 (31.8%)
Alcohol dependence	72 (34.1%)
Substance dependence	106 (50.2%)
Alcohol abuse	40 (19.0%)
Substance abuse	56 (26.5%)
Age	41.33 (11.22)
Last Month's Income	$781.03 (839.7)
Lifetime Months of Homelessness	68.03 (102.67)
Number of Children Under 18	1.04 (6.68)

Data collection. Baseline consumer narrative interviews focused on life before enrolment in the programs, while the 18-month consumer narrative interviews focused on changes that participants had experienced since the baseline interview. See Appendix 5 for a model information letter/consent form, Appendix 6 for the baseline consumer narrative interview guide, Appendix 7 for the 18-month follow-up interview guide, and Appendix 8 for the post-interview observations by the interviewer. All interviews were digitally recorded and transcribed (see Appendix 9 for the transcription protocol for the consumer narrative interviews). All audio files and transcripts for the interviews are stored with Health Diary under each participant's ID. At the conclusion of the project, they will be moved to a Virtual Machine at St. Michael's Hospital in Toronto for storage.

Quality control. It is important to verify the quality of qualitative data collected through interviews (Meyrick, 2006). All interviewers at the sites were trained in qualitative interviewing and how to use the baseline and follow-up consumer narrative interview guides. Members of the site research teams conducted ongoing checks of the initial interviews and provided feedback to the interviewers regarding interview length, listening skills, building rapport, and respecting the integrity of participants.

Members of the National Qualitative Research Team developed checklists that were used as a quality control measure for both the baseline and 18-month interviews (see Appendices 10 and 11). The checklist included both interview domains and interviewer skill. At baseline, there were 26 checklist items, 15 pertaining to interview domains and 11 to interviewer skill. At the 18-month follow-up, there were 14-16 interview domain items (depending upon the participant's treatment condition) and 10 interviewer skill items.

One site researcher and one member of the National Qualitative ResearchTeam independently reviewed and rated five interviews per site (except for Moncton, where only two interviews were reviewed). The two raters listened to the audio recording of the interviews, reviewed the transcripts, and completed the checklists for each interview. For the review, each site randomly selected one baseline consumer narrative interview from each experimental condition: 1- HF High Needs; 2- HF Moderate Needs; 3- TAU High Needs; 4- TAU Moderate Needs; 5- Site-specific Third Arm. The total sample at baseline included 23 interviews, while the follow-up sample included 22 interviews. There were only two reviews for Moncton since it had only one treatment and one control condition.

Two methods were used to analyze these data. The first was to examine the per centage of items checked, which provides an indication of the degree to which the interviewer followed the protocol and did so in a skillful manner. The second method was to compute the Kappa statistic to determine the level of agreement between the two raters (McGinn et al., 2004).

A numerical analysis of the checklist was conducted, in addition to a thematic analysis of the comments on interview quality. For the 23 interviews, there were a total of 575 "items" to check (23 interviews x 25 items on the checklist). Of the 575 items, 533 items were checked (97 per cent of the items). The checklist divided the items into "interview domains" items and "interviewing skill" items. For "interview domains," 329 items were checked out of 345 total items (95.4 per cent of items). For the "interviewing skill" items, 204 items were checked out of 230 total items (88.7 per cent of items). In terms of the interview questions, 95.7 per cent of pathways to homelessness items were asked by the interviewers; 97.1 per cent of life on the streets or in a shelter items were asked; 97.1 per cent of experiences with mental health services items were asked; and 95.7 per cent of high, low, and turning point stories were asked. 100 per cent of items regarding life before homelessness; services, supports and community organizations; vision for housing for the future; and experiences with the mental health system were asked. In terms of the quality of the interviewing, 89.6 per cent of "Questioning" items were checked; 87 per cent of "structuring the interview" items were checked; and 88.4 per cent of "probing" were checked. Strengths included demonstrating a neutral attitude (95.7 per cent); asking questions in a neutral manner (91.3 per cent); and making effective use of probing techniques (91.3 per cent). There were no

apparent differences between the sites, and no apparent differences between experimental conditions (HF vs. TAU, high needs vs. moderate needs). The thematic analysis revealed that interviewers paraphrased well and made questions understandable, that participants brought up topics ahead of questioning, and that participants struggled with difficult subject matter.

Data analysis. The first step in the analysis was to do open coding of the transcripts. Coders were encouraged to avoid focusing on the participants' treatment conditions and to be open-minded about who shows change and not just assume that it is only participants in HF who will show change. Coders examined each participant's baseline interview and 18-month follow-up interview for the analysis. Helpful theoretical and empirical sources on different types of change that might be coded included the literature on conceptualizations of possible selves (i.e., the cognitive components of hopes, fears, goals, and threats) (Markus & Nurius, 1986), Prochaska and Velicer's (1997) transtheoretical stage model of change (stages of precontemplation, contemplation, action, and maintenance), and narrative theory about turning points and identity shifts (Kearney & O'Sullivan, 2003; McLean & Pratt, 2006). In addition to coding changes from baseline to 18-months, coders examined factors that helped or hindered the changes. The following template was used for open coding.

Table 4.4
Template for Open Coding of Consumer Narrative Interviews

	BASELINE CONSUMER NARRATIVE	18-MONTH CONSUMER NARRATIVE	CHANGES (BASELINE TO 18-MONTHS)	WHAT CAUSED THESE CHANGES?
Life Changes				
- Positive Experiences				
- Current Challenges				
Typical Day				
- Time spent alone				
- Where do you go (neighborhood / community)				
- Daily activities				
- People you spend time with				
- Use of transportation				
- Experiences of stigma/discrimination				
- Leisure activities				
Education				
- Looking into / researching educational opportunities				
- Academic courses				
- Job skills training				
Work				
- Seeking employment				
- Volunteering				
- Current work status				

