



Mental Health
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of Canada

Commission de
la santé mentale
du Canada

Baseline Consumer Narratives of Lived Experience of the Mental Health Commission of Canada's At Home/Chez Soi Project:

CROSS-SITE REPORT

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CROSS-SITE REPORT

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KEY MESSAGES

This report documents the findings of the baseline consumer narrative interviews of the At Home/Chez Soi initiative. It provides a summary of the emergent themes from each of the five sites, based on the individual site reports. These baseline consumer narratives will enable the research teams to analyze the nature and extent of change in comparison to the 18-month follow-up narratives. The overall objective of this report is to identify key themes regarding: (1) pathways into homelessness, (2) life on the streets and in a shelter, and (3) experiences of mental health issues and mental health services.

Pathways into homelessness: The analysis revealed that family discord, abusive relationships, substance use, mental illness, the loss of a loved one, trauma, financial hardship, problematic transitions from institutional settings, and other difficult life events precipitated homelessness for most participants.

Life on the streets/in a shelter: For participants, survival entails learning how to navigate the streets and struggling to cope with ongoing addictions and mental health problems. Prior to involvement in the At Home/Chez Soi project, most participants described overwhelmingly negative experiences with housing. When envisioning the future, participants emphasized the importance of securing and maintaining safe housing, which would provide them with a sense of permanence and security, allowing them to pursue work or school and establish or re-establish meaningful relationships.

Experiences of mental health issues and mental health services: Most participants reported first experiencing mental health symptoms during middle childhood or adolescence. Early family problems, difficulties with relationships, early substance use, and trauma from child abuse were identified as contributing factors to mental health problems. While many participants described heavy service use, others avoided services completely, due to stigma, discomfort, and a perceived lack of personal safety. Overall, participants did not perceive that service providers listened to them, leading them to feel increasingly stigmatized.

Several cross-cutting themes emerged: (1) stigma and discrimination are pervasive in the lives of participants; (2) contextual and environmental factors underlying homelessness are important to understand; (3) complex interrelationships exist between substance use, mental illness, relationship difficulties, and barriers to housing in the lives of participants; (4) participants desire greater social support; (5) participants experience a general sense of mistrust and dissatisfaction with mental health services; (6) participants discuss widespread experiences of trauma; (7) participants convey a sense of hope, in spite of significant obstacles; (8) housing occupies an essential role as participants envision a different future.

The widespread experience of stigma and discrimination underscores the need for interventions to support participants in developing relationships and becoming integrated into their communities. Chronic homelessness is not just a problem faced by individuals, but is heavily influenced by structural injustices and economic inequalities. It is important to collaborate with participants to facilitate social opportunities and to improve relationships and social skills as they work toward recovery. Previous mistrust and dissatisfaction with mental health services may lead to initial reluctance to engage with service providers at an early stage of the intervention. Housing was identified as a factor that contributes to the participants' vision of a more fulfilling future, suggesting that individuals can work on barriers to recovery most effectively when the basic need for stable housing is met.

EXECUTIVE SUMMARY

This report documents the findings of the baseline consumer narrative interviews of the At Home/Chez Soi initiative. It provides a summary of the emergent themes from each of the five sites, based on the individual site reports. Designed to complement the traditional outcome measures collected for the project, the baseline consumer narratives were elicited to understand the lived experiences of participants through life story interviews. These baseline consumer narratives will enable the research teams to analyze the nature and extent of change in comparison to the 18-month follow-up narratives. The overall objective of this report is to identify key themes regarding: (1) pathways into homelessness, (2) life on the streets and in a shelter, and (3) experiences of mental health issues and mental health services.

Pathways into homelessness: The analysis revealed that family discord, abusive relationships, substance use, mental illness, the loss of a loved one, trauma, financial hardship, problematic transitions from institutional settings, and other difficult life events precipitated homelessness for most participants.

Life on the streets/in a shelter: Participants emphasized their struggles to survive through securing shelter, food, and clothing. Finding shelter emerged as their most significant concern, above maintaining physical and mental health and wellbeing. For participants, survival entails learning how to navigate the streets and struggling to cope with ongoing addictions and mental health problems. A typical day in the life of participants was described as boring and repetitive. Participants seek establishments that are open 24 hours per day and try to sleep in relatively safe places. For many, drug use is a central activity, along with finding opportunities to make money. Most participants described the negative impact their typical daily activities had on their self-esteem and sense of identity. Participants reported using a number of services, including shelters, soup kitchens, and community centres. While many described heavy service use, others avoided services completely, due to stigma, discomfort, and a lack of personal safety, particularly in shelters. Most discourse on shelters revolved around negative aspects, including the lack of safety, cleanliness, rampant substance use, and concerns about or experiences of violence. When discussing relationships, participants indicated a desire for stable and healthy social supports, yet often reported a lack of such relationships in their lives. Participants emphasized differences between relationships of convenience with street-involved acquaintances, and real relationships, characterized by mutual support and caring. Prior to involvement in the At Home/Chez Soi project, most participants described overwhelmingly negative experiences with housing. Previous housing lacked privacy and cooking facilities and was perceived as unsafe, dirty, and infested. Participants reported that they were discriminated against when seeking housing due to welfare status, race, ethnicity, and/or sexuality, mental health problems, and/or appearance. Some were evicted from previous housing following psychiatric hospitalization.

Experience of mental health issues and mental health services: When envisioning the future, participants emphasized the importance of securing and maintaining safe housing, which would provide them with a sense of permanence and security. For some, their envisioned futures entailed pursuing work or school, and establishing or re-establishing meaningful relationships. Participants viewed mental health symptoms, drug use and relapse, associations with problematic neighbourhoods, boredom, loneliness, financial problems, and a lack of support as potential barriers to achieving a preferred future.

Most participants reported first experiencing mental health symptoms during middle childhood or adolescence. Early family problems, difficulties with relationships, and trauma from child abuse were identified as contributing factors to mental health problems. For many, early substance use compounded these problems. The accumulation of stress from addiction, family and relationship problems, a lack of social support, and difficulties securing and maintaining housing contributed to ongoing mental health difficulties.

Participants described long histories of involvement with mental health services. Psychiatric hospitalization was commonly experienced, and many reported accessing community mental health services and crisis services. Many participants received medication as a central component of treatment, and perceptions of medication were mixed.

Both positive and negative interactions with service providers were reported, though most participants described interactions as problematic. Participants did not perceive that service providers listened to them and respected them, leading them to feel increasingly stigmatized and invalidated. Many reported that services are designed in a manner that leads consumers to become dependent and disempowered. Participants described recovery as the potential to heal and to move toward greater self-acceptance. For many, recovery would allow them to re-establish relationships, reconnect with faith and spirituality, reduce or abstain from substance use, and address mental health problems.

Several cross-cutting themes emerged: (1) stigma and discrimination are pervasive in the lives of participants; (2) contextual and environmental factors underlying homelessness are important; (3) complex interrelationships exist between substance use, mental illness, relationship difficulties, and barriers to housing in the lives of participants; (4) participants desire greater social support; (5) participants experience a general sense of mistrust and dissatisfaction with mental health services; (6) participants discuss widespread experiences of trauma; (7) participants convey a sense of hope, in spite of significant obstacles; (8) housing occupies an essential role as participants envision a different future.

The experience of stigma and discrimination was among the most salient themes across the five sites. The participants described being stigmatized by their families, in shelters, and on the streets. For many participants, the experience of stigma caused them to avoid accessing services. Discrimination limited the participants' opportunities to obtain work, education, and stable and safe housing, contributing to continued marginalization. Many participants internalized the stigma they routinely experienced. Stigma adversely impacted their identities, leading to further social isolation and poor self-esteem.

Additionally, several sites described the importance of understanding environmental and contextual factors that shape the lives and experiences of individuals who are homeless. Among these contextual factors is the nature and character of neighbourhoods where participants spend much of their time. Many participants feel trapped in neighbourhoods with widespread substance use problems and high concentrations of homelessness, as affordable housing, shelters, and services tend to be centralized there. Further, all sites described how substance use, mental illness, problematic relationships, and difficulties securing housing are interrelated for the participants. The participants described how problems in each domain contributed to other concerns in their lives. Another key theme across the sites is the perceived importance of social support in the lives of participants, but the sense that healthy relationships are lacking or absent.

The participants reported widespread concerns, problems, and a general sense of mistrust regarding psychiatric services. Many participants described undesirable side effects of medication and emphasized that they would prefer to have opportunities to speak with someone who will listen, as opposed to being placed on medication as a first course of action. Others reported problems with the disjointed care that resulted from multiple hospitalizations, and participants expressed significant concerns about being subjected to involuntary treatment. The participants described widespread experiences of trauma, including childhood abuse and experiences of loss and violence during adulthood. Numerous participants described hopes for the future, including a desire to recover by managing mental health symptoms and reducing or abstaining from substance use. Further, many participants hoped to become involved in work or education, to maintain safe and stable housing, and to develop more healthy and satisfying relationships. For many participants, housing plays an important role in facilitating hopes for recovery and their visions for the future.

These cross-cutting themes suggest particular lessons. The widespread experience of stigma and discrimination underscores the need for interventions and services to support participants in developing social relationships and in becoming integrated into their communities as valued members. From a policy standpoint, this finding suggests the need for campaigns to address and minimize stigma and discrimination. Further, it is essential to understand the neighbourhood, community, social, and cultural contexts in which the participants are embedded. Chronic homelessness is not just a problem faced by individuals, but is heavily influenced by structural injustices and economic inequalities.

Issues of mental illness, substance use, relationship problems, and barriers to housing are complex and intertwined. Thus, there is a need to identify the unique strengths and needs of each participant, and to offer supports that best address barriers to recovery and to maintaining housing. It is important to collaborate with participants to facilitate social opportunities and to improve relationships and social skills as they work toward recovery. Previous mistrust and dissatisfaction with mental health services discussed by participants provides a reminder about the need to understand initial reluctance to engage with service providers at an early stage of the intervention. Further, the findings underscore the importance of trauma-informed care, as experiences of early developmental trauma and ongoing trauma during adulthood were pervasive. The Housing First model promotes choice and agency, which can be a more respectful way of initiating collaborative relationships with service users. Housing was identified as a key factor that contributes to the participants' vision of a more fulfilling future. This finding also supports the logic model of the Housing First intervention, which holds that individuals can work on barriers to recovery most effectively when the basic need for stable housing is met.

ACKNOWLEDGMENTS

This cross-site report is based on the baseline consumer narrative site reports from Moncton, Montréal, Toronto, Winnipeg, and Vancouver. We would like to acknowledge and thank the members of the Qualitative Research Team for their dedication in collecting and analyzing the data and developing the individual site reports. We would also like to thank the members of the Qualitative Research Team for their feedback on earlier versions of this cross-site report.

