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'At Home/Chez Soi' Project Baseline Consumer Narrative Report

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INTRODUCTION

Homelessness remains a significant social issue in Canada, and particularly in Toronto, its largest city. The Street Needs Assessment conducted in 2009 estimated that, on a given night, there were more than 5,000 homeless people in Toronto, 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. Research has shown that homeless people also often have complex mental health needs (Fischer & Breakey, 1986; Padgett et al., 1990). Approximately one-fourth to one-third of homeless individuals in Toronto has a serious mental health problem 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 problems (Toronto Shelter Support and Housing Administration, 2006. While the service landscape in Toronto is typically characterized as having a wealth of available mental health services, it is estimated that only 25-50% of those eligible for services actually receive them. Although this may in part be attributed to a lack of capacity, it is also influenced by the absence of coordination amongst the existing services. There are ongoing efforts to develop a centralized access point for certain community services including case management, ACT, and supportive housing.

The 'At Home/Chez Soi' Research Demonstration Project (henceforth referred to as "the Project") is a health intervention that explores a 'Housing First' approach to improving the lives of clients who experience both homelessness and serious mental health problems.[1] 'Housing First' is a promising service model that has been increasingly implemented in North America, in which individuals experiencing homelessness and severe mental health problems are provided with housing free of prerequisites for sobriety and treatment, and given flexible access to supportive health and social services (Stefancic & Tsemberis, 2007). The Project is funded by the Mental Health Commission of Canada (MHCC) and builds on existing evidence and knowledge in the field, and applies it to the Canadian context. The Project is occurring in five cities across Canada: Moncton, Montreal, Toronto, Winnipeg, and Vancouver. Each of these sites has a specific target population or sub-study; these are: rural and francophone; social housing; ethnoracial; Aboriginal; and homeless people with concurrent disorders. The project aims to develop evidence on effective services and interventions for homeless people with mental health problems, and will help inform policy and programming to end homelessness in Canada. In Toronto, a total of 581 participants have been enrolled in the study. One hundred (100) participants have been randomized to an intervention designed for those with high service needs, 104 have been randomized to a moderate needs intervention, 102 are participating in an ethnoracial intervention arm, and 275 have been randomized to a 'care as usual' arm.

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[1] A potential candidate for participation has to demonstrate the presence of a serious mental health problem when (i) the threshold for a diagnosable "illness" is met as established by the Modified MINI International Neuropsychiatric Interview or (ii) at least one psychotic behavior is observed/reported by the referring source in the past month or (iii) has documentation of a diagnosed mental health condition AND serious functional impairment is observed/reported by the referring source in the past month.

In order to further understand early trajectories into homelessness and experiences of mental health problems, as well as pathways out of homelessness and related impact on mental health and service use, we conducted a series of in-depth, narrative interviews with a sub-sample of 60 ‘At Home/Chez Soi’ Project participants in Toronto. These interviews provide participants with the opportunity to tell their stories and discuss their lived experience in their own words. Participants participated in a baseline interview approximately one month after their enrollment in the study, and are to participate in another interview 18 months after their baseline interview in order to capture changes in housing status and mental health over the course of the Project. This report reflects the findings of the baseline narrative interviews (refer to Appendix A for a description of the local project context: site description, characteristics of homelessness situation, and description of Care as Usual). The themes presented in this report will be useful for increasing our understanding of pathways in and out of homelessness, determinants of homelessness and the interconnectedness of housing status and mental health, as well as the complex service needs of this population. Findings will also be helpful in identifying key intervention ingredients and contexts that may affect project outcomes, and will assist in informing the development of similar interventions in the future.

I. METHODOLOGY

As part of a cross-site effort guided by the ‘At Home/Chez Soi’ National Qualitative Research Team, this report aims to provide insights into the lived experiences of study participants in their own words through life-story interviews. Qualitative methods were used to study how people who experience both homelessness and serious mental health problems construct their life stories and their experiences with homelessness, housing, and the mental health system. Qualitative methods enable an in-depth understanding of the personal stories and lived experience of study participants and how those stories inform the practice, service delivery and policy implications of the study.

Sampling

A total of 60 participants from the Toronto site ‘At Home/Chez Soi’ project took part in in-depth qualitative interviews. These interviews were conducted with 24 participants from the Intervention group (12 from high needs and 12 from moderate needs), 24 from the Care as Usual group (12 from high needs and 12 from moderate needs), and 12 from the Ethnoracial Intervention. Demographic information for the study sample is presented in Table 1 (below).