APPENDIX 4

	BASELINE CONSUMER NARRATIVE	18-MONTH CONSUMER NARRATIVE	CHANGES (BASELINE TO 18-MONTHS)	WHAT CAUSED THESE CHANGES?
Physical Health				
- Chronic conditions				
- Health status				
Mental Health/Recovery				
- Mental health/well-being				
- Challenges to mental health				
- Gains in mental health				
- Coping skills				
Substance Use				
- Type/Nature of substance use				
- Frequency/extent of substance use				
Relationships				
Nature of Relationships/Frequency of contact: - Family members - Children - Neighbors - Romantic partners - Acquaintances				
- Developing new relationships				
- Feeling part of the community				
Housing/Living Situation				
- Current housing situation				
- Number of moves				
- Reason for moves				
- Opinion of current housing				
- Experiences with landlord				
- Experiences in neighborhood				
- Incidents of Homelessness				
- Incarceration				
Finances/Material Situation				
- Food quality/availability				
- Earning money				
- Managing money				
Mental Health Services				
- Types of Services Used (e.g. counseling, medication management)				
- Helpful Services				

	BASELINE CONSUMER NARRATIVE	18-MONTH CONSUMER NARRATIVE	CHANGES (BASELINE TO 18-MONTHS)	WHAT CAUSED THESE CHANGES?
- Unhelpful Services				
- Relationships with Providers				
- Experiences with Medications				
- Hospitalization				
Other Services				
- Types of Services Used (e.g. soup kitchens, community centers, shelters)				
- Helpful Services				
- Unhelpful Services				
- Relationships with Staff				
Hopes for the Future				
- Goals: Social Relationships				
- Goals: Work and School				
- Goals: Other				
- Ideal Future Housing				

In addition to the open coding, researchers wrote brief, one to two paragraph summaries of the narrative, and they were asked to reflect on the following question: "What factors (including housing and factors beside housing) seem to account for the changes (positive or negative) in this person's life? If this person has experienced few changes, what might account for this?"

In the second step, the open codes identified in the first step were inserted into matrix displays by treatment condition (Miles & Huberman, 1994) to answer the three main research questions regarding changes, helping or hindering factors, and factors or qualities that distinguish those with positive trajectories and those with more neutral or negative trajectories. Analysis for the first research question examines changes by treatment condition; analysis for the second research question examines helpful and unhelpful factors by treatment condition; and analysis for the third research question brings the first two conditions by connecting what factors or qualities are related to changes within each treatment condition. A sample matrix display is provided in Table 4.5.

Table 4.5
Toronto Site Matrix Display

RESEARCH QUESTIONS	TAU	HF + ACT, ICM, OR ETHNORACIAL ICM
1. Changes (life changes, typical day, recovery, mental health, well-being, relationships, material situation, housing stability, hopes for the future)		
2. Factors that Help or Hinder Changes (housing, mental health services)		
3. Factors or Qualities that Are Related to Positive Trajectories vs. Neutral or Negative Trajectories		

The third step in the analysis was for the National Qualitative Research Team to create a cross-site baseline and 18-month follow-up consumer narrative report using the five site reports. The data analysis for the cross-site report used the following matrix display to guide the analysis. Outcome and process themes from the site reports were inserted into the cells of this matrix.

Table 4.6
Cross-site Analysis Comparing the Housing First and TAU Participants on Data Pertaining to the Three Research Questions

RESEARCH QUESTIONS	SITES	TAU	HF + ACT, OR ICM + 3RD ARM PROGRAMS
1. Changes (life changes, typical day, recovery, mental health, well-being, relationships, material situation, housing stability, hopes for the future)	Moncton		
	Montréal		
	Toronto		
	Winnipeg		
	Vancouver		
2. Factors that Help or Hinder Changes (housing, mental health services)	Moncton		
	Montréal		
	Toronto		
	Winnipeg		
	Vancouver		
3. Factors or Qualities that Are Related to Positive Trajectories vs. Neutral or Negative Trajectories	Moncton		
	Montréal		
	Toronto		
	Winnipeg		
	Vancouver		

Researchers from the sites were involved in a process of review wherein the National Qualitative Research Team shared the first draft of this cross-site report with site researchers, invited them to read it over along with their teams, and solicited their comments and suggestions. Comments from every site were incorporated into the final version of this report.

SAMPLE INFORMATION LETTERS AND CONSENT FORMS
For Consumer Narrative Interviews MHCC At Home Chez Soi Project

Informed Consent Statement

You are invited to participate in a research study on the personal stories of people who have experienced mental health and homelessness issues in [site name]. The purpose of this research is to understand your life experiences and life story. The principal researchers for this project are [names]. Altogether, about 240 people in five Canadian cities will be interviewed for this research.

INFORMATION

This research is part of the Mental Health Commission of Canada Research Demonstration Projects in Mental Health and Homelessness. This aspect of the research involves participation in an individual interview. The interview will be conducted by a member of the research team from the local site. The interview will be arranged at a time and place that is convenient for you.

During the interview, the Site Researcher will ask you a number of questions about your life, including questions about particularly memorable life events. We will give you the questions in advance so you have a chance to think about them. You are free not to answer any question or to pass on any question that is asked. The interview will last no more than one hour. With your consent, the Site Researcher will audio record the interview. There is no deception involved in the research.

RISKS

We do not believe that you will experience any significant risks to your well-being by participating in this interview. It is possible that if you have had a negative experience in your life, that you may find yourself becoming upset recalling such an experience.

BENEFITS

We do envision significant benefits to your participation in this study. First of all, you may find it interesting to reflect back on your life and some of the experiences you have had. Secondly, your experiences could be useful in improving services for people experiencing mental health and homelessness issues. Finally, the results of this study will make a contribution to the research literature on mental health and homelessness.

CONFIDENTIALITY

Your responses to the interview questions will be kept completely anonymous. That is, your name will not be associated with anything you say during the interview. We will keep everything you say confidential and private, and your name will not be associated in any way with your responses. A transcription of the interview will be identified by code number and stored in a locked filing cabinet to protect the confidentiality of your responses. However, the quotations will not contain any information that allows you to be identified. Should you consent to the use of your quotations, they may be used in write-ups and/or presentations on this research; however, the quotations will not contain any information that allows you to be identified.

All audio files and transcripts of digitally recorded interviews will be stored on a secure (password protected) server provided by the vendor EHealth, which is accessible only to members of the site research team and the national research team. Transcriptions of the interviews will be stored in a locked filing cabinet [add location – probably the office of the Site Researcher]. All audio files will be deleted and paper transcripts destroyed by December 31, 2016.