The five site reports are:

Rapport sur les récits de vie de base. Rapport écrit par Natasha Prévost pour l'étude en milieu rural et Danielle Nolin pour le site de Moncton. Entrevues réalisées et analyse effectuée pour l'étude en milieu rural par Linsay Flowers, Danielle Nolin et Natasha Prévost. Pour le site de Moncton par Hélène Albert, Danielle Nolin et Lise Savoie.

Chez soi: Projet de recherche et de démonstration sur la santé mentale et l'itinérance de Montréal: Premier rapport sur les récits de vie. (2012, février) par Christopher McAll, Pierre-Luc Lupien, & Antoine Rode avec la collaboration de Aimee Fleury et Marc-Andre Menard.

At Home/Chez Soi Project baseline consumer narrative report - Toronto. (February, 2012) by Marrit Kirst, Deborah Wise Harris, Erin Plenert, Jeyagobi Jeyaratnam, Bonnie Kirsh, Patricia O'Campo, Vicky Stergiopoulos, & Stephen Hwang. Centre for Research on Inner City Health, St. Michael's Hospital.

At Home/Chez Soi research demonstration project Winnipeg baseline consumer narrative report. (February, 2012) by Corinne Isaak. University of Manitoba, Department of Psychiatry.

Baseline personal story interviews from the Vancouver At Home study. (February, 2012) by Michelle Patterson, Melinda Markey, & Faith Eiboff. Simon Fraser University, Faculty of Health Sciences.

¹ For more information please refer to: <http://www.mentalhealthcommission.ca>

² For more information on past Advisory Committees please refer to: <http://www.mentalhealthcommission.ca>

INTRODUCTION

This report presents a synthesis of the findings of the baseline consumer narrative interviews collected for the At Home/ Chez Soi project¹. This pan-Canadian project, which is funded by the Mental Health Commission of Canada (MHCC),² is a five-year research demonstration study exploring interventions for adults who are homeless and have mental illnesses. At Home/Chez Soi applies evidence-based interventions in the Canadian context to better understand which housing, service, and system interventions can best help adults experiencing homelessness with mental illnesses. The At Home/ Chez Soi project has been implemented in five Canadian cities: Moncton, Montréal, Toronto, Winnipeg, and Vancouver. A detailed description of the five sites is provided in Appendix A.

This report focuses on the baseline consumer narratives that were collected through semi-structured individual interviews from December 2009 to June 2011. The At Home/Chez Soi project is a randomized controlled trial (RCT) of Housing First versus Treatment as Usual (TAU) (Goering et al., 2011; Nelson, Goering, & Tsemberis, 2012; Tsemberis, Gulcur, & Nakae, 2004). Within each experimental condition, there are two groups of participants: (1) individuals classified as having high needs, who receive support from Assertive Community Treatment (ACT) teams in the Housing First condition, and (2) individuals with moderate needs, who receive services from Intensive Case Management (ICM) programs in the Housing First condition. Each of the five research sites had the option of developing a “third arm”, meaning an intervention condition that was tailored to address specific needs within their local context. At the time of data collection, participants in the Housing First condition were either awaiting housing or had very recently received housing. The principles of Housing First can be found in Appendix B.

The purpose of this research on the baseline consumer narratives is to understand the lived experience of consumers through life story interviews. This component of the research was designed to provide a baseline of these lived experiences, which will enable the researchers to perform an analysis of change in the consumers’ narratives over time. The baseline narrative analysis was designed to complement the more traditional outcome measures collected for the project.

There are three main **objectives** of this research::

- 1. To identify themes regarding (a) pathways into homelessness, (b) life on the street or in a shelter, and (c) experiences of mental health issues and mental health services;**
- 2. To identify new or unexpected themes about issues surrounding homelessness; and**
- 3. To provide an understanding of the lived experiences of the participants at baseline, which will provide a point of comparison with the 18-month follow-up interviews.**

¹The 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 (McNaughton, 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, McNaughton, Eckerle Curwood, Egalité, Piat, & Goering, 2011).

²The Mental Health Commission of Canada (MHCC) is a catalyst for improving the mental health system and changing the attitudes and behaviours of Canadians around mental health issues. Through its unique mandate from Health Canada, the MHCC brings together leaders and organizations from across the country to accelerate these changes. The MHCC is funded by Health Canada and has a 10-year mandate (2007-2017). Among its initiatives, the MHCC’s work includes the country’s first mental health strategy, working to reduce stigma, advancing knowledge exchange in mental health, and examining how best to help people who are homeless and living with mental health problems.

The central research questions guiding this study of the baseline consumer narratives are:

1. **What are the pathways into homelessness?**
2. **How do consumers describe life on the streets and in shelters?**
3. **How do consumers envision the future?**
4. **How do participants describe their experiences with mental illness and with the mental health system?**
5. **What cross-cutting themes emerge from the baseline consumer narratives across the five sites?**

BRIEF METHODOLOGY³

RESEARCH APPROACH

Given the exploratory nature of this phase of the research, qualitative methods were used to examine the manner in which people who experience both homelessness and serious mental health problems construct their life stories and understand their experiences of homelessness, housing, and the mental health system (Padgett, 1998). Moreover, we adopted a social constructionist approach to the research (Guba & Lincoln, 2005). Accordingly, we do not suggest that the findings reported here reflect any singular “truth” about such a reality; rather, we present findings that reflect the multiple constructions or experiences of research participants involved with the At Home/Chez Soi project.

SAMPLING AND SAMPLE

Across each of the five sites, sampling was purposeful in order to ensure diverse representation of participants (e.g., gender, ethnicity, age, sexuality, etc.). In some cases (e.g., Winnipeg and Toronto) sampling was stratified by study group (i.e., High Need Treatment As Usual, High Need ACT, Ethno-racial ICM, etc.); while in other cases (e.g., Vancouver and Montréal), sampling was randomized (e.g., every tenth person enrolled in the program was selected to complete a baseline narrative interview). The goal was to obtain 10 per cent of the larger sample, or about 10 participants for each of the treatment and control groups at each site.

In all, 225 consumer narrative interviews were conducted in English and French between December 2009 and June 2011. Demographic characteristics of participants varied by site, but more males were interviewed than females; the average age was low to mid 40s; and participant ethnicity was representative of the full study sample at each project site.

DATA COLLECTION

The approach to data analysis at each of the sites involved thematic analysis and content coding (Morse & Field, 1995). Site researchers sought and identified “common threads” throughout the data, drawing out significant concepts that emerged from individual interviews along with cross-cutting themes and concepts that occurred across interviews. Site researchers also used the constant comparative method of making comparisons during each stage of the analysis to further develop themes (Charmaz, 2006). Some sites (e.g., Toronto and Winnipeg) explicitly stated using grounded theory methodology which employs inductive strategies, systematic coding, and comparative analysis procedures to analyze individual interview cases, develop conceptual categories, and build up to theoretical frameworks (Charmaz, 1990; Strauss & Corbin, 1990). Some sites (e.g., Toronto and Moncton) employed qualitative data analysis software (e.g., NVivo and Transana), whereas other sites (e.g., Montréal) created word processing documents synthesizing transcripts and coding frameworks. See Appendix E for the general coding template used across the sites.

After sites reached consensus regarding transcript coding, qualitative researchers at each of the sites produced site reports summarizing content areas across the consumer baseline narrative interviews. After receiving reports from each site, we fleshed out a framework for creating the cross-site report that was based on (1) the primary content areas covered in the Baseline Consumer Narrative Interview Guide; and (2) the content coding categories reported by each site. During a conference call of the National Qualitative Research Team, consensus was reached to use this framework to create the cross-site report. The cross-site report relied on the site reports as the source of data rather than reviewing transcripts or other data from each site. Not working directly with the transcripts constituted a limitation in undertaking this secondary analysis, although each site provided evidence demonstrating the quality of the data (see below).

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

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

ASSESSING QUALITY OF DATA

Before interviewing commenced at each site, all interviewers were trained on qualitative interviewing and how to use the Baseline Consumer Narrative Interview Guide. Sites conducted early and ongoing checks of initial interviews, providing interviewers with feedback regarding interview length, listening skills, building rapport, respecting the integrity of participants, and so forth. Members of the National Qualitative Research Team also conducted a quality assurance review of the audio and transcript files for five interviews per site and provided feedback where necessary (see Appendix D for the Quality Control checklist).

Once coding began, sites met regularly to discuss coding frameworks and to reach consensus regarding key content areas. The constant comparative method of coding and refining themes ensured that researchers were engaged in critical reflection regarding the content and quality of data. Some sites performed additional measures to ensure reliability during the coding process. For example, researchers and interviewers at the Toronto site double-coded six interview transcripts, met regularly to compare the accuracy of their codes, and refined coding where discrepancies existed. In general, there was a high degree of consensus in the coding for each site.

FINDINGS

The findings are organized into the following sections: (a) pathways into homelessness;(b) life on the streets; and (c) experience with mental health issues and mental health services. Emergent themes across the sites are described, and illustrative quotes are provided to capture the lived experience of homelessness in the voices of the participants.

PATHWAYS INTO HOMELESSNESS

Life before homelessness. Some participants reported happy, stable childhoods and positive relationships with family members and loved ones before they became homeless. A number of participants discussed how partners and family members provided them with security and support with cooking, child care, and other daily tasks. Living with romantic partners was noted as a particularly positive experience:

“Yeah, it’s good there you know, they are like a family, like...you know, when you have a woman living with you...and when you are living alone, it’s not the same.” (Toronto report, p. 14).

Participants also recalled times when they had nice, stable housing:

“Well, it was nice in a sense that it had two French windows um, and it was fairly spacious...it was green every year at the front, there was a good view of the Toronto skyline at the back...” (Toronto report, p. 15).

However, the family histories described by most participants highlight an “intergenerational cycle of poverty, abuse, mental illness, alcohol, and drug abuse” (Vancouver report, p. 14). Histories of abuse were particularly salient for female participants. For example, only one out of 16 female participants at the Montréal site reported fond memories of childhood; and 31 per cent of female participants in Montréal reported experiences of sexual abuse and incest.

Aboriginal participants in Vancouver reported early housing instability via repeated moves on and off a reserve. Numerous participants across all five sites discussed coming from unstable backgrounds in which they moved often and lived with different family members, in foster care homes, or in juvenile detention settings due to parental substance use, divorce, abusive relationships, or death of family members:

“They put me in a house with a family of more than six children, mother, father. Worse, they put my younger brother with another family. He [the husband] drank every weekend...the woman [the wife] ran into the attic all the time because she did not want to fight with him.” (Moncton report, p. 18).