Table 1. Demographics and Measures

Characteristic	Percentage/ (n)
Need Level	
High Needs	40% (24)
Moderate Needs	60% (36)
Gender	
Male	67% (40)

Table 1. Demographics and Measures	
Female	30% (18)
Transgender	2% (1)
Not Indicated	2% (1)
Ethnoracial	
Yes	55% (33)
No	45% (27)
Aboriginal	7% (4)
Age (Years Old) (mean)	41
Education Level	
Completed Graduate School	3% (2)
Completed University or business, trade, technical school	14 % (8)
Attended University or business, trade, technical school	11% (7)
Completed High School	22% (13)
Attended High School, not completed	37% (22)
Completed grate 8 or less	13% (8)
Months Homeless in Lifetime	
≤ 6	13% (8)
7 to 12	13% (8)
16 to 24	17% (10)
30 to 72	29% (18)
≥ 84	27% (16)

Specifically, interviews were conducted with 40 men and 18 women; one participants identified as transgender. Data on gender was not available for one participant. In terms of ethnicity, the sample was weighted in favour of ethnoracial participants, who constituted 55% of the sample. Also, approximately 7% of participants identified themselves as Aboriginal.

A total of 24 participants were identified as High Needs, and 36 were identified as Moderate Needs.[2] With respect to education level, 3% of participants completed grade 8 or less. While 22% of participants completed high school, 37% reported that they did not. Further, 14% of those interviewed reported having completed some form of post-secondary education (University or business, trade or technical school), while 11% reported having attended but not completed post-secondary education. Notably, 3% of study participants reported having completed graduate school.

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[2] Study participants were classified as high or moderate need using criteria that correspond to Section 3 of the Ontario Standards for Assertive Community Treatment (ACT) teams. Study participants who met two or more of the criteria were determined to be high need. All other study participants were classified as moderate need.

Finally, when asked about the number of months in their lifetime in which they had been homeless, 13% of participants reported having been homeless for six months or less; 13% had been homeless for seven to twelve months; 17% had been homeless for sixteen to twenty-four months; 29% had been homeless for thirty to seventy two months; and, 27% reported having been homeless for seven or more years.

Potential participants for the baseline narrative interviews were selected by sampling every 10th participant to be randomized to each study arm (high needs Assertive Community Treatment [ACT]; moderate needs Intensive Case Management [ICM]; Ethnoracial-Intensive Case Management [ER-ICM]; and Care as Usual). The sampling frame was adjusted four times in order achieve a distribution of participants that satisfied the sampling criteria and was representative of the demographic distribution of study participants at the Toronto Site of the Project.

Recruitment

Participants were selected using their participant identification code from the 'At Home/Chez Soi' study database (Health Diary). Potential participants were contacted by phone or in-person and invited to participate in a narrative interview within 1 month of being randomized into the study. A total of 151 participants were selected and contacted to participate in a narrative interview. Barriers to recruitment included participants failing to show up for a scheduled interviews, and unsuccessful contact with a selected participant for a period significantly greater than 1 month of entering the study. The rate of recruitment was also influenced by the rate of participant recruitment into the overall study, as well as the randomization of participants into the intervention and control groups.

Interview

Interviews were conducted by a group of three research staff and were completed between March 2010 and June 2011. One of the interviewers identified as a person with lived experience (PWLE) with mental health problems and the mental health system. Another interviewer identified as ethnoracial and conducted the interviews with participants from the Third Intervention Arm. Interviews were conducted onsite, at the project office for the 'At Home/Chez Soi' Project, or in participants' homes. All participants provided written, informed consent to participate, and agreed to have the interviews audio-recorded. Interviews ranged from approximately 45 minutes to 1.5 hours in length. Interview participants each received an honorarium of $25, two transit tokens, and a resources sheet outlining health and social services in the Toronto area. The study was approved by the St. Michael's Hospital Ethics Review Board.

Data Analysis

Analysis of the interview transcripts followed the grounded theory method of analysis. The grounded theory analysis process is focused on building theory and involves the turning of rich, in-depth narratives of individuals' experiences into theoretical frameworks (Charmaz 1990; Glaser & Strauss 1967). It does so by employing inductive strategies, systematic coding and comparative analysis procedures to analyze "individual cases, incidents, or experiences and develop progressively more abstract conceptual categories to synthesize, to explain and to understand…data, and to identify patterned relationships within it" (Charmaz 2004; 497).