COMPENSATION

For your participation in this interview, you will receive compensation in the amount of [dollar amount].

CONTACT

If you have questions at any time about the study or the procedures, or if you experience adverse effects as a result of participating in this study, you may contact [insert name and contact information], This project has been reviewed and approved by the Research Ethics Board at [university name]. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact [insert name and contact information for local REB].

PARTICIPATION

Your participation in this study is purely voluntary and you have the right to decide that you do not want to take part in the research. Your decision to take part or to not take part will in no way affect your usual educational, health or community services. We will ask you to participate in a second interview that is similar in format16 months from now. If you withdraw from the study, we will not transcribe any of your responses to the interview. You have the right to omit or withdraw your response to any question or procedure without penalty. You will still receive compensation in the amount of [dollar amount] even if you don't answer all of the questions.

FEEDBACK AND PUBLICATION

During the interview there may be things that have been discussed which you may have concerns about. If you have any questions or concerns about yourself or your family, the researcher will distribute to all participants a list of names and phone numbers of people and agencies in your community that can assist with any questions or concerns that you might have.

A summary of the results of this research will be sent to you when the data have been analyzed, no later than [date]. Information from this research will be used to inform reports on the experiences of individuals who have experienced mental homelessness and health issues at each of the five sites that are part of this study, as well as a cross-site report developed by the national research team. Additionally, we plan to present the results of the research at professional and scientific conferences and to publish the findings in professional and scientific journals.

WHERE CAN I GET ADDITIONAL HELP OR RESOURCES IF I NEED THEM?

If you have any questions concerning the collection of this information, please contact:

[Site Researcher name and contact information]

or

[REB name and contact information for local university]

MHCC AT HOME/CHEZ SOI PROJECT

RESEARCH CONSENT FORM

I have received a copy of the INFORMED CONSENT STATEMENT. I have read it or had it read to me and understand it. It describes my involvement in the research and the information to be collected from me.

1. I agree to participate in an interview for this research.

   ○ Yes ○ No

2. I agree to have the interview audio-recorded.

   ○ Yes ○ No

3. I understand and agree that my quotations may appear in published reports.

   ○ Yes ○ No

____

Participant's Signature Date

____

Researcher's Signature Date

INTERVIEW GUIDE FOR BASELINE CONSUMER NARRATIVE MHCC AT HOME/CHEZ SOI PROJECT

Introduction

[Complete informed consent]

This interview is an opportunity for you to tell the story about your experiences living on the streets or in a shelter and your experiences with the mental health system. We're interested in learning about what life has been like before and after you started living on the streets or in a shelter. You've been asked about some of these issues in the previous interviews. This interview is an opportunity for you to share those experiences and to talk about your life using your own words. All of this will help us learn how the project works, so we can help make lives better for people who have been homeless. Take the time you need. For most people it takes about 90 minutes, but how much time we take to do the interview is up to you. We can take a break if you wish.

Just as a reminder, please be aware that your participation in the study is completely voluntary. You can decide not to participate, to withdraw your participation at any time, and to skip any questions that you do not wish to answer. Also, your decision to participate or not participate will not affect the services or support your receive. You may find some of these questions sensitive or disturbing. We will only proceed with the interview today if you feel comfortable doing so. We are interested in hearing about your life. Please keep in mind though that this is a research interview and not a clinical or therapeutic interview. If you do have concerns and questions about resources or support, we will be able to provide you with information after the interview. We will hold everything that you say in confidence. Please note that your name will not be associated in any way with your responses. You will receive a written summary of the findings when the research is completed.

Do you have any questions before we get started? I'm going to start the recorder now – is that still okay with you?

Part I: Story of Living on the Streets or in a Shelter

I'm interested in learning about your experiences with your housing situation. Now I'm going to ask you about that.

Theme 1: Pathways into Homelessness (or Precarious Housing)

a. Life before Homelessness

- Tell me please what life was life before you started living on the streets or in a shelter.
- Tell me about the first house or apartment that you remember. *(probes: things that kept you housed prior to homelessness; things that kept you housed;)*

b. How the Person First Became Homeless

- Now, I'd like to hear the story about how you first became homeless. *(issues or experiences that led to you living on the streets or in a shelter [e.g. relationships, poverty, health, exclusion, requirements for medication compliance/sobriety, re-hospitalization, etc.])*

c. Recurrent Experiences of Homelessness

- Have you been homeless more than once? If so, when you think of your various experiences with homelessness, please talk about any common barriers that stand in the way of your attempts to find and keep housing.

d. Most Recent Experience of Homelessness

- Tell me please about your most recent experience of becoming homeless. *(probes: how you found the housing your most recent housing; issues/experiences related to living on the streets or in a shelter; issues that prevented you from finding housing.)*

Theme 2: Life on the Streets or in a Shelter

Now, I'd like to talk about what life has been like for you while you've been living on the streets or in a shelter.

a. Typical Day

- First of all, I'd like you to tell me about what your average day is like. For example, if yesterday was an average day, tell me about what your day was like. *(probes: where did you sleep, places visited, people met with, nature of encounters with people, etc.)*

b. Services, Supports, and Community Organizations

- Now, I'd like you to tell me about the services, supports, or community organizations that you have used while living on the streets or in a shelter. *(probes: what they're like; types of services/supports/community organizations found to be most helpful [e.g., services, family, friends, church]; types of services/supports found to be least helpful; sort of involvement in the community while living on the streets or in a shelter?)*

c. Experiences with Housing

- Now I'd like you to tell me more about your experiences with housing during the period of time when your housing situation has been unstable. *(probes: places lived [quality, safety, support]; relationships with landlords, superintendents or neighbours; experience of stigma, discrimination or other barriers in relation to services and housing; any positive experiences)*

d. Vision for Housing for the Future

- Now, I'd like you to talk about how you envision your housing situation in the future and how you might get there. *(probes: what does home mean to you; what would be an ideal housing situation [individual vs. shared living situations; landlord relationships; location; safety issues]; the kinds of challenges that would have to be addressed to allow you to achieve a more ideal housing situation);*
- Only for those in one of the housing interventions – What do you think of the "At Home" intervention project in which you will be involved? *(probes: hopes, fears, challenges)*

e. Life on the Streets or in a Shelter

- I want to ask you a few general questions about life on the streets or in a shelter.