In addition to early housing instability, participants reported difficulties in school, with many either dropping out or being expelled. Participants also described feeling isolated and having difficulties fitting in with others in social situations. Some struggled with being bullied and teased:

“Kids used to tease me at school. I got tired of it, and I left home when I was 13. So, I only had a grade 7 education...” (Vancouver report, p. 15).

Although some participants reported becoming homeless when they left home for the first time, others were provided with housing through social services, and some moved into apartments with friends, roommates or romantic partners. Some also moved to seek out education or work:

“The first time I moved, I think I was 21 or 22. I moved to go to University.” (Moncton report, p. 14).

Precipitators of initial homelessness. Whether participants had experienced stable or unstable lives before homelessness, many cited negative events, experiences or circumstances that led them into homelessness. As already mentioned, participants’ ties to family and the circumstances around leaving their family homes impacted future housing stability. Some participants became homeless after being kicked out of family homes or running away to escape abuse or conflict. Others became homeless as a result of the death of parents or guardians.

Similarly, several participants cited the loss of romantic partners due to death or divorce as a cause of initial homelessness. One participant recounts losing her assets to her ex-husband:

“I think it all started with my divorce, my kid’s father—my husband—he practically took everything from me and worse he scammed welfare, and I have to pay for it. He just left me without nothing. He left with all of our money and all the furniture and the appliances in the house.” (Toronto report, p. 16).

One of the most frequently cited contributors to initial homelessness across all five sites was substance use problems. At the Montréal site, for instance, 41 per cent of participants noted substance use as the primary precipitator of homelessness. In many cases across sites, substance use was discussed as a way to cope with other life stressors, including family issues, unhealthy relationships, and trauma:

“My daughter died. She was killed by a drunk driver. And it just sent me over the deep end, and I ended up blowing a million and a half dollars on drugs over the last 10 years... I totally lost it.” (Vancouver report, p. 16).

Participants also discussed the manner in which substance use contributed to other factors, which then led to homelessness. For example, in some cases, landlords became aware that drug dealing or substance use activity was taking place at participants’ homes, and they were subsequently evicted. Drug and alcohol use also impacted participants’ ability to maintain employment and afford housing.

Numerous participants also cited the role of mental health problems in their initial homeless experiences. For example, compromised psychosocial functioning such as anxiety, severe depression and paranoia made it hard for some participants to use public transit or to be around other people, which in turn prohibited them from gaining employment or accessing government assistance programs. Some participants at the Winnipeg site admitted to having poor anger management and conflict resolution skills, which led to irritation and aggression toward landlords or neighbours. This behaviour, in turn, led to evictions. The presence of mental health problems was cited as an explanatory factor for initial homelessness by 28 per cent of participants at the Montréal site. For participants across sites, repeated hospitalizations led to housing instability and eventual homelessness, while for others, having a mental illness led to other unhealthy behaviours (e.g., substance use, harmful relationships, and poor financial decisions), which then brought about the initial episode of homelessness.

Other circumstances, including financial hardship, lack of safe and affordable housing, lack of education, and having few life skills, were frequently cited as contributors to homelessness. Several participants voiced concern over the lack of transitional support services for individuals released from institutional settings, such as psychiatric hospitals, juvenile detention centres and prisons:

“When my time was up, they just kicked you out. And they didn’t tell you to set up anything or go anywhere. They just said, ‘Your time’s up and you gotta go.’” (Vancouver report, p. 17).

In addition to the factors cited above, lack of family support was also identified as a key precipitating factor in initial experiences of homelessness. Some participants became homeless immediately upon leaving their parents’ home as a result of being kicked out, running away, or otherwise escaping family conflict:

“The lowest point was when my mom had to, to let me go. I had to start living on the streets...yeah, it was the lowest point. I had no job, I had no money, I had to live on the streets and at the homeless men’s shelter.” (Toronto report, p. 17).

“My childhood would be being abused by both parents, physically, mentally, and sexually. Uh, my first assault charge was with my dad. I’d seen him hit my mom, and I hit him with a two-by-four in the back of the head. And that was when I was 12.” (Vancouver report, p. 14).

Cultural variables also played a role in initial experiences of homelessness. For instance, participants at the Winnipeg site spoke of the transition from the First Nations community to the city as disconnecting them from services and

supports. Participants also spoke of racial discrimination from landlords and property managers:

“And that’s the way that hotel is. It’s management that does that, and they treat Indians really bad over there.” (Winnipeg report, p. 11).

Finally, although the attraction of the street lifestyle was typically expressed relative to the negative environments from which individuals were trying to escape, a few participants spoke about being attracted to the freedom that the homeless lifestyle brought:

“I don’t know, it probably just became a choice to be homeless I guess. It’s just that I felt like I had more freedom living on the outside, and I didn’t have any responsibilities like paying rent or paying power or something like that.” (Participant, Winnipeg report, p. 11).

However, this attitude was by no means universal:

“I don’t want to be homeless. Nobody wants to be homeless. There’s not enough housing in this area.” (Vancouver report, p. 17).

Most recent experiences of homelessness. The majority of participants across sites reported recurrent periods of homelessness in which they could find temporary shelter, but had difficulty locating and keeping permanent housing.

“I was homeless for almost three years...How can we get out of homelessness? It’s not an easy thing to do. As soon as you get outside and you get kicked out, you turn around and there’s nothing! There’s nothing around! It took me two years to find a place. I passed through two winters. There was some shelters and everything...but the system makes it very hard to get back on your feet.” (Vancouver report, p. 17).

Similarly, some participants spoke of recent experiences of homelessness being a revolving door between living in institutional settings (e.g., psychiatric facilities and prisons) and living on the streets. Prolonged stays in institutions had an adverse effect on the ability of participants to maintain a supportive social network, while also reducing their ability to develop stable housing, employment, and credit.

“Cause when you get out, after, like, you do more than five years, you don’t know how to live out here... you know, I didn’t know how to go to the Welfare Office and fill out a form.” (Vancouver report, p. 17).

Participants also expressed frustration over long waiting lists for housing and reported feeling demoralized by rules of “the system and service providers” (Vancouver report, p. 18). For these and other reasons, some participants expressed feelings of ambivalence or helplessness in terms of being able to leave the life of long-term homelessness.

Some participants described the role that cultural and gender variables play in their recurring homeless experiences. At the Vancouver site, female participants expressed that it is much harder to feel safe as a woman who is homeless:

“Uh, my room was getting broken into and all my stuff was getting stolen...and uh, people—there was drug dealers that lived above me, and they were assaulting girls upstairs, and I could hear it perfectly, you know? I just left whatever I had there and never went back...’cause I was too scared.” (Vancouver report, p. 18).

Perceived racial discrimination was another cultural variable reported by some participants as impacting their recent experiences of homelessness:

“Being Aboriginal and homeless in Winnipeg sucks. You know, I hate to say it, but it’s the truth. You can have three aboriginal homeless people and one white homeless person; and that white homeless person will get help before the other three. And they’ll get a home before us...” (Winnipeg report, p. 10).

Life on the Streets/In a Shelter

The key emergent theme regarding the lived experience of being on the streets revolved around “mastering the means of survival” (Winnipeg, p. 11). The participants described constant struggles to provide for their physical and health needs, through securing shelter, food, and clothing. Because many experienced daily survival struggles, “shelter becomes the primary concern over and above maintaining health and wellbeing” (Toronto report, p. 18). The challenge of survival is particularly acute during the winter months. As a participant from Toronto explained:

“...the idea in the winter is to stay away from the winter. So you have no choice, you have to think where you’re going to go or where you’re going to survive.” (Toronto report, p. 18).

In addition to the challenge of meeting one’s basic needs for shelter, many participants described the need for “street smarts”, which entailed understanding how to navigate life on the streets in a manner that ensures one’s physical safety. Many participants discussed how life on the street and in shelters could be a dangerous and scary experience. Additionally, the participants struggled to cope with ongoing addictions and mental health issues. The participants discussed the adverse impact of street life on both physical and mental health extensively. Many participants described the significant impact of stigma and discrimination, particularly as they discussed how others viewed and treated them.

A typical day. Some participants described a typical day as long, boring, and repetitive (Moncton report; Winnipeg report; Toronto report). Each day entailed “killing time”. As one participant noted, “Every day is just like a year for me.” (Toronto report, p. 7). A participant from Winnipeg explained:

“Pretty much you just sit around all day. I think that’s why a lot of people have addictions, because there’s nothing to do...a lot of people can’t go to malls and stuff because they get weird looks, security asks them to leave.” (Winnipeg report, p. 12).

Across the five sites, the participants also described walking all day to try to find a place to sleep, someone to socialize with, a place to stay warm and dry, or establishments that are open 24 hours. Some described the frustration of needing to walk around each day while carrying all of their belongings. The participants explained how difficult it is to meet the basic need for sleep while living on the streets. Because of concerns about safety, many participants attempt to stay up all night and to then get a few minutes of sleep during the day in public places. As a participant from Winnipeg explained:

“I hung out pretty much anywhere that was open 24 hours. I’d be in there...there’s quite a few of us who actually teach ourselves to learn how to sleep with the lights on so that way if we go to an open 24 hour Walmart, then we can, if we need to we can go into the bathroom and sleep.” (Winnipeg report, p. 13).

Many described how the stigma of being homeless causes them to keep moving along, as others find their presence undesirable (Moncton report). As a participant from Toronto explained:

“You’re always, always tired. I remember being in the baths, just trying to keep my eyes open. If I could close my eyes at one time, it was just like, bonus...but it’s pretty hard because libraries, malls—if they find you sleeping in there, they’ll kick you out. They make it very embarrassing for you.” (Toronto report, p. 7).

Additionally, several participants described how it was difficult to maintain hygiene while homeless (Moncton report; Winnipeg report; Toronto report). As a participant from Winnipeg reported:

“Very often I would sleep on the ground by a fire, but unfortunately the fire would go out at 5:00 in the morning. I’d be covered in soot, my hair was just terrible. I, I had quite long hair and I, eventually I had to shave it all off because I couldn’t find a place to, to clean it.” (Winnipeg report, p. 13).

Many participants described how walking around in pursuit of drugs and recovering from the effects of drugs filled most of their days, in addition to trying to find or make money to pay for the drugs. The participants reported spending much time walking around neighbourhoods with high concentrations of people experiencing homelessness and drug activity, such as the Downtown Eastside (DTES)/Hastings Corridor (Vancouver report).

As a participant from Winnipeg reported:

“What I did a lot was just walked around. [Laughing] I did a lot of walking. I walk along the river, get together with people. The thing for me was, ah, for me was getting high.” (Winnipeg report, p. 11).

A participant from Moncton described:

“It’s the same thing every day. It does not matter if you’re doing it for two days or for two years, it’s the exact routine every day, from when you get up to when you go to bed. You go for the high.” (Moncton report, p. 25).