In this study, the analytic process began with coding the interview transcripts. Two of the qualitative interviewers who conducted the study interviews coded all of the interview data using NVivo (QSR International, version 9) software. They first engaged in line-by-line coding, which involves reading through sections of transcripts of interviews carefully to identify key concepts (Charmaz 1990). To ensure reliability during this process, the interviewers double-coded 6 interview transcripts, and met regularly to compare the accuracy of their codes and worked by consensus to refine discrepancies. In general, there was a high degree of consensus in the coding, with slight differences in the wording of codes. However, there were instances in the reading of the double-coded transcripts when each interviewer added codes that the other had not coded. Interviewers also identified difficulties in faithfully coding some participants' transcripts when the apparent content validity of the narrative was low. This was a particular issue for transcripts of participants demonstrating low insight into their mental health problems. These issues were discussed and resolved in consultation with the original interviewer or with a qualitative research supervisor.

The interviewers then transformed codes into higher-level categories by analyzing and grouping similar codes into conceptual categories, using the constant comparative method of analysis (Charmaz, 1990). The constant comparative method involves the comparison of themes and concepts that emerge from the data as the analysis progresses and facilitates the refinement of the theory by constantly incorporating new themes that may emerge through the analysis process (Charmaz 1990). Sensitizing questions that pertain to key interview guide topics were also used to code relevant statements/ideas to capture themes that were related to these topics.

Additionally, field notes were recorded by the interviewers upon completion of each interview; these notes served to support quality assurance measures, and for interviewers to identify and reflect upon themes from the narrative interview (refer to appendix B for quality assurance measures).

A larger group of qualitative researchers from the team met on 5 occasions to discuss the emerging categories and to collectively reduce the categories to a smaller set of higher-level themes. Once a set of higher-level themes was developed, a meeting was convened of the larger qualitative team including the study principal investigators to receive feedback and to ensure that the themes reflected the experiences of study participants.

II. FINDINGS

Findings from the Baseline Consumer Narrative Report are presented in seven sections. Each section faithfully details participants' accounts of: 1) their experiences and pathways into homelessness; 2) experiences with life on the streets or in a shelter; 3) experiences with mental health problems; 4) social supports; 5) mental health and social services; 6) thoughts on current or potential housing; and, 7) other hopes for the future.

A) Pathways and Experiences of Homelessness

Experiences before Homelessness

When 'At Home/Chez Soi' study participants were asked about experiences before homelessness, two narratives seemed to emerge from the interviews: stories of stable lives and reflections that life was "good" before homelessness; and stories recounting often interconnected events and experiences related to instability that preceded homelessness.

Reflections on a "good" life

Regarding life before homelessness, some participants recalled times when life was "stable" and "good". They noted factors that were helpful for keeping housing, or generally supporting well-being. A number of participants discussed living with family, either parents, or partners and children, as a positive experience before they became homeless. Positive relationships with partners were cited by many as important parts of their lives when things were "great". One participant described the benefits of living with his partner: "Yeah, it's good there you know, they are like a family, like […] you know, when you have a woman living with you and, and when you are living alone it's not the same."

A number of participants discussed how partners/family members provided them with security, and/or were supportive by helping them with cooking, childcare and other daily tasks. Some felt that living with family was beneficial and was an important factor keeping them housed because they received housing but did not have to pay rent. Some participants noted how they also helped out their family in return. One participant described a mutually-beneficial family relationship:

> *Oh she [grandmother] had died and my mother took it over and we renovated the basement and I had my daughter, so I lived in the basement to help my mother and she helped me, because I was working and so she'd babysit so it was nice, yeah.*

Some participants associated employment and attending school with a time when life was stable. Many, such as the following participant, noted responsibilities that they had had and some also expressed pride in work and receiving an education:

> *Well, a good time in life was when I was working and I had a girlfriend and I planned on marrying her […] I've got a good, good full-time job and I was you know, I had responsibilities and […] I pretty much ran a factory […] I was production coordinator […] and the girl you know was, she's beautiful and loved me and all that stuff but the booze finally took over that. But that was a high point, that's when I was with her, it was great.*

Some participants discussed that this was a time when they had nice housing and good relationships with landlords. This participant vividly described his former home:

> *Well, it was nice in a sense that it had two French windows um, and it was fairly spacious, and as I said the squirrels would come around, it was green every year at the front, there was a, a good view of the Toronto skyline at the back sort of thing. It was, it was relaxing, it was, it was nice, if it hadn't been for the stairs I would probably have stayed there.*

Another participant described the ways in which a landlord had improved his quality of life:

> *I came to Canada where, where, where she had moved to and she found me a bachelor apartment, a basement apartment in a house not far from where she lived and as it turned out I, I realized that my landlord he was doing pretty well doing my housework for me because my apartment was always spotless and I did hardly any work any housework. So, it was very, it was satisfactory, everything was fine…*

Instability before homelessness

In contrast to narratives of a "good life" discussed by some participants, several participants discussed consistent experiences of instability through their lives before homelessness characterized by negative events and experiences such as abuse, conflict with family, death of family members, conflict with the law, poor mental health, substance use, and discrimination.