- How has your life changed since you started living on the streets or in a shelter? *(probe re: feelings about oneself, relationships, family, friends, health, involvement in the community, poverty, stigma, addictions)*
- What has been hardest since living on the streets or in a shelter? (probe re: feelings about oneself, relationships, family, friends, work, health, involvement in the community, poverty, stigma, addictions);
- What keeps you going? *(probe: what do you enjoy doing?)*

Theme 3: Experiences of Mental Health Issues and Mental Health Services

- In this part of the interview, I'd like to hear more about your experience with mental health issues and the mental health system.

a. First Experiences

- First of all, please talk about when you first remember thinking that something was different, or that something was not quite right. *(probes: what life was like at that time; feelings about oneself, relationships, family, friends, physical health, involvement in the community, poverty, stigma, addictions)*

b. Experiences with the Mental Health System

- What have been your experiences with receiving help from the mental health system?
- I'm interested in hearing about your experiences with the relationships that you've had with mental health professionals and service-providers. *(probes: first experiences; experience with mental health services and with mental health providers since that first time; current experiences; did services or providers meet needs; inadequate or unfair treatment; any changes or improvements needed)*

c. Recovery

- What would recovery (or healing) mean in your situation?
- What kind of support would you need to realize this idea of recovery or healing?

Part II: High-, Low-, and Turning Point Stories

In the final part of the interview, I'd like to ask you about some of the key moments in your life. So, I'm now going to ask you to highlight a high-point, a low-point, and a turning-point from your life. What would you like to start with? a high point, a low point, or a turning-point[5]?

> *Note to Interviewers: Make sure that the participant addresses all of the following questions, especially ones about impact and what the experience says about the person. Do not interrupt the description of the event. Rather ask for extra detail, if necessary, after the participant has finished initial description of the event*

a. High Point Story

- I would like you to reflect on a high point in your life, what you might think of as the best moment in your life. It could be a moment or time in your life where you experienced very positive feelings, such

[5] If the participant has already recounted a high-, low-, and/or turning-point story earlier, there is no need to ask about this again here at the end of the interview. However, be sure to clarify that the stories are high-, low- or turning- point stories for the participant, rather than assuming that they are.

as joy, excitement, happiness, or inner peace. Does an event or time like this come to mind? Describe it for me in detail. Make sure to tell me what led up to the scene, so that I can understand it in context. What happened in the scene? Where and when did it happen? Who was involved? What were you thinking and feeling in the event? Why is it an important event? What impact has this event had on who you are today?

b. Low Point Story *(note to interviewer: you may want to check in with person as to whether they've already told a low point story, especially if what they've already talked about sounds traumatic; however, you should leave the choice up to the participant about what topic constitutes the low point they choose to talk about)*

- Think back over your entire life and try to remember a specific experience or event where you felt really low: it could involve emotions such as deep sadness, fear, strong anxiety, terror, despair, guilt, or shame. You might think of this as the worst moment in your life. Please describe this scene for me in detail. Again, tell me what led up to the scene, so that I can understand it in context. Where and when did it happen? Who was involved? What happened? What were you thinking and feeling? Why is it an important event? What impact has this event had on who you are today?

c. Turning Point Story

- In looking back on your life, are there any big "turning points" that come to mind? This could be times when you experienced an important change in your life.
- IF YES: Please choose one key turning point scene and describe it in detail.
- IF NO: Describe a particular time in your life that comes closer than any other to qualifying as a turning point – a scene where you changed in some way.
- Again, tell me what led up to the scene. What happened? Where and when did it happen? Who was involved? What were you thinking and feeling? Why is it an important event? What impact has this event had on who you are today?

Ending the Interview

- How are you feeling right now?
- Is there anything that we have not covered that you think is important for me to know about how being homeless has affected your life?
- What are your plans for the future?
- What did you think of the interview?
- Did you feel comfortable doing this interview?
- Is there anything we can do to improve the interview?
- Do you have any questions of me?

Thank you very much for participating in this interview. I appreciate your willingness to share your story with me – this is an important part of the project.

INTERVIEW GUIDE FOR BASELINE CONSUMER NARRATIVE MHCC AT HOME/CHEZ SOI PROJECT

Introduction

[Complete informed consent]

This interview is an opportunity for you to tell the story about your experiences over the past year. We're interested in learning about your life experiences, personal changes, housing, and supports. You've been asked about some of these issues in the previous interviews. This interview is an opportunity for you to share those experiences and to talk about your life using your own words. All of this will help us learn how the project works, so we can help make lives better for people who have been homeless. Take the time you need. For most people it takes about 90 minutes, but how much time we take to do the interview is up to you. We can take a break if you wish.

Just as a reminder, please be aware that your participation in the study is completely voluntary. You can decide not to participate, to withdraw your participation at any time, and to skip any questions that you do not wish to answer. Also, your decision to participate or not participate will not affect the services or support your receive. You may find some of these questions sensitive or disturbing. We will only proceed with the interview today if you feel comfortable doing so. We are interested in hearing about your life. Please keep in mind though that this is a research interview and not a clinical or therapeutic interview. If you do have concerns and questions about resources or support, we will be able to provide you with information after the interview. We will hold everything that you say in confidence. Please note that your name will not be associated in any way with your responses. You will receive a written summary of the findings when the research is completed.

Do you have any questions before we get started? I'm going to start the recorder now – is that still okay with you?

Part I: Life story for the past year

I would like to hear about your experiences over the past year ... I will ask you some questions about some of your experiences.

Theme 1: Life Changes, Typical Day

a. Life Changes
   1. First of all, in general, please tell me about how your life has been over the past year.
   2. What has your housing situation been like over the past year?

b. Typical Day
   1. Tell me about what your average day is like or what you do on a typical day. For example, if yesterday was an average day, please tell me about what your day was like.
      a. What did you do?
      b. What places did you go to?
      c. Who did you meet?

2. How, if at all, has the way you spend your typical day changed over the last year?
    a. Why do you think this has changed?
    b. What are your favourite places to go in the community?
        - What do you do there?
        - How often do you go to these places?
    c. How easy or hard is it for you to get around your community?
    d. Who do you typically spend time with in the community?
    e. Tell me about any experiences of discrimination or stigma that you have experienced in the community in the past year?