For participants across the five sites, a typical day entails attempts to obtain money, whether it be through prostitution, theft, collecting bottles and cans, panhandling, busking, or looking for odd jobs. As a participant in Winnipeg explained:

“I walk around, look for beer cans and pan handling and...stuff. Not eating proper, eating from the garbage.” (Winnipeg report, p. 12).

Many participants described the negative impact their typical daily activities and interactions had on their self-esteem and sense of identity. As a participant in Toronto reported:

“I am kind of embarrassed about myself...when people walk by and say something stupid, like look at this bum or you know, disrespecting you. Where am I supposed to go? I’ve got to sleep on the streets.” (Toronto report, p. 19).

Although it was far less common, some participants described engaging in daily activities that they found meaningful, such as sports, art, caring for pets, cooking, volunteering, and working (Moncton report).

Experiences with supports, services, and community organizations. Across the five sites, participants reported using a number of services, including shelters, soup kitchens, and community centres. While many participants described heavy service use, others avoided services completely due to stigma, discomfort, and a perceived lack of safety.

Participants described the specifics of accessing services. According to the participants, some shelters and services are widely known in their respective cities. However, other participants relied on peers to inform them about which services to access, as they were generally unfamiliar with options for support (Montréal report; Winnipeg report). Services tended to be more available on certain days and at certain times. Participants from Toronto reported that shelters closed during the day, making them feel “kicked out” and that they had to kill time, even when it was cold outside (Toronto report). As a participant from Winnipeg described:

“The hardest days of the week are Saturday and Sunday. Saturday mainly after 2 because the shelter is shut down after 2...and Sunday is the worst because none, nothing is open. So we’re just walking around all day.” (Winnipeg report, p. 14).

Participants in Moncton described a general lack of services in rural areas (Moncton report). Some participants in Montréal described problems accessing shelters located in certain parts of the city, particularly due to physical health problems that made walking long distances difficult. In contrast, participants in Toronto typically perceived having many shelter options, particularly in the downtown area, which afforded them more choices (Toronto report). However, participants also expressed concerns about feeling institutionalized and becoming dependent on the shelters (Toronto report).

Most discourse about services centred on shelters, with participants highlighting aspects of shelters that are problematic. The majority of participants described a lack of cleanliness and privacy in shelters (Montréal report). Numerous participants described significant concerns for personal safety while staying in shelters (Montréal report), contributing to a feeling that they needed to sleep with “one eye open” (Toronto report, p. 22).

Numerous participants feared becoming victims of physical violence, sexual assault, or muggings (Montréal report; Toronto report). Participants in Winnipeg described witnessing drug and alcohol use in shelters, as well as fights, with

one participant reporting that he once saw someone killed in a shelter (Winnipeg report). A few participants in Moncton reported that they were assaulted in shelters (Moncton report). Others discussed violence related to substance use as a significant concern, as individuals used drugs openly (Toronto report). As a participant in Montréal said:

“I did not feel like getting killed in the middle of the night or have the blood of someone else who wanted to [inject drugs].”

Participants' perceptions regarding the quality of a shelter were based on several factors, including rules, the level of safety, and the food. The participants held different perspectives about rules in shelters. While some appreciated curfews and rules prohibiting substance use, as this increased feelings of safety and comfort (Toronto report), others found rules vague and infantilizing (Montréal report). In Toronto, female participants felt safer in shelters that have rules and promote accountability than they did on the streets (Toronto report). In contrast, participants in Montréal explained that excessive rules in shelters limited their autonomy and decision-making capabilities (Montréal report). These participants were unaware of particular rules until they violated them and were asked to leave (Montréal report).

Participants reported mixed perceptions of staff members in shelters and community organizations. Some participants described staff as helpful, while others found them to be lacking in compassion and generally neglectful (Toronto report; Winnipeg report; Moncton report). In Vancouver, participants explained that helpful staff members are accepting and proactive. Helpful staff members advocated for the participants and connected them with other services (Vancouver report). Participants in Montréal appreciated working with staff members who are warm and familiar to them (Montréal report). In Montréal, some participants found staff members helpful, as they are “representatives of the normal” (Montréal report, p. 22). Participants were particularly appreciative of staff members who helped them to obtain ID and apply for benefits, and to search for jobs and housing (Vancouver report). In contrast, participants described staff members negatively when they displayed a lack of awareness and training necessary for working with individuals with complex needs. Judgmental attitudes and failure to listen were also described as problematic (Vancouver report; Montréal report; Moncton report).

As participants described their experiences with services, the topic of food was frequently discussed. In Toronto, participants typically described finding many options for food. As one participant explained:

“In Toronto, you're never, never going to go hungry downtown. I know where to go eat. All kinds of programs, food programs, but you know, to tell you the truth, I'd rather have my own place and cook my own meals.” (Toronto report, p. 19).

In addition to shelters, participants described using food banks and drop-in centres to obtain meals. Other participants across the five sites described foraging through dumpsters in search of food. Participants in Winnipeg and Moncton noted that food was often scarce, particularly in overcrowded shelters (Winnipeg report; Moncton report).

In contrast to participants who access a wide range of services, there was a subgroup of participants within each site who reported avoiding services completely. Participants who avoided services typically described refusing to frequent what they described as dirty and undesirable places. As a participant from Moncton reported:

“I find shelters very dirty and even though you're an addict, anybody can go there and there's a lot of dirty things that go on there. I've never stayed at a shelter, I would stay outside and starve before I'd go to a shelter.” (Moncton report, p. 25).

Others perceived the experience of needing services as a low point in life, as it leads to a cycle that is “impossible to escape” (Winnipeg report, p. 15). According to these participants, accessing services contributes to the stigma experienced by individuals who are homeless (Winnipeg report).

Experiences with informal supports. Participants within each site described the role of relationships in their lives. They made strong distinctions between significant relationships and superficial or convenient relationships. In Toronto, this theme emerged as participants distinguished between “real” and “drug” friends (Toronto report, p. 24).

When discussing their peers, participants in Toronto described making acquaintances from the streets, while others explained that they try to avoid interacting with other street-involved people (Toronto report). As one participant explained:

“Because you know, like people that are in the shelter system aren’t the healthiest themselves, so those relationships tend to be a little more draining or unhealthy.” (Toronto report, p. 20).

In Montréal and Toronto, participants explained that street-involved peers play an important role in their lives, as they offer advice about how to navigate the streets and about accessing services (Montréal report; Toronto report). Further, some participants explained that peer interactions are important, as other individuals experiencing homelessness can identify with them (Montréal report; Toronto report; Moncton report). Many participants expressed a desire for more social opportunities to cultivate relationships, as they reported having insufficient opportunities to develop supportive relationships (Moncton report).

In terms of family relationships, many participants described family support and acceptance as meaningful and as important to their recovery (Toronto report). However, many participants became alienated from their families as a result of their mental health problems and addictions.

Experiences with housing. Across the five sites, the participants widely reported negative experiences with housing. In Vancouver, for instance, participants noted that previous housing often lacked privacy and had no cooking facilities. Housing was perceived as unsafe, and participants described it as dirty, infested with bugs or vermin, and in disrepair (Vancouver report). Several participants described experiences with violence and theft, and generally feared for their safety (Vancouver report). According to the participants, their landlords did not fix problems and were believed to be involved in the drug trade (Vancouver report). Participants described a lack of affordable and safe housing options (Moncton report).

Participants also described stigma and discrimination as significant barriers to securing comfortable and safe housing (Toronto report; Vancouver report). Participants felt that they were discriminated against as they were looking for housing, due to their welfare status, ethnicity, sexual orientation, or appearance (Vancouver report). Some participants reported that they were evicted from housing due to their problems with mental illness and substance use, or following psychiatric hospitalization (Toronto report; Vancouver report).

Positive descriptions of housing were rare, but some participants appreciated family-oriented, subsidized housing. Participants also reported feeling positive about housing when they developed good relationships with their neighbours and when they were able to live harmoniously with families and friends. Participants also appreciated living in clean environments with locks (Vancouver report). For many, the At Home/Chez Soi project represented their first positive housing experience (Vancouver report).

Vision for the future. For most participants, securing and maintaining housing was at the centre of their vision and goals for the future (Vancouver report; Toronto report; Moncton report). To most, obtaining and maintaining a home would provide a base and sense of security from which they could pursue goals for the future. Participants defined ideal housing differently, as some preferred to live with others, while others preferred to live alone (Vancouver report). Most preferred to live away from problematic neighbourhoods with heavy drug activity, and desired a home that gave them “a sense of permanence, privacy, and security”. (Vancouver report, p. 25).

Many participants reported that, in addition to their goal of maintaining housing (Toronto report; Vancouver report; Moncton report), their envisioned futures entailed pursuing work or school (Toronto report). As one participant described:

“I want a future, I don’t want to be on disability for the rest of my life. I want to be working a regular job with great benefits and old age security, I want all of that.” (Toronto report, p. 42).

For many, envisioning the future revolved around a desire to establish or re-establish relationships. Participants in Moncton wished to visit their children more regularly and to develop close relationships in the future. For others, the

ultimate goal was to regain custody of children and to have a safe environment in which to raise them (Moncton report). Participants identified having a home and transportation as important steps in rebuilding relationships. One participant from Toronto reported:

"After my son was born, it was, 'Okay, he's not with me but when he comes back, I want him to be proud of his mom.'...And that's my goal, to make my child come back home to me and be like, 'My mother is something'." (Toronto report, p. 43)

Several participants described the importance of pursuing paid or volunteer work and school for re-establishing a positive identity and sense of self:

"I have to prove to myself that I could have been who I wanted to be. I am going to get my Grade 12 and I am going to take my nursing course..." (Toronto report, p. 42)

Similarly, participants in Moncton described engagement in meaningful activities as important to their envisioned futures. Some wished to develop their talents in painting, woodworking, and clairvoyance (Moncton report).

For some participants, future recovery has a strong spiritual or religious component. Some described the importance of getting away from drugs and closer to God, while others hoped that God would take away their mental health symptoms (Moncton report).

Participants identified perceived barriers to achieving their future goals. In Moncton, many participants struggled to envision a time in which they will recover, and anticipated a future of mental health struggles. Participants in Toronto hoped that their mental health symptoms would subside enough for them to pursue future goals:

"I hope that maybe one day I will get healed, I won't have to take medications anymore...I wouldn't have to be drowsy and I can do what I want, get a job, you know? And fulfill my dreams." (Toronto report, p. 42)

Participants in Moncton described the importance of detecting when mental health symptoms are reaching the point of crisis, and hoped to gain the tools necessary to avoid crisis states, such as coping skills for managing the accumulation of stress (Moncton report). Other participants believed that learning to be assertive by saying "no" and setting boundaries is important to achieving future goals (Moncton report). For several, developing self-esteem and confidence is important for future recovery, as this will provide them with "a strong foundation" (Moncton report, p. 34).