Several participants discussed coming from unstable backgrounds in which they moved around and lived with different family members, due to parental substance abuse, divorce or abusive relationships. Parental mental health problems also had a negative impact on participants in their childhood, such as for the following participant:

> *I was living with my aunt before that, my mom and dad are dead, my dad shot himself when I was 8 months old and my mother burned in a fire when I was 17 so, and my mother was an unfit mother like what they said, I was awarded to the court when I was 8, she beat me and she was schizophrenic and a heroin addict and she prostituted herself to support her habits and she's very, I loved her I mean, she was sick and it wasn't her fault that she did these things, they didn't have the understanding of mental health then that they do now and so, I was raised a lot by my grandmother, grandpa.*

A number of participants discussed early experiences with their own mental health problems and substance use that affected the stability in their lives. One participant explained:

> *Smoking weed and drinking in the beginning. That was like my first encounter with like, I knew I was crazy even before I started smoking weed, and I was like pretty crazy like I had like symptoms of like OCD.*

Several participants discussed a lack of supportive relationships and problems in their marriages prior to becoming homeless. Problems ranged from general conflict and feelings of being taken advantage of by partners, to experiences of domestic violence. In these cases, there was a sense that negative relationships and lack of social supports interfered with otherwise stable lives, such as for the following participant:

> *When I was living with my ex-husband and my son, everything was good, he provided everything I never had to work, I did not wish to disclose his means of money because I feel this is about me, but I never had to work and my son was always well taken care of it's just that our marriage was a disaster. I think his intention after many years of being together was that he was going to get his status, I don't even have a status.*

A few participants spoke of conflict with family due to lack of understanding related to their sexual orientation. For one participant, this resulted in feelings of guilt and shame:

> *I felt shame, I felt guilt I felt so much guilt because, I brought so much shame to my family's name you know, we were a very well respected family in the community and my homosexuality brought shame to the family.*

Transitions/Pathways into Homelessness

Whether participants had experienced stable or unstable lives before homelessness, many drew clear linkages between particular negative events or experiences that led them into homelessness. Several participants attributed substance use issues and negative social relationships to their loss of housing or housing instability. Often landlords became aware that drug dealing or substance use activity was going on in the participants' home and they were subsequently evicted. One participant lost control of his housing and saw his apartment turn into a "crack house":

> *I lived in Kensington Market, I had a nice bachelor apartment there […] same thing crack addicts, they overtook my apartment, I didn't realize until it was too late and the crack dealer upstairs above me was sending all of his clients to my house, to my door to do his drug deals […] and that's when the house was so full of people […] because they were doing their deals of crack in my apartment…*

Others discussed conflict and break up with partners as a key factor related to homelessness, due to both emotional and financial consequences. 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 worst he scam welfare and I have to pay for it. He just left me*

> *without nothing, he left, he left with all of our money and all the furniture and the appliances in the house.*

Financial hardship related to job loss emerged as another factor leading many participants into homelessness, as for one participant:

> *I lost my job [….] Therefore, I couldn't keep my housing. Bills started to come in. By that time I already had credit cards. By that time I already had a car, which I lost. I had to […] they came and picked it up. I lost everything. Within a matter of, like, a year, I had nothing, you know?*

Many discussed a chain of interconnected events leading to homelessness. For example, some participants were "kicked out" of their family homes, which contributed to mental health and substance use issues related to their housing instability, as was the case for the following participant:

> *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.*

In another example of the chain of interconnected events leading to homelessness, one participant experienced the death of his parents and the end of an important relationship within a short period of time, began abusing substances as a coping mechanism and was then evicted by a family member:

> *And then my parents passed away and I lost the girl I was going to marry and this that, and that happened and […]I moved to Windsor […] Bought a house in cash, sat in the house for awhile and then everything went in arrears because I was an alcoholic […] and I was into cocaine and in the end sold the house, drank that money and snorted it. I ended up in my sister's place in Mississauga, […] stayed there for a little, about a couple of months and then she threw me out and I landed on the streets.*