Theme 2: Recovery/Mental Health/Wellbeing, Relationships, Material Situation

a. Recovery, Mental Health, and Wellbeing
    1. Please describe any personal changes that you have experienced over the last year with regard to your health or wellbeing.
    2. What has been helpful to your health or well-being over the last year? What keeps you going?
    3. What have you had difficulty with that has gotten in the way of your health or wellbeing over the last year?
    4. What mental health issues were you experiencing at the start of the At Home project? How have you been coping/dealing with these issues over the past year?

b. Relationships/Social Support
    1. Tell me a bit about your relationships over the past year. Have there been any important changes in your relationships during this time?
        a. Changes in relationships with family, friends or acquaintances (including new or renewed relationships)
        b. Changes in sense of community
        c. Changes in feelings of stigma
    2. Over the past year, who in the community have you been able to trust or count on for support?
        a. How have they supported you?

For participants who are parents. For participants who are NOT parents, proceed to section c: Material Situation below.

        b. How has housing instability affected your roles as a mother/father?
        c. (This question should be asked only of those parents who have obtained housing.) How has stable housing affected your role as a mother/father?

c. Material Situation

1. Tell me about your situation with money. Has it improved, stayed the same, or gotten worse over the past year?
    a. Probe about any changes
2. Tell me a bit about your financial responsibilities. How have you been managing those responsibilities over the past year?
3. How have you been eating over the past year?
    a. Probe about the quality of food and access to food

Theme 3: Housing

I. For the Treatment as Usual participants who have successfully obtained housing

1. How were you able to find your current housing?
2. What do you think of your housing?
    a. Privacy
    b. Quality
    c. Location
    d. Choice
3. What do you like most about your housing? What do you like least about your housing?
4. What is your understanding of your responsibilities as a tenant?
5. What have been your experiences with your landlord(s)?
6. How do you like your neighbourhood? (What do you like/not like about it?)
7. What has helped you to keep your apartment? What are the challenges in keeping your apartment?
8. Can you tell me about anything you find yourself missing about the way your life was before you became housed?

II. For all Treatment as Usual participants

1. What do you like most about your housing situation? (Note that this question might not be appropriate for participants who are still living on the street or shelter)
2. What do you like least about your housing situation?
3. If not housed, what are your current challenges?

III. For the Housing First intervention participants

1. What do you think of the housing that you have obtained through the At Home/Chez Soi project?
    a. Privacy
    b. Quality
    c. Location
    d. Choice
2. How did you select your apartment?
    a. Did you accept the first apartment that was presented to you? Why or why not?
    b. Would you make the same decision today? Why or why not?
3. What do you like most about your housing? What do you like least about your housing?
4. What is your understanding of your responsibilities as a tenant?
5. What is your understanding of the responsibilities of the At Home/ Chez Soi project?
6. What have been your experiences with your landlord(s)?
7. How do you like your neighbourhood?
8. What has helped you to keep your apartment?
9. What are the challenges in keeping your apartment?
10. Can you tell me about any aspects of your life before you became housed that you miss now that you have housing?

Theme 4: Mental Health Services

*Section differs depending on client group (ACT, ICM, TAU - see below)

I'd like to hear about your experiences with people working in the mental health services system during the past year. Tell me about the support and treatment that you have received from mental health service-providers during the last year.

For ACT clients (ask about):

1. Services/supports received through the team
    a. Which services offered in the last year have been the most helpful?
    b. Which services offered in the last year have been the least helpful?
    c. What other kinds of services have you been using in the past year, and what have your experiences been like with them?
        - Relationships with service providers
        - Experiences with medications
        - Types of information and support provided

2. Clinical supports, i.e. hospital-based care or treatment received outside of the team
    a. What has been helpful about the mental health services that you have used during the last year?
    b. What has been unhelpful about the mental health services that you have used during the last year?
    c. Relationships with service providers
    d. Experiences with medications
    e. Types of information and support provided
3. Other community services received outside of the team
    a. note: This information may be available through the service inventory so qualitative interview would be used to probe existing information rather than asking this question again
    b. I'd like to hear about your experiences with people working outside the health services system during the past year
        - Relationships with service providers
        - Experiences with medications
        - Types of information and support provided

For ICM clients (ask about):

1. Services received directly by their case manager
    a. What has been helpful about the mental health services that you have used during the last year?
    b. What has been unhelpful about the mental health services that you have used during the last year?
    c. Relationships with service providers
    d. Experiences with medications
    e. Types of information and support provided
2. Community services brokered through their case manager
    a. What has been helpful about the mental health services that you have used during the last year?
    b. What has been unhelpful about the mental health services that you have used during the last year?
    c. Relationships with service providers
    d. Experiences with medications
    e. Types of information and support provided
3. Hospital/treatment-related services received outside of the team
    a. I'd like to hear about your experiences with people working outside the health services system during the past year
    b. What has been helpful about the mental health services that you have used during the last year?
    c. What has been unhelpful about the mental health services that you have used during the last year?
    d. Relationships with service providers
    e. Experiences with medications
    f. Types of information and support provided

For TAU participants (ask about)

1. Any mental health services/supports that they have received
   a. What has been helpful about the mental health services that you have used during the last year?
   b. What has been unhelpful about the mental health services that you have used during the last year?
   c. Relationships with service providers?
   d. Experiences with medications?
   e. Types of information and support provided?

Theme 5: Hopes for the Future

I. Plan for the Future

1. What are your plans or goals for the coming months or further in the future?
   a. Social/relationship goals
   b. Occupational/work/school goals
   c. Other personal goals
2. What do you need to accomplish your future plans or goals?

II. Vision for Housing for the Future

1. Now, I'd like you to talk about how you envision your housing in the future and how you might get there.
   a. Ideal housing situation
   b. Challenges to obtaining ideal housing
   c. Pets

Part II: HIGH, LOW, AND TURNING POINT STORIES

In the final part of the interview, I'd like to ask you about some of the key moments in your life over the past year. So, I'm now going to ask you to highlight a high-point, a low-point, and a turning-point for the past year. What would you like to start with? a high point, a low point, or a turning-point[6]?