Further, for some participants, overall health is important to their envisioned futures. Some described the importance of addressing chronic health conditions and finding a good doctor who will listen. One participant in Moncton described the importance of overall health:

"...just to take care to be healthy...[then] I can think for myself, take an apartment." (Moncton report, p. 34)

Additionally, participants described drug use and relapse, associations within problematic neighbourhoods, boredom, loneliness, financial problems, and the lack of support as potential barriers to achieving a preferred future (Vancouver report).

EXPERIENCE OF MENTAL HEALTH ISSUES AND SERVICES

Initial experiences with mental health issues. Across the five sites, the majority of participants reported first experiencing mental health symptoms during middle childhood or adolescence. Participants in Vancouver reported early feelings of being different and perceptions of something being “wrong”. In Winnipeg, many described how a lack of understanding regarding mental health issues was a barrier to addressing early symptoms. As participants in Moncton and Montréal reported, symptoms that first surfaced during middle childhood worsened during adolescence and young adulthood. For some participants in Vancouver, mental health symptoms first manifested through social withdrawal and antisocial behaviour. The participants described many contributing factors to the onset of mental health problems.

Early family problems and difficulties with relationships emerged as a theme across the five sites. As participants in Vancouver described, family discord tended to worsen the experience of anxiety and depression that some participants faced in early life. Participants in Montréal described the experience of family violence and parental substance use. In Moncton and Montréal, participants described how early trauma from childhood abuse was a precursor to mental health problems.

The majority of participants across the five sites described the role of early substance use on their mental health. Most initiated substance use during middle childhood through adolescence. For some, initiating substance use was a response to mental health symptoms. As a participant in Vancouver noted:

“I felt like there was something wrong with me because the first time I did cocaine—I was 14—it felt like the missing part of me...it made my thoughts and feelings clearer.” (Vancouver report, p. 26).

Most participants perceived a link between their substance use and mental health problems. A participant in Toronto reported:

“After I started using drugs like marijuana and I started drinking then I just became very psychotic. Like it all escalated since then.” (Toronto report, p. 28).

Similarly, several participants in Montréal believed that their substance use caused their mental health problems, as they first attempted suicide or became psychotic after using (Montréal report). A participant in Moncton reported:

“I got into drugs when I was 17. I started taking drugs, and I messed up my head quite a bit. I stayed with my parents after that, I was really messed up and it made me sick.” (Moncton report, p. 20).

For the majority of participants, difficulties and stressors in life accumulated in an overwhelming fashion, contributing to what some participants in Vancouver termed a “break” in their mental health. As one participant in Vancouver described:

“A lot of stuff contributed to my mental health problems: relationships, kids, people passing away when you’re not there, other things. Stuff that you weren’t there for when you could have been. There are lots of things. I can’t really pinpoint each one. It just builds up and builds up, right? And then you’ve got your own thing to handle that you’re not letting anyone know about, so it all just builds up and comes out.” (Vancouver report, p. 26).

Ongoing experiences with mental health issues. Across the five sites, participants described numerous stressors that continued to contribute to their mental health problems. Participants in Montréal described how the accumulation of stress from unpleasant work environments and poverty played a role in their worsening mental health. Participants described how physical health problems and cancer diagnoses contributed to worsening mental health problems; for a few participants, traumatic brain injuries were cited as factors that impact their overall health and mental state (Montréal report). In Toronto, participants described the adverse impact of losing custody of their children on their

mental health. Further, participants in all five sites articulated how losing a loved one was a significant factor that worsened mental health problems.

For many participants, family relationships continue to be strained due to mental health and substance use problems. As a participant in Toronto explained, family relationships are sometimes contingent on adherence to treatment:

“My mom, she was willing to help me out like with a place to stay but under her conditions. That I was to see a doctor and get medicated.” (Toronto report, p. 30).

The majority of participants described the importance of family for social support. However, many participants described how their families had a general lack of understanding regarding their mental health problems. A participant in Winnipeg explained:

“My family wasn’t dealing with it in the way that they should have been. But you know, in their defense, you know they, people just didn’t know that much about it.” (Winnipeg report, p. 19).

The complex nature of mental health problems and family relations emerged in the data. Many participants explained that losing relationships had a negative impact on their mental health. Likewise, worsening mental health issues often adversely affected their romantic relationships and relationships with family members.

The experience of being homeless exacerbates ongoing mental health issues, particularly during the winter months, when survival struggles become more acute. Participants in Toronto described the difficulties they faced in terms of obtaining good mental health treatment while on the streets. A participant in Winnipeg describes how his mental health issues contributed to becoming homeless:

“And because I was in mania, I really didn’t understand, I don’t know, I didn’t understand, but uh wasn’t doing as much as I probably should have been doing to try to find appropriate housing. Because I didn’t know where to turn.” (Winnipeg report, p. 18).

The cyclical nature of mental health problems, substance use issues, the loss of relationships, and the loss of housing was described across all of the research sites. As a participant in Toronto explained:

“I bounced around for a while, I got heavily into pills and because I was depressed, I didn’t see a way out and I was young, my source of income was gone and then slowly bit by bit I couldn’t afford housing anymore so then I went into a shelter.” (Toronto report, p. 29).

Initial and ongoing experiences with mental health services. Many participants described long histories of involvement with mental health services. During their youth, some participants were placed in juvenile detention and foster care settings. In Toronto, a few participants described early mental health interventions as helpful, though most “recalled being told that they were troublemakers and attention-seekers and developed a sense of being unwanted by society” (Vancouver report, p. 32). Across the sites, participants frequently reported that their initial problems were overlooked or minimized by providers.

Across the five sites, many participants reported experiencing repeated psychiatric hospitalizations. Participants described both voluntary and involuntary hospitalizations. Involuntary hospitalization emerged as a theme in Toronto and Montréal, in particular. In Montréal, the majority of participants were hospitalized involuntarily. Multiple hospitalizations seemed to result in “disjointed psychiatric treatment” (Toronto report, p. 33). Reasons for hospitalization included suicide attempts, psychotic symptoms, depression, social withdrawal, and trauma from violence (Montréal). Participants who were voluntarily hospitalized reported that they entered treatment for diagnostic purposes, to receive further support, to receive medication, or to have someone listen (Montréal).

In addition to hospitalization, participants described accessing other mental health services. In Toronto, participants described using community and crisis centres, in addition to emergency departments. Some participants in Montréal participated in self-help groups and AA (Montréal report). While many participants described heavy system use, it was perceived to have only limited benefits, as services were uncoordinated (Vancouver report).

For many participants, medication is a central component of the services they are currently receiving. While the majority of participants in Toronto described taking medication and feeling helped by it, the majority of participants in Vancouver did not feel helped by medication. Some participants in Winnipeg expressed discomfort with taking medication and seemed to perceive it as stigmatizing:

*"I don't know, I don't want to pop some wacko pill that's, you know, you know, leaves me comatose."
(Winnipeg report, p. 19).*

In Winnipeg, other participants described experiencing negative side effects from medications. Many participants expressed concern that medication was the first line of treatment before counseling (Winnipeg report; Vancouver report; Toronto report).

Across the five sites, participants described both positive and negative interactions with service providers. The participants perceived service providers as helpful when they listened and were compassionate, when they were respectful (Vancouver report; Montréal report, Moncton report), and when they were consistent and followed through (Vancouver report). The participants widely articulated the importance of being heard by providers. As a participant in Toronto explained:

*"I got connected to a therapist...and she saw me and she was really great, you know? The first person, she was the first person I spoke to, she listened to me so I felt...you know? I was getting somewhere."
(Toronto report, p. 35).*

Many participants expressed that they were routinely denied the opportunity to be heard by providers (Toronto report; Vancouver report). Negative experiences with providers were reported more frequently than positive interactions in Vancouver (Vancouver report). The participants felt stigmatized and discriminated against by providers, and found them dismissive and poorly skilled (Vancouver report). Negative interactions with providers led to disengagement from treatment. Further, the participants explained how they must be proactive in terms of obtaining treatment, but that this is often difficult due to substance use and mental health problems. As a participant in Vancouver explained:

*"They aren't really a lot of help unless you do the footwork. And, of course, when you are a drug addict, the footwork just doesn't get done. You just keep sliding, sliding, sliding."
(Vancouver report, p. 27).*

In Winnipeg, many participants reported a lack of trust in providers, as they felt "invalidated" and blamed (Winnipeg report). Some participants preferred to see an elder for spiritual healing rather than a service provider. Participants in Winnipeg also spoke about a lack of same-culture service providers:

*"[what was missing was] a connection with...another aboriginal, feeling like someone that's like me, you know. Being able to talk to someone who will understand what I talk about that I trust and you know, that comfort feeling, comfortable feelings."
(Winnipeg report, p. 20).*

Participants' perceptions about psychiatrists and psychiatric care was also mixed. Some articulated that psychiatrists played a central role in facilitating their recovery (Toronto report; Montréal report). As a participant in Toronto noted, "I am indebted to them." However, other participants found that psychiatrists lacked compassion and offered only conditional support. As a participant in Toronto explained:

*"[The psychiatrist] slammed his door in my face one day...because I was in his office and...I was upset and I started saying something about the devil. And I said something like 'Satan, I bind you in the name of Jesus' in his office and he said, 'why do you have to do this in here?' Then he finished the session with me and then he stood at the door, opened the door, and as I went through the door and I was turning to say goodbye, I just hear [a door slam] right in my face."
(Toronto report, p. 32).*

Most participants in Vancouver reported negative experiences with hospitals and psychiatrists, particularly because of the involuntary nature of services, as medications were administered or changed without their permission:

*"I just stay away from doctors. I hate hospitals. I hate doctors. Every time you go to see a doctor, you end up getting strapped down and filled with a bunch of medication. I hate taking medications. Every time I see a doctor, they're trying to push it on me."
(Vancouver report, p. 27).*

Others articulated that medication seemed to be the first course of treatment, and that they were not fully informed about the nature and side effects of the medications (Moncton report). Some perceived that they were overmedicated, as indicated by this quote from Moncton:

“Well, I...they gave me enough pills that they did not know what they’ve given me. So they tried all sorts of ways, I know that the first time, I guess I was taking twenty pills.” (Moncton report, p. 21).

The majority of participants described the complex relationship between mental health problems and substance use with which they continue to struggle. This creates further difficulties, as they perceive service providers as unwilling to address their needs. Many participants across the sites described being shuffled between addiction and mental health services. A participant in Vancouver explained:

“I’ll drink sometimes when I start to go manic and that’ll make it worse. And once I start that, psychiatrists don’t even want to talk to me. Drinking and being bipolar, the combination of the two, it’s a nasty one.” (Vancouver report, p. 27).