A few participants reported mental and in some cases physical health problems and subsequent hospitalization that made it difficult for them to meet the demands of employment and make rent payments, subsequently leading to loss of housing. The following participant explains how hospitalization related to his mental health and led to his eviction:

> *I ended up getting sick[…] and being in the hospital for a few weeks and nobody is taking care of my cat[…] so that, the landlord found out about the cat and uh, and he found out that I was in the hospital at the same time so he yeah, he didn't even uh, give me the rest of the month, like there was another 2, 1 ½ weeks or something before the end of the month and he wouldn't reimburse me for that he just kicked me out. So, that wasn't very nice.*

B) Life on the Streets/in a Shelter

Life on the Streets

The challenge of meeting basic needs

The experiences of living on the streets varied widely across the study population. For some participants, this was their first experience navigating the streets and the shelter system, while others had spent a large proportion of their lives living this way. More often than not, this experience was not linear and many participants spoke about periods of being housed interspersed with shelter stays, ‘couch surfing’, or sleeping on the streets.

Many participants characterized the challenge of meeting their basic needs while navigating life on the streets as an issue of survival. The impact of street life on people’s health – both mental and physical – is often described as being quite severe. Especially for individuals who have various health problems, it is very difficult to keep themselves stable and cared for, as for the following participant:

> *If it’s [housing] unstable then my health is poor because then the primary concern for me […] is the housing I have to get […] especially in the dead of winter. So, I have to let go of my physical and mental health as well, eh? Until I get the home again.*

As the participant above stated, shelter becomes the primary concern over and above maintaining health and well-being. From riding the subway until close, to sitting in coffee shops, to seeking shelter in abandoned buildings, individuals are finding places to protect themselves from the elements. As one participant stated, “I made a plan because 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.”

The term ‘survival’ emerged numerous times in regards to meeting basic needs – and more specifically staying safe – while living on the streets. One participant talked about the need for street smarts: “That side I did not learn in school. That side you have to get on the streets to learn. Knowledge comes a lot of times with pain.” Female participants in particular described the streets as frightening and dangerous, as for the following participant:

> *I would never sleep because I am a paranoid person and if I slept, it would be taking turns with people or sleeping in the middle, because I am a very petite girl so people can do anything to me.*

Random acts of violence, muggings, and sexual assaults were not uncommon experiences. One participant talked about sleeping in bank entrances because these areas are under video surveillance and are therefore perceived to be safer.

Participants found it challenging to meet their basic need for sleep while living on the streets. Because of a lack of safety and security, many people would stay up all night or try to get a few minutes of sleep in public places:

> *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.*

Self-care and hygiene were other basic needs and, as one participant noted, some of the hardest to meet while living on the streets. Participants would go to laundromats, public pools or community centres, public washrooms, and drop-in centres in order to wash and to clean their clothes. For some participants, maintaining a level of cleanliness was not only an issue of hygiene, but also a question of self-esteem:

> *I was the homeless guy that you never knew was homeless… You know, there are some homeless people that […] make it very obvious. They have big, long beards, they don't dress nice. Me, you couldn't tell that I was in the streets for a long time.*

The lack of privacy and self-determination that comes with life on the streets or in a shelter also made it challenging for study participants to maintain self-esteem. Some describe their experiences as degrading and shameful:

> *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 street.*

A number of participants noted that life on the streets only gets more difficult with age and that they are feeling the impact of aging on their well-being: "I'm getting old and getting tired, so I am less optimistic these days […] my outlook is much darker than it was 10 years ago."

Food services

When describing the community services that they use (in addition to mental health and shelter services), participants spoke primarily of food services provided in the community, including prepared meals and food banks. Prepared meals are offered throughout the day in drop-in centres, usually at no cost. Participants indicated that they have choices in terms of where to eat, especially in the downtown area, and that some agencies provide better quality food than others. One participant explained: "In Toronto, you're never, never going to be hungry downtown. I know where to go to 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."

Use of time

For individuals living on the streets or in a shelter, the days can be long. As one participant stated, "Everyday, just like a year for me." Many participants described a typical day as "killing time". Especially for those individuals who were staying in shelters, the day-time closing of shelters, and subsequent need to kill time emerged as a problem for many.

Many participants spoke about visiting different drop-in centres during the day – for meals or to access a variety of different services. Internet use, volunteering, exercise and sport, walking, and socializing were other common activities that participants engaged in to fill their days.