Note to Interviewers: Make sure that the participant addresses all of the following questions, especially ones about impact and what the experience says about the person. Do not interrupt the description of the event. Rather ask for extra detail, if necessary, after the participant has finished initial description of the event

I. High Point Story

I would like you to reflect on a high point in your life over the past year, what you might think of as the **best moment in your life over the past year**. Is there a high point that comes to mind?

[6] If the participant has already recounted a high-, low-, and/or turning-point story earlier, there is no need to ask about this again here at the end of the interview. However, be sure to clarify that the stories are high-, low- or turning- point stories for the participant, rather than assuming that they are.

Describe it for me in detail. It could be a moment or time where you experienced very positive feelings, such as joy, excitement, happiness, or inner peace. Make sure to tell me what led up to the scene, so that I can understand it in context.

- What happened?
- Where and when did it happen?
- Who was involved?
- What were you thinking and feeling?
- Why is it an important event?
- What impact has this event had on who you are today?

II. Low Point Story

(note to interviewer: you may want to check in with person as to whether they've already told a low point story, especially if what they've already talked about sounds traumatic; however, you should leave the choice up to the participant about what topic constitutes the low point they choose to talk about)

Think back over the past year and try to remember a specific experience or event where you felt really low. You might think of this as the worst moment in your life over the past year. Is there a low point that comes to mind?

Please describe this scene for me in detail. It could involve emotions such as deep sadness, fear, strong anxiety, terror, despair, guilt, or shame. Again, tell me what led up to the scene, so that I can understand it in context.

- What happened?
- Where and when did it happen?
- Who was involved?
- What were you thinking and feeling?
- Why is it an important event?
- What impact has this event had on who you are today?

Turning Point Story

In looking back on your life over the past year, I would like you to think of a particular time when you experienced an important change. Is there a big "turning point" that comes to mind? .

Describe it for me in detail. This could be one particular event or a moment or time where you experienced change or when you changed in some way. Again, tell me what led up to the scene.

- What happened?
- Where and when did it happen?
- Who was involved?
- What were you thinking and feeling?
- Why is it an important event?
- What impact has this event had on who you are today?

Concluding Remarks

- Consider asking participants if there is anything they would like to add regarding how their lives have been in the past year.
- Before we bring this interview to a close, I would like to ask if there is anything you wish to add about what you life has been like in the past year.
- I would also like to know about your experiences (how you feel, what you are thinking) about having participated today/tonight. What was it like for you to participate in this interview?
- Is there anything we could do to improve the interview?
- I am now shutting off the recorder. What questions do you have of me?
- Thank you very much for your participation in this interview. I appreciate your willingness to share your experiences with me.

FIELD NOTES TEMPLATE FOR CONSUMER NARRATIVE INTERVIEWS MHCC AT HOME/CHEZ SOI PROJECT

Participant Code # ____ Date: _____________________________________

Starting Time: ____ Finish Time: ______________________________

A. FIELD NOTES

Relevant background *(context, observations, pre-session info/comments re/by participant)*

Location of interview *(and observations on setting)*

Interview climate *(Nonverbal Behaviours, comfort level, etc.)*

Methodological issues (process or "how it went": strengths and needed improvements)

Post-session comments of relevance *(after tape recorder turned off)*

B. INITIAL HUNCHES/ANALYTIC IMPRESSIONS

(from session, from read through)

C. FOLLOW UP

Technological Problems to address

Needed Followup from Sessions (clarifications, missed info or questions; sharing info re methodological concerns with team, information, referral information, clinical attention needed by participant, etc.?.)

D. PERSONAL REFLECTIONS

(to be kept in a journal by interviewer, not entered in field note template) (use of self, emotions, reactions, over-attention to issues?)

TRANSCRIPTION PROTOCOL FOR CONSUMER NARRATIVE INTERVIEWS MHCC AT HOME/CHEZ SOI PROJECT

- File names should be in the following format: ID # XXX - MHCC Consumer Narratives
- Files should be saved in .doc, .docx, or .rtf format.
- The first paragraph of each file should be in the following format: Interview conducted (date) by (interviewer name); transcribed (date transcription completed) by (transcriptionist name).
- Please use 1 inch (left) and 2 inch (right) margins and Times New Roman 12 pt font.
- Pages and lines should be numbered. Page numbers should be inserted in the top right corner (in Microsoft Word, Insert Page Numbers). Line numbering in Microsoft Word can be inserted through Page Layout Line Numbers Continuous.
- If the interview follows a path that allows you to do so, please use the following headers in "Heading 1" style to divide the interview into sections:
  - Pathways into Homelessness
  - Life on the Streets or in a Shelter
  - First Experiences of Mental Health Issues
  - High Point Story
  - Low Point Story
  - Turning Point Story

  In each section of the interview, please use italics to indicate interviewer speech and plain text to indicate participant speech.
- Please transcribe speech as naturally as possible, including "you knows", "ums", etc.
- Insert paragraph breaks after all obvious changes of topic.
- Other transcription conventions that may prove useful:

[descriptor]	Descriptors of speech or behaviours in square parentheses e.g., [sarcastically], [laughter], [P# laughs]
(2.0)	Extended pause (seconds)
'Aw...'	Extended sounds shown by colons in proportion to the length of the sound
Word	Underline shows stress or emphasis
Wor-	Hyphen indicates that a word or sound is broken off
WORD	Increase in amplitude is shown by capital letters
(word)	Parenthesis bound uncertain transcription, the transcriber's "best guess"
((incomp))	Incomprehensible

- File Management: Completed transcripts should be saved to the Health Diaries site in the folder "Site Consumer Narratives Baseline Transcripts" under the name "ID # XXX - MHCC Consumer Narratives"
- Template: A template in MS Word format is attached to this transcription protocol.

- Interview conducted (date) by (interviewer name); transcribed (date transcription completed) by (transcriptionist name).
- **Pathways into Homelessness**
- *Interviewer's speech in italics*
- Participant responses in normal text
- **Life on the Streets or in a Shelter**
- **First Experiences of Mental Health Issues**
- **High Point Story**
- **Low Point Story**
- **Turning Point Story**

ESTABLISHING QUALITY IN THE CONSUMER NARRATIVE INTERVIEWS

This appendix is concerned with how we established the quality of the qualitative data for the At Home/Chez Soi consumer narrative interviews (Whittemore, Chase, & Mandle, 2001). In their article on auditing quality in social science research, Akkerman, Admiraal, Brekelmans, and Oost (2008) make a distinction between establishing the quality of data gathering and establishing the quality of data analysis and interpretation. This distinction seems useful for the qualitative research in the At Home/Chez Soi project.