A strong theme that emerged across the five sites was widespread participant perceptions of stigma, discrimination, and marginalization as a result of their mental health problems. Participants in Toronto explained that the stigma of mental illness has prevented them from seeking treatment. Others described how mental health services should be empowering, as opposed to deficit based. As a participant in Vancouver said:

“I think the system really needs an overhaul, you know?...people don’t need to be dependent on services. They need to be empowered so they can be the services themselves too, you know? Like you’re strengthening some, not pushing them down.” (Vancouver report, p. 28).

Recovery. Across the sites, there were several emergent themes as participants described their personal meaning and vision regarding recovery. When discussing recovery, many participants articulated their desire to address mental health problems and substance use issues (Toronto report; Vancouver report). As a participant in Toronto explained:

“I hope that maybe one day I will get healed, I won’t have to take medications anymore...I can do what I want, get a job, you know? And fulfill my dreams.” (Toronto report, p. 40).

For many, recovery entails self-acceptance and a willingness to move forward. As a participant from Vancouver noted:

“I think it’s a lot of awareness and a lot of self-love and a non-judgmental attitude for myself and acceptance and commitment, I guess, to myself, to I don’t know...keep trying.” (Vancouver report, p. 28).

The participants also described how recovery would facilitate their ability to establish or re-establish positive and supportive relationships. Many believed that securing stable housing would be an important starting point for healthy relationships. Others indicated a desire to reconnect with their faith and spirituality (Toronto report). For many participants, housing played an important role in facilitating recovery (Toronto report; Vancouver report).

Many participants made the link between housing and recovery explicit. Recovery was perceived to be dependent on stable housing. As a participant in Toronto described:

“...A place to live and then from there I can start doing my things, like getting better and going out. Getting into a routine. Finding a job, getting the training for something else.” (Toronto report, p. 41).

Some participants viewed their participation in the At Home/Chez Soi project as a starting point for hope and recovery. As a participant from Toronto explained:

“I’ve lived a very rough life but I’ve made it. I am here today to say that this program has helped me in so many ways in my life, as a turning point where I don’t have to think about drugs and I don’t have to think about being homeless, I don’t have to think about anything but positive things from now on. Like I had doubts when I first came even when I got accepted but when I see everything happening according to the way they said it would, I was like this is the start of a new life for me.” (Toronto report, p. 41).

CROSS-CUTTING THEMES AND LESSONS LEARNED

Several cross-cutting themes emerged: (1) stigma and discrimination are pervasive in the lives of participants; (2) it is important to understand contextual and environmental factors underlying homelessness; (3) there are complex interrelationships between substance use, mental illness, relationship difficulties, and barriers to housing in the lives of participants; (4) participants desire greater social support; (5) participants experience a general sense of mistrust and dissatisfaction with mental health services; (6) participants convey a sense of hope, in spite of significant obstacles; (7) housing occupies an essential role as participants envision a different future.

Stigma and discrimination. The experience of stigma and discrimination was among the most salient themes across the five sites. The participants described being stigmatized by their families, in shelters, and on the streets. For many participants, the experience of stigma caused them to avoid accessing services. Discrimination limited opportunities to obtain work, education, and stable and safe housing, contributing to continued marginalization. Issues of stigma and discrimination were so pervasive that the Toronto site recommended that programs and services raise awareness of the issue by implementing training and strategies for lessening stigma and discrimination (Toronto report).

Many participants internalized the stigma they routinely experienced. Stigma adversely impacted their identities, leading to further social isolation, poor self-esteem and worsened mental health (Toronto report). Participants in Winnipeg described the accumulation of stress from stigma and marginalization, as they perceived widespread discrimination due to homelessness, mental illness, and being Aboriginal (Winnipeg report). The Vancouver report described the tensions that emerged as participants described their identities:

“Many participants evidenced a struggle between viewing themselves as survivors who deserve respect and as illegitimate citizens who are a burden on society and their families.” (Vancouver report, p. 32).

Contextual and environmental factors. Additionally, several sites described the importance of understanding environmental and contextual factors that shape the lives and experiences of individuals who are homeless, as these factors lead participants to experience a sense of entrenchment in that situation (Vancouver report; Toronto report; Moncton report). Among these contextual factors is the nature and character of neighbourhoods where participants spend much of their time. In Vancouver in particular, the participants described Hastings Corridor as “an unsafe place, (particularly for women), that they wanted to escape from” (Vancouver report, p. 31). However, the participants felt trapped in Hastings Corridor, as affordable housing, shelters, and services tended to be centralized in the area (Vancouver report). This is one of many examples of how daily needs and the experience of entrenchment “pushes [participants] toward entering unsafe spaces in the neighbourhood”, even when they wish to disengage from these contexts (Vancouver report, p. 5).

Complex interrelationships regarding risk factors. Further, all sites described how substance use, mental illness, problematic relationships, and difficulties securing housing are interrelated for the participants. The participants described how problems in each domain contributed to other concerns in their lives. In Winnipeg, some participants identified how early disengagement from relationships, community, and supports precipitated initial homelessness. In Montréal, the role of traumatic or problematic early relationships and attachments significantly shaped the trajectories of the participants, and mental illness and substance use continued to compound these problems during adulthood. Substance use, particularly, brought about significant problems for participants, including the experience of violence, involvement in prostitution and other illegal activities, and, for some, incarceration (Montréal report).

Desire for social support. Another key theme across the sites is the perceived importance of social support in the lives of participants, but the widespread sense that healthy relationships are lacking or absent (Winnipeg report). The lack of social support emerged as a factor that influenced initial pathways to homelessness. Additionally, difficulty maintaining relationships while homeless and a need for caution in developing relationships with others in similar situations also emerged as a theme, particularly in Toronto (Toronto report). Although most participants wished for satisfying relationships, few reported having such relationships at the time of the interviews. Some participants desired relationships in theory, but avoided them in practice (Vancouver report).

Prior to the data analysis that took place at each site, two researchers from the National Team conducted an analysis of early findings from the baseline consumer narratives to determine participant responses to being housed at an early stage (n=28). Like the individual site reports, this analysis found that participants viewed housing as a potential catalyst for establishing and re-establishing relationships (see Appendix G for the full early findings report). By receiving stable housing, participants discussed the possibility of strengthening healthy relationships, re-establishing relationships with family and friends, and disentangling themselves from unhealthy relationships, often with drug-involved peers on the streets.

Mistrust and dissatisfaction with services. The participants reported widespread concerns, problems, and a general sense of mistrust regarding services (Winnipeg report). One of the key emergent themes was strong dissatisfaction with psychiatric services. Participants across the five sites expressed concern that their psychiatrists over-relied on medication. Many participants described undesirable side effects of medication and emphasized that they would prefer to have opportunities to speak with someone who will listen, as opposed to being placed on medication as a first course of action. Others reported problems with the disjointed care that resulted from multiple hospitalizations, and expressed significant concerns about being subjected to involuntary treatment (Toronto report).

Although some participants reported satisfaction with certain services and providers, many participants described being “trapped or stuck in ‘the system’” (Vancouver report, p. 7). The participants reported becoming increasingly dependent on services that limited their opportunities and future prospects, and they expressed that most services are of limited help to them. Because this theme was so prevalent, the Vancouver report noted that:

“Far too often, the resources designed to help individuals are in conflict with their needs and their abilities to help themselves...further research is needed to better understand how institutions, including those responsible for health and social welfare, can contribute to homeless people’s continued marginalization.” (Vancouver report, p. 6).

Widespread experiences of trauma. Across the five sites, participants reported extensive experiences of trauma prior to, during, and after experiencing homelessness. Intergenerational problems of poverty, childhood abuse and neglect, substance use, and mental illness were widely reported. Some sites, including Montréal, noted that trauma from childhood sexual abuse was frequently reported, particularly by female participants (Montréal report).

For many participants, early exposure to traumatic events led to placement in the homes of other relatives, foster homes, and juvenile detention centres. These experiences of trauma and housing instability were compounded for many, who continued to become entangled in abusive and unhealthy relationships throughout adulthood. It was not uncommon for participants to describe witnessing violence and becoming victims of violence during the course of being homeless, both on the streets and in shelters. Participants also commonly described family discord and the loss of loved ones as traumatic life events that occurred during adulthood.

Hope in spite of obstacles. In spite of significant life problems experienced by the participants, including the “struggle with issues of survival, safety, isolation and addiction”, many “have not given up hope for the future” (Toronto report, p. 8), and demonstrate “resilience and resourcefulness” (Winnipeg report, p. 8). Numerous participants described hopes for the future, including a desire to recover by managing mental health symptoms and reducing or abstaining from substance use. Further, many participants hoped to become involved in work or education, to maintain safe and stable housing, and to develop more healthy and satisfying relationships (Moncton report; Toronto report; Vancouver report). The Vancouver report underscored the need for future research to continue exploring strengths and resilience regarding this population.

The role of housing in envisioned futures. For many participants, housing plays an important role in facilitating hopes for recovery and their visions for the future. For many, housing “provided a stable foundation from which to rebuild their lives” (Toronto report, p. 44). At the time of data collection, participants in the intervention group had only been housed for a short time. However, many described:

“...improved ability to get a good night’s sleep, see family, attend to their mental health and substance use issues and cook and eat healthy food. Some began to envision work, education, and a hopeful future.” (Toronto report, p. 44).

Likewise, the early findings analysis found that, for many participants, housing facilitated their ability to move beyond the daily struggle for survival and to begin thinking about and orienting toward the future. For some, housing provided initial motivation to “get back on track”, and to become more independent. Housing provided the experience of “privacy, dignity, and safety” that many participants articulated as important to recovery (see Appendix G).