Social interaction

Many participants spoke about engaging casually with other people in shelters or drop-in centres but made a clear distinction between acquaintances from the street and friends: “Yeah, I talk to the people but like there’s no friends business there.” Rather, these were people to hang out with or people who taught them ‘how to survive’ the streets.

Other participants spoke about choosing to limit their interaction with other street-involved people as a way to stay out of trouble and take care of themselves:

> *Because you know, like people that are in the shelter system aren’t the healthiest themselves so those relationships tend to be a little bit more draining or unhealthy.*

For further discussion of social interaction while homeless, see *Social Supports*.

Life in a Shelter

Choice of shelters

Most participants in the study reported having accessed shelters at some point, either briefly or for a longer period of time. While some had previous knowledge of the shelter system, other participants discussed a complete lack of knowledge about shelter services prior to their first experience of homelessness.

What was clear throughout the interviews, though, was that participants see Toronto as having a large number of homeless shelters, particularly in the downtown core, but also in the broader GTA. Participant viewed the density of shelter services in Toronto as affording them a certain amount of choice. A large majority of participants who had used shelters discussed accessing more than one during their time on the streets. Some participants spoke about choosing shelters that were specifically geared towards certain populations, including women, youth, and LGBTQ-friendly. Others may have traveled the ‘shelter circuit’ – moving from one shelter to another – due to factors such as being barred or evicted from one shelter or due to quality issues.

Quality of shelters

A number of participants spoke about differentiating between shelters based on quality. Quality was determined by factors such as rules, safety, shelter staff and services.

Shelter rules

Shelter rules also distinguished one shelter from another in terms of quality. Several participants described certain shelters as more lenient than others with respect to substance use:

> *Certain shelters have criterion of sobriety, you needed to be sober to get in. If you’re drunk and acting up, they won’t put up with it so there’s certain shelters that do and usually the ones that do have drunks around, they’re filthy and loud and dangerous.*

The prevalence of substance use in certain shelters was a challenge for those individuals who were working to get themselves onto a path of recovery from substance abuse. One participant describes his experience staying clean as a struggle:

> *I've got to fight just to stay clean. I mean like it's hard to stay clean but when you have people with drugs right in your face every day it makes it a little tougher to stay clean.*

For this reason, many study participants spoke about having to isolate themselves from other residents or having to move from one shelter to another, in an attempt to distance themselves from negative social influences.

For some participants, shelter rules, such as curfews, had a positive impact, providing a level of structure to the day and encouraging accountability and motivation.

> *I guess you are a little more accountable because you'll think about the consequences of your actions a little more if it's like, well I could lose the roof over my head tonight if I do this or I don't come home in time […] It forces you to look a little bit at where you're heading or what you are doing.*

Safety and security in shelters

Like living on the streets, living in shelters brings its own safety and security concerns. Female participants in particular spoke about feeling safer in shelters than on the streets. However, the level of violence in some shelters, particularly in those that are lenient regarding substance use, was also a concern for some study participants, regardless of gender:

> *You have like 50 guys you're living with and you have to get along with, you have to accept the way they are, if they want to curse and swear, they want to use drugs or talk about beating people up or whatever. All the things that go along with homelessness. And drugs and violence are two of them.*

Discrimination was another major security concern for a number of different participants, who recalled experiences of discrimination based on sexuality, gender, race/ethnicity, religion, and mental health status.

In some cases, shelter staff were responsive to complaints of discrimination by other shelter residents; other times, it was the staff who perpetuated the discriminating behaviour. One participant talked about how this affected her use of the shelters:

> *I've got it. I've got my hair pulled. I've got my shit stolen because I'm Indian. I've got called 'Paki', I've got all the names but I had to live with it. I had no choice […] a lot of people – workers, people in the shelters. That's why I never really stuck around in any shelters. I would stay for a night and then I'd be back out.*

Theft and other concerns about personal possessions were also commonly discussed. Even if shelters had lockers for residents, often they were too small to hold all of a person's belongings.

One individual stated: “If you didn’t hold onto your personal belongings tight enough, they got stolen.” Another participant talked about not wanting to take their nighttime medication out of fear that their things would be taken if they fell asleep. The overall attitude seemed to be: “keep one eye open.”

Shelter services and shelter workers

Some participants mentioned that certain shelters provided more services than others, such as access to social workers, counselors, health care services, and housing and job support workers/programs and these participants often availed themselves of these services when they were offered.

While some participants had positive experiences with workers, others described shelter workers as uncaring and unprofessional