Quality of the Data Gathering

A survey was done across the five sites to gather information on actions undertaken to ensure quality, and to stimulate reflection on the quality of consumer narrative data collection and analysis. As well, relevant literature on establishing quality in qualitative research was reviewed and ideas from those sources were incorporated into this document.
The primary concern regarding the quality of the consumer narrative interview data is "How well are the interviews conducted?" Criteria, questions, and methods to ensure the quality of the data gathering are outlined in the following table.

Table 10.1
Quality Assurance Methods for the Baseline and Follow-up Consumer Narrative Interviews

DATA ANALYSIS AND INTERPRETATION	
CRITERIA AND QUESTIONS	QUALITY ASSURANCE METHODS
SAMPLE SELECTION • How is the sample for the narratives being selected? • What steps are taken to ensure that the sample for the narratives reflects the larger sample? Is the process for selecting the sample documented?	• Site to provide write-up of sample selection, including any changes in sampling. • Site to provide a description of process for selecting a sample. For each participant selected, describe reason for inclusion. • If sites are also doing purposeful sampling (selecting specific cases for in-depth study, e.g., the experience of women who are homeless and who have children), document process for selecting this purposeful sample.
INTERVIEWERS • Who is conducting the interviews? Are peer interviewers involved? • How are the interviewers trained? • How are the interviewers supervised?	• Keep a record of all interviewers and the specific interviews they conducted. • Keep a record of interviewer training (when, where, participants, aims, outcomes) • Keep a record of interviewer supervision (by whom, how, how often)

DATA ANALYSIS AND INTERPRETATION	
CRITERIA AND QUESTIONS	QUALITY ASSURANCE METHODS
QUALITY OF INTERVIEWS • What steps are taken to ensure the quality of the narrative interviews? • Are the interviewers asking the questions about the main topics or questions in the interview guide? • Are the interviewers asking probes to follow up on important issues that are raised by those participants who are interviewed? • Does the interviewer demonstrate good listening skills in eliciting the experiences of the participants? • Sound quality: is the audio recording clear and easy to understand?	• Designate at least one person (Interview Supervisor) who is in charge of ensuring the quality of data • Each site's Interview Supervisor(s) to review a sample of at least five (three for Moncton because of their smaller sample) interviews (audio file, transcript) and provide feedback to interviewers on quality of the interview: - Housing First + ACT (1) - Housing First + ICM (1) - Treatment as Usual High Needs (1) - Treatment as Usual Moderate Needs (1) - Site-specific Program (1) • Use the Quality Control for Narrative Interviews Checklist (see Appendix II.A.6) based on the interview protocol to ensure that the main topics or questions are being asked, and that probes are being used (Shaffer et al., 2004) • Interviewers to review the audio files of their interviews and assess sound quality
TRANSCRIPTIONS • Is someone validating the accuracy of the transcriptions?	• Each site's Interview Supervisor(s) to review a sample of at least five (three for Moncton) transcripts and provide feedback to transcribers on accuracy: - Housing First + ACT (1) - Housing First + ICM (1) - Care as Usual High Needs (1) - Care as Usual Moderate Needs (1) - Site-specific Program (1)
EXTERNAL VALIDATION • What steps are being taken by external members to ensure quality of interviews?	• Members of the National Qualitative Research Team will review the same sample of five (three for Moncton) interviews (audio file, transcripts) reviewed by each site and provide feedback on the quality of the interviews to the site's Interview Supervisor: - Housing First + ACT (1) - Housing First + ICM (1) - Care as Usual High Needs (1) - Care as Usual Moderate Needs (1) - Site specific Program (1) • Discussions during National Qualitative Research Team Meetings on issues and specific cases surrounding quality of data collection

Quality of the Data Analysis and Interpretation

Lincoln and Guba (1985) argue that qualitative researchers must be able to establish the trustworthiness of their data. "The basic issue in relation to trustworthiness is simple: How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of? What arguments can be mounted, what criteria invoked, what questions asked, and what would be persuasive on this issue?" (p. 290). Lincoln and Guba propose four criteria for trustworthiness and several techniques for meeting these trustworthiness criteria (see Chapter 11 in their 1985 book). The four criteria are as follows:

a. Credibility - To demonstrate the "truth value" of one's findings, one must adequately represent multiple constructions of reality. Some of the techniques that they suggest that can determine credibility are field activities that enhance credibility (prolonged engagement in the setting, persistent observation, and triangulation of sources, methods, and/or investigators), peer debriefing, and member checks. Feeding back the information to participants for verification in the research is very important for establishing the credibility of the research.

b. Transferability - This refers to the extent to which the findings can be transferred to another context. Since findings are context-bound, it is necessary to provide a "thick description" of the context. In this way, if findings are found or not found to transfer to other contexts, the researchers can consider similarities or differences in context that might account for the transferability or non-transferability of the findings.

c. Dependability - The extent to which findings are consistent or dependable can be verified through what Lincoln and Guba (1985) refer to as an "audit trail." The audit trail consists of a documentation of all the steps that were taken to analyse the data. In this regard, it is important to keep a journal or record of everything that was done in the data analysis.

d. Confirmability - While naturalistic inquiry assumes that objectivity is impossible, it does suggest that the data themselves can be confirmed through an audit process as well.

Some potential criteria/questions and methods to establish whether the criteria are being met are as follows.