Each cross-cutting theme suggests lessons learned:

1. *Stigma and Discrimination:* While the pervasive impact of stigma and discrimination in the lives of the participants is not surprising, this theme underscores the need for interventions and services to support participants in developing social supports and becoming integrated into their communities as valued members. From a policy standpoint, this theme suggests the need for campaigns to address and minimize stigma and discrimination, such as the Opening Minds campaign initiated by the Mental Health Commission of Canada in 2009.
2. *Contextual and Environmental Factors:* As researchers and practitioners seek to better understand the lived experiences of homeless individuals with mental illness, this analysis conveys the importance of understanding the neighbourhood, community, social, and cultural contexts in which the participants are embedded. Specifically, several participants described a desire to avoid neighbourhoods with high concentrations of homeless persons and drug activity, but experienced difficulties disentangling themselves from these contexts. This theme highlights the importance of understanding chronic homelessness not as a problem faced by individuals, but as a problem that is heavily influenced by structural injustices and economic inequalities.
3. *Complex interrelationships regarding risk factors:* Issues of substance use, mental illness, problematic relationships, and housing instability are complex and intertwined. Thus, there is a need to identify the unique strengths and needs of each participant, and to offer supports that best address barriers to recovery and to maintaining housing. These complex interrelationships regarding risk factors underscore the need for an intervention like Housing First, which allows individuals to take steps toward recovery while being stably housed. For participants, addressing mental health and substance use problems is a significant challenge, and being in a safe home represents an important step that can allow individuals to begin to address their problems and to orient toward the future.
4. *Desire for Social Support:* Most participants emphasized how important establishing and re-establishing healthy and satisfying relationships is in their lives. This suggests the importance of collaborating with participants to facilitate social opportunities and to improve relationships and social skills. Further, peer support can play an important and empowering role in the lives of participants, as they take steps toward recovery.
5. *Mistrust and Dissatisfaction with Services:* This finding provides a reminder about the need to understand why some participants may be reluctant to engage with service providers at an early stage of the intervention. By design, the Housing First logic model promotes choice and agency, which can be a more respectful way of initiating collaborative relationships with service users (Tsemberis, 2004).
6. *Widespread Experiences of Trauma:* The baseline consumer narrative analysis found experiences of early developmental trauma, including attachment instability, abuse, and neglect, to be pervasive, a finding that is consistent with previous research (Hopper, Bassuk & Olivet, 2010). Further, as others have indicated, homelessness itself is a highly traumatic experience (Hopper et al., 2010; Fitzpatrick, LaGory & Ritchey, 1999). A key consideration for service providers is the importance of understanding and providing trauma-informed care. Trauma-informed care emphasizes practitioner awareness of trauma, safety for consumers,

and opportunities for consumers to rebuild a sense of control, particularly by emphasizing choice and agency. Trauma-informed care is rooted in a strength-based approach (Hopper et al., 2010).

7. *Hope in Spite of Obstacles:* In spite of significant experiences with trauma and difficult life events, many participants continued to express hope for the future. Hope is a key element of recovery, as it allows individuals to begin to envision possibilities of a future life and a future self (Ridgway, 2001). Housing was identified as a factor that contributes to the participants' vision of a more fulfilling future. This finding also supports the logic model of the Housing First intervention, which holds that individuals can work on barriers to recovery most effectively when the basic need for stable housing is met (Tsemberis et al., 2004).
8. *The Role of Housing in Envisioned Futures:* Because many participants identified housing as a turning point regarding their ability to orient toward the future, it is important for practitioners to understand the important role that housing can play in regard to facilitating recovery. Although housing does not alleviate the complex risk factors and problems that participants face, for many it does provide a sense of stability and “ontological security” necessary for moving forward (Padgett, 2007). From the standpoint of services, practitioners may be able to collaborate with participants on developing a plan for recovery, given the sense of momentum that housing provides. This also underscores the relevance of the data collection for At Home/Chez Soi. The findings at baseline shed light on participant experiences of the Housing First intervention, particularly regarding the manner in which participants experience housing at an early stage. In addition to contributing to the literature on Housing First, these findings can play an important role in determining aspects of the intervention that may improve the lives of the participants, in addition to providing key information to mental health providers about approaches to best support adults who experience homelessness and mental illness.

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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 2 million. While Vancouver boasts a reputation as one of the most livable cities in the world, Vancouver is also home to the infamous Downtown Eastside where homelessness, drug addiction, and other health and psychosocial problems are rampant and highly visible. For example, it has been estimated that 5,000 injection drug users in this community are infected with hepatitis C or HIV/AIDS. People with serious mental illness in Vancouver are often co-morbid with addictions. "The 2008 Metro Vancouver Homeless Count found 1,372 people who were homeless in the City of Vancouver. This number of homeless individuals represents a 23 per cent increase since the previous count in 2005" (Vancouver site report, p. 12).

In spite of these significant problems, "best practice" housing and mental health services in Vancouver have been very slow to develop. Until the At Home/Chez Soi project, the Housing First approach was not evident in Vancouver. Instead, people with serious mental illness have been housed in congregate, custodial housing, such as single-room occupancy (SRO) hotels concentrated in downtown Vancouver. Moreover, housing is very costly in Vancouver, and the average rent for a bachelor apartment is close to double the shelter allowance that recipients of social assistance receive for their housing. Mental health services, such as Assertive Community Treatment (ACT) and Intensive Case Management (ICM), have also not taken hold in Vancouver until the At Home/Chez Soi project. While the Vancouver Mental Patients Association (MPA) has been in existence since the 1970s, mental health consumer participation has not become part of mainstream practice in Vancouver either. Thus, treatment as usual (TAU) for people with mental illness and co-occurring substance use has tended to be a custodial and medical model in nature.

Recently, there have been initiatives to address the problems of homelessness, mental illness, and addictions and to improve housing and mental health services.

In November 2008, Vancouver's Mayor Gregor Robertson, 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). (Vancouver site report, p. 13).

WINNIPEG

With a population of more than 600,000, Winnipeg is the capital and largest city 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. While there has never been a census of homelessness in Winnipeg, it has been reported that there are at least 350 people living on the streets and 1,900 people who use shelters on a temporary basis.

There is a very low vacancy rate in Winnipeg, around 1 per cent, and roughly 40 per cent of the rental stock is concentrated in downtown Winnipeg, much of which is older and in need of repairs. "Prospective landowners and managers in the public market have the power to be particular in tenant selection. Some property owners and managers may avoid renting to tenants who are considered marginalized due to perceived drug and alcohol use and misuse, mental health issues and matters relating to affordability and institutional discrimination" (Winnipeg site report, Appendix 1, p. C). Racism and stigma are major obstacles to housing Aboriginal people with mental illness

and/or addictions. The shelter allowance provided through social assistance falls roughly \$144 short of covering the costs of the average bachelor apartment in Winnipeg. Moreover, there are long waiting lists for social housing. Many low-income people live in rooming houses, residential hotels, or in shelters. Roughly 70 per cent of the shelter population is male and Aboriginal.

While there are 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 has been little to no history of collaboration between mental health service providers and organizations serving the Aboriginal population.

TORONTO

Toronto is the capital of Ontario, Canada's largest province, which is located in central Canada. The Greater Toronto Area has the largest urban population in Canada of roughly 4.5 million. The demographic profile has changed a great deal in recent decades.

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 (City of Toronto, 2000). There is a lack of data on service utilization among immigrant groups, but what data exist indicate low general levels of access and satisfaction with services, and significant barriers to accessing mental health services in particular (Access Alliance, 2005). (Toronto site report, p. 2).

Toronto has a significant homelessness problem.

Homelessness remains a significant social issue. The Street Needs Assessment conducted in Toronto in 2009 estimated that there were more than 5,000 homeless people in Toronto on that night, with about 79% living in shelters, 8% on the street, 4% in health care or treatment facilities, and 6% in correctional facilities (Toronto Shelter Support and Housing Administration, 2009). Approximately 30,000 different individuals use shelters in Toronto over the course of one year. Homeless people also often have complex mental health needs; about one-third of homeless individuals in Toronto have a serious mental illness such as schizophrenia, major depressive disorder, or bipolar affective disorder. Within the current system, a large proportion of these individuals do not receive the proper level of care for their mental health issues (Toronto Shelter Support and Housing Administration, 2006). (Toronto site report, p. 1)

Dating back to the inception of the Toronto Supportive Housing Coalition in the 1980s, Toronto has a relatively long history of providing a range of housing options, including those based on the Housing First approach, to people with mental illness. The City of Toronto's Streets to Homes, which has been in operation since 2005, has as its goal helping people who are homeless to access permanent housing. Toronto also boasts a relatively well-developed array of community mental health services.

There also exists a sizeable mental health service network serving homeless and housed individuals in Toronto, comprised of in-patient and outpatient care, case management, assertive community treatment, supported housing, supported employment, early intervention programs, court support services, crisis programs, and ethno-racial specific agencies, among other services.

However, there is a significant unmet need for these services among homeless individuals in the Toronto area (Stergiopoulos, Dewa, Chau et al., 2008). (Toronto site report, p. 2).

Toronto also has a relatively long history of consumer participation in mental health and consumer leadership which dates back to the 1970s. Not only do consumers work in mental health agencies, they have played prominent roles in research, program governance, planning, advocacy, and policy making. Moreover, consumers in Toronto have operated their own businesses and peer-run organizations for nearly 30 years.

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 (Weinreb et 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. (Montréal site report, p. 2).

Existing housing programs for people with mental illness include social housing (a congregate program for low income people), 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, it 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 référence* (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'action interministériel 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 Health Care Action Plan, 2005-2010) tabled in 2005, recommends consolidation of community services to help persons with mental health problems and to facilitate their social re-integration (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. (Montréal site report, p. 1).

MONCTON

While Moncton is a relatively small city, it is the largest city in New Brunswick and it is one of the fastest growing cities in Canada. Situated on the east coast in one of the Maritime Provinces, the geographical area is a central location within the Atlantic Provinces and is in close proximity to the Trans-Canada Highway, which links Halifax to the south, and Fredericton, Saint John, Québec, and Ontario to the north/west/east. Greater Moncton includes the Cities of Moncton, Dieppe and the Town of Riverview. The Greater Moncton area population exceeds 126,000, having experienced a growth of 6.5 per cent between 2001 and 2006. The language composition of the population is approximately two-thirds Anglophone (62 per cent) and one-third Francophone (35 per cent) (City of Moncton, 2009).

The location of the rural arm of the Moncton site 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 an area stretching over 2,000 square kilometres. 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. Adults with severe mental illness in this region have lived in custodial facilities operated by the private sector or with their families-of-origin.

Approximately 70 per cent of dwellings in the Greater Moncton region are owned with the remaining 30 per cent being rental units. With respect to core housing needs, there have been positive improvements noted in housing adequacy, suitability and affordability since 1991. In particular, the percentage of rental dwellings considered in “core housing need”³ decreased from 33 per cent to 25 per cent over the 20-year period from 1991 to 2001 (Human Resources and Social Development Canada, 2007).

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 is the absence of provincial standards to regulate the safety and suitability of rooming and boarding houses. The Community Plan Assessment Framework (2007) developed for Greater Moncton identified approximately 15,500 individuals at potential risk of homelessness in the Greater Moncton area (Human Resources and Social Development Canada, 2007).

These individuals were identified as living in substandard rental units (in core housing needs), as well as experiencing significant financial demands related to covering their basic shelter and living costs (approximately 50 per cent of income dedicated to shelter/housing costs).

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).

Relative to the other sites, 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 clients that can accommodate up to 76 individuals; 26 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 (three two-bedrooms and nine three-bedrooms) available for clients 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.

Publicly-funded mental health services are delivered in Moncton and in the adjoining rural region through community mental health centres (CMHCs), tertiary and secondary facilities, and psychiatrists in private practice. The tertiary and secondary facilities and psychiatrists in private practice are located in Moncton. These services are managed and operated by two regional health authorities, Regional Health Authority A and Regional Health Authority B.

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, psychosocial rehabilitation) (Health Systems Research and Consulting Unit, 2009). Types of services delivered by these programs include case management services, community support services, and rehabilitation services (Health Systems Research and Consulting Unit, 2009).

³A 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 per cent 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).

Addiction services deliver counselling and withdrawal management support for individuals with problem substance use. Programs available in Greater Moncton include a detoxification centre, outpatient counselling, health promotion, and wellness activities and school-based youth support services.

Housing First and ACT were new programs in Moncton and in the province of New Brunswick. TAU in Moncton consists of accessing the above services, all of which have long waiting lists. In comparison with the other sites, housing and services available to people with severe and persistent mental illness are relatively sparse, with many individuals from this population receiving no services or infrequent services.

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:

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

BASELINE CONSUMER NARRATIVE INTERVIEW GUIDE

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 you 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 like 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 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 point⁴?

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 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

⁴ 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.

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.

QUALITY CONTROL FOR NARRATIVE INTERVIEWS CHECKLIST

HOUSING FIRST AND ACT

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

Interview 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 interviewer 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).

CODING TEMPLATE FOR NARRATIVE INTERVIEWS

TIME PERIOD	CODES (fine grain units of meaning derived from line by line or paragraph by paragraph)	THEMES (a theme includes several codes that cluster together)
Life before homelessness		
First experiences of homelessness		
Recurrent experiences of homelessness		
Most recent experiences of homelessness		
A typical day		
Vision for the future		

SERVICES AND SUPPORTS	CODES (fine grain units of meaning derived from line by line or paragraph by paragraph)	THEMES (a theme includes several codes that cluster together)
Services, supports, and community organizations		
Housing		
Life on the streets or in a shelter		
Experiences with the mental health system <ul style="list-style-type: none"> • first experiences • continuing experiences 		
Vision for recovery		

STORIES/EPISODIC EVENTS/MEMORIES	CODES (fine grain units of meaning derived from line by line or paragraph by paragraph)	THEMES (a theme includes several codes that cluster together)
High point		
Low point		
Turning point		

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/ANALYSTIC IMPRESSIONS

(from session, from read-through)

C) FOLLOW-UP

Technological Problems to Address

Needed Follow-up 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 reflexive journal by interviewer, not entered in field note template.

(use of self, emotions, reactions, over-attention to issues?)

EARLY FINDINGS REPORT: QUALITATIVE OVERVIEW

Summary of findings/themes

- The participants' comments reflected their perceptions regarding the importance of the project for allowing them to think beyond their immediate survival needs and to orient toward the future.
- The findings revealed that the ability to envision "getting back on track" also provides participants with some initial motivation to make necessary life changes to achieve their goals.
- Against this sense of hope, however, were comments by some participants that reflected profound demoralization. Several participants expressed concerns about the possibility of "never feeling better."
- Another theme reflected the appreciation participants had for the sense of independence, safety, and belonging that came from having their own place. However, other participants expressed concerns that having their own place would lead to isolation and place them at risk for further substance use and mental health problems.
- The next theme revealed that the participants see the project as an opportunity to establish a sense of community and to strengthen their social connections, either by disentangling themselves from unhealthy relationships or by re-establishing lost relationships with significant others. In contrast to this, some participants worried that they didn't have the skills or capacity to form healthy relationships.
- The appreciation of the project's support was another strong theme. For instance, the participants noted that receiving unconditional support as they strive toward future goals is especially helpful. However, some participants expressed concerns about the ability of the project to provide them with the type or amount of support required.
- Finally, several participants identified the project as either a high point or turning point in their lives, as it provides them with a strong sense of hope. However, the participants also expressed a sense of urgency about the needs of other deserving people and about the future sustainability of the initiative and its resources.

Theme: Getting back on track

- The most prevalent theme expressed was the participants' sense of the project as an opportunity to "get back on track", "explore new avenues" and otherwise envision what a different future would look like for themselves.
- Having a place allowed people who had previously been "trapped", a chance to come "out of the dirt", and gave them the ability to "reflect", "not feel so overwhelmed," and "deal with issues" that stood in the way of them moving forward (for example, one person talked about the project as an opportunity to deal with "all the dying" of people around her.)
- Participants expected that by having a chance to address their issues, it would then allow them to start to disentangle themselves from their past predicaments and begin to orient themselves to the future.
- People envisioned changes such as reconnecting with significant relationships, going back to school, or reconnecting with past interests and/or work. "I used to be an ice-maker," said one person. As another participant said, being able to envision a different future gives her "the motivation to do all she can to achieve that."
- This previous comment fits with a general theme about the project not only helping people think about the future, but also giving them the motivation to actually change their lives. Having a place to call one's own, for instance, provided motivation to make the changes necessary to "keep my place."
- Participants also envisioned being able to "give back", "contribute" or otherwise "be of service". "I could be of service or something, instead of just doing what I'm doing," said one man.

Theme: Dealing with demoralization

- Other participants expressed concern about being able to make the changes necessary to move forward in their lives.
- In some cases, participants' comments expressed profound demoralization. One participant, for instance, said that he had overheard project staff say "let's get this guy off the street before he dies", but acknowledged that the project had helped him "big time." Nonetheless, he also said that he still envisions "dying with a bottle in his hand."
- Another person said "I can't imagine a life without drugs", while still another said he couldn't imagine that he "was ever going to feel better."
- Given repeated experiences of failure, other participants expressed concern that they would be able to make the changes (e.g., being assertive enough to stop street friends from "crashing" overnight) necessary to keep their place.
- One participant wondered whether the complexity of his health challenges (memory problems, physical and mental health problems) would prevent him from eventually living in his own place.

Theme: Housing as an opportunity for independence

- Despite the concerns of some, many participants viewed housing as an opportunity to be independent.
- For people who had experienced the "institutional" environments of shelters or a mental hospital, housing was an opportunity to "live by my own rules", and "take back control" over their lives, including aspects such as relationships with their offspring, and being able to come and go freely.
- Connected with a sense of independence of having one's "own place" was also a sense of privacy, dignity and safety, for instance, not having to worry about things such as "getting along with other people", "having your door kicked in," or "step(ping) over other people's piss."
- One participant noted, "It's nice to have my own place and to sit in my living room and watch TV and go to sleep every night in a nice double bed."
- Several participants described how the project allowed them to experience a sense of being at home. One participant noted, "I can come and go as I please, without multiple layers of security and cameras watching my movements." He went on to remark, "A sense of belonging matters. So if you give people four walls and all the things like a kitchen and everything...they start to belong to something. Developing a sense of home helps people."
- In contrast to the appreciation of independence and all that comes with it, came the concern by some people about potential drawbacks of having one's own place, particularly about isolation. As one person put it, "I'm used to having people around me all the time." Another person expressed worry that without the structure she was used to in the shelter system, and without people around her, she "would slip back" into depression and drinking.

Theme: The project as an opportunity to establish new connections and community

- In general, participants saw the project as an opportunity to disentangle themselves from unhealthy relationships and to, as one woman said, "meet regular people." Said another: "Being around normal people makes all the difference."
- Participants also expressed appreciation for gaining access to housing and feeling a sense of belonging in more healthy neighbourhoods, where as one man put it "I can stay out of trouble" from drugs, and as another woman said "I can walk somewhere else other than Main Street and not have people looking at me like I'm a piece of crap."

- Apart from a chance to establish new, healthier support networks, participants also expressed hope that the project would help them re-establish past relationships, and regain the esteem of people who had been important in their lives. For one woman, this meant wanting to rebuild her relationship with her grandchildren, and having them see that “I’m not such a screw-up.” Another participant expressed, “I’d like to get my kid a plane ticket and have her come down and visit—she’d be impressed.”
- For other participants, however, establishing healthy relationships was envisioned as an ongoing source of difficulty. One woman expressed concern that she “was not good at relationships,” and envisioned the possibility of becoming isolated. Other people expressed concern about their ability or opportunity to stay clear of relationships that had been harmful in the past, and “running into (these) people” in the program.

Theme: Appreciation for the project’s support

- Comments from participants indicated appreciation for the project’s support, both in terms of the support offered, and the unconditional style in which it was offered.
- One participant expressed, “Everyone that I’ve come into contact with [through the project] has been really supportive and treated me like a human...I’ve never really felt like that before.”
- One woman commented how she appreciated that staff were “not judgmental” when she was struggling (“they didn’t tell me: if you don’t change, you’re going to be on the street...that made me reach up and do my part”).
- Another man talked about how, because of adverse effects, he’d stopped taking his medication and expressed wonderment that his “psychiatrist still wanted to keep seeing him.”
- In terms of the kind of support offered, participants talked about support for “becoming independent”; another talked about support in keeping with his desire to “go back to school.” Further, several participants described a desire to have a “normal” life and to “live properly”. One participant expressed, “I’d like to have nice, new clothes. I’d like to have dishes...I’d like to have...just everything that a normal person would want.”
- In contrast, another participant talked about his concerns that the project could “become complacent”, i.e., offer him support at the beginning but then not much after.
- Others talked about how the support they needed was quite intense. “I’ve got my name on the door at the detox place”, said one man. “The whole 10-day detox thing doesn’t work,” said another.

Theme: The project as a turning point

- When asked about critical life events, some participants identified the project itself as either a lifetime high point or turning point, leading to a renewed sense of hope. As one participant expressed, “You don’t know how much hope means until you have none. This [project] kinda gives me hope.”
- Other participants described how the project allowed them to feel that they are getting out of a “whirlpool” or “trap”, which is how they described the precarious housing conditions that they experienced prior to the project. One woman said “I was ready to give up when this project came along.”
- Another participant said: “I’m ecstatic about (the project).” For this woman, being taken from her parents (and dislocated from her Aboriginal culture) as a young child had been her life’s low point. She talked about her life’s high point in terms of how the project was enabling her to reconnect with her family, and “who she was.”
- As another person said, he had waited a long time for housing, but finally getting it was “the light at the end of the tunnel.”

- Another participant noted, “I just feel better now about myself...I have a roof over my head and I can go home any time I want.”
- Others described how the project allowed them to feel that they are “restarting life again.”
- While participants appreciated the opportunities the project had brought them, they also talked about lost opportunities, both in their own past, and for other people. “I wish the project had come along 10 years ago. People are dying out there.”

BACKGROUND

The National Qualitative Research Group put together the above synopsis of early findings, which is based on an analysis of emerging themes focused on one particular question from the baseline narrative interview: “What do you think of the At Home/Chez Soi project so far?” Two members of the team independently reviewed transcripts from four of the five sites for a total of 28, and collaborated to identify the emerging themes. The themes presented reflect the early impact of the initiative on participants who were interviewed shortly after entering the project.