Table 10.2
Quality Assurance Methods for the Baseline and Follow-up Consumer Narrative Interviews

DATA COLLECTION	
CRITERIA AND QUESTIONS	QUALITY ASSURANCE METHODS
MEMBERS OF THE SITE TEAMS • Who is involved in the analysis? How are researchers, staff, consumers involved? • Are interviewers also involved in data analysis? Are they analyzing the interviews they conducted?	• Site to provide a description of the role of site members in the analysis of data • Keep a record of the role of interviewers, if any, in data analysis
CODING • How many people are coding interviews? • Are coders using the Coding Template for Narrative Interviews • How are codes/categories/themes developed? • How is consensus reached on coding?	• Triangulation: have at least two people involved in coding • Completion of Coding Template for Narrative Interviews for the data analysis • Reflexive journal: coders keep a journal of their process of coding and data analysis • Keep a record of decisions taken throughout the coding process, focusing as much on cases in which coders disagree as on cases in which they agree (Clavarino et al., 1995)

DATA COLLECTION	
CRITERIA AND QUESTIONS	QUALITY ASSURANCE METHODS
FIELD NOTES • Are the interviewers completing field notes after each interview?	• Field notes to be completed after each interview, matched to interview transcript and incorporated into the data analysis
AUDIT TRAIL • Are all steps in the data analysis documented, including decisions being taken?	• Keep a written record of the audio tapes, transcriptions, field notes, meetings, key methodological decisions taken during each phase of the research for audit trail
EXTERNAL VALIDATION • What steps are being taken by external members to ensure the quality of the data analysis?	• Members of National Qualitative Research Team to provide broad coding template for narrative interviews, and exchange on coding with sites • Discussions during National Qualitative Research Team Meetings on issues and specific cases surrounding quality of data analysis and interpretation

QUALITY CONTROL FOR BASELINE CONSUMER NARRATIVE INTERVIEW CHECKLIST MHCC AT HOME/CHEZ SOI PROJECT

Length of the interview (in minutes): ____

Interview Data

The interviewer asked questions and probes to the participant about the following topics:

PART I: STORY OF LIVING ON THE STREETS OR IN A SHELTER

Theme 1: Pathways into Homelessness (or Precarious Housing)

- ◯ a. Life before Homelessness
- ◯ b. How the Person First Became Homeless
- ◯ c. Recurrent Experiences of Homelessness
- ◯ d. Most Recent Experience of Homelessness

Theme 2: Life on the Streets or in a Shelter

- ◯ a. Typical Day
- ◯ b. Services, Supports, and Community Organizations
- ◯ c. Experiences with Housing
- ◯ d. Vision for Housing for the Future
- ◯ e. Life on the Streets or in a Shelter

Theme 3: Experiences of Mental Health Issues and Mental Health Services

- ◯ a. First Experiences
- ◯ b. Experiences with the Mental Health System
- ◯ c. Recovery

PART II: HIGH-, LOW-, AND TURNING POINT STORIES

- ◯ a. High Point Story
- ◯ b. Low Point Story
- ◯ c. Turning Point Story

Interviewing

Questioning

- ◯ The interviewer seemed comfortable using the interview guide.
- ◯ The interview asked questions in a clear manner, spoken distinctly and understandably.
- ◯ The interviewer was able to interpret questions and rephrase questions that were unclear to the participant.
- ◯ The interview was able to retain and bring up information from the participant's answers given earlier in the interview.
- ◯ The interviewer demonstrated a neutral attitude and allowed the participant to elaborate on answers without expressing disapproval, judgment or bias.

Structuring the interview

- ◯ The interviewer made smooth transition between sections by using the transition messages contained in the interview guide.
- ◯ The interviewer was able to recognize when the participant provided a response that addressed a separate question or a scripted follow-up question.

Probing

- ◯ The interviewer used the probes suggested in the interview guide to capture an adequate degree of depth and detail of the participant's experience.
- ◯ The interviewed made effective use of probing techniques: e.g. repeating; summarizing; reflecting participant's tone; asking for more information, clarifications, or focus.
- ◯ The interviewer knew which probes and reinforcements to use to elicit needed information that was missing in the participant's initial response.
- ◯ The interviewer used probes appropriately for the high, low, and turning point stories.

QUALITY CONTROL FOR 18-MONTH FOLLOW-UP CONSUMER NARRATIVE INTERVIEW CHECKLIST MHCC AT HOME/CHEZ SOI PROJECT

Length of the interview (in minutes): ____

Interview Data

The interviewer asked questions and probes to the participant about the following topics:

PART I: LIFE STORY FOR THE PAST YEAR

Theme 1: Life Changes, Typical Day

a. Life Changes

b. Typical Day

Theme 2: Recovery/Mental Health/Well-being, Relationships, Material Situation

a. Recovery, Mental Health, and Well-being

b. Relationships/Social Support

c. Material Situation

Theme 3: Housing

a. Perceptions on housing situation

b. Facilitators/Barriers to keeping housing

c. Experiences as a tenant/w landlord/in neighbourhood

Theme 4: Mental Health Services

For ACT participant

a. Services/supports received through the team

b. Clinical supports, i.e. care or treatment received outside of the team

c. Other community services received outside of the team

For ICM participant

a. Services received directly by their case manager

b. Community services brokered through their case manager

c. Hospital/treatment-related services received outside the team

For TAU participant

a. Any mental health services/supports that they have received

Theme 5: Hopes for the Future

a. Plan for the future

b. Vision for housing for the future

PART II: HIGH-, LOW-, AND TURNING POINT STORIES

a. High Point Story

b. Low Point Story

c. Turning Point Story

Interviewing

Questioning

The interviewer seemed comfortable using the interview guide.

The interviewer asked questions in a clear manner, spoken distinctly and understandably.

The interviewer was able to interpret questions and rephrase questions that were unclear to the participant (Mack et al., 2005).

The interviewer was able to retain and bring up information from the participant's answers given earlier in the interview (Kvale, 1996).

The interviewer demonstrated a neutral attitude and allowed the participant to elaborate on answers without expressing disapproval, judgment or bias (Kvale, 1996).

Structuring the interview

The interviewer made smooth transition between sections by using the transition messages contained in the interview guide..

The interviewer was able to recognize when the participant provided a response that addressed a separate question or a scripted follow-up question (Mack et al., 2005).

Probing

The interviewer used the probes suggested in the interview guide to capture an adequate degree of depth and detail of the participant's experience.

The interviewed made effective use of probing techniques: e.g. repeating; summarizing; reflecting participant's tone; asking for more information, clarifications, or focus (Kvale, 1996).

The interviewer knew which probes and reinforcements to use to elicit needed information that was missing in the participant's initial response (Mack et al., 2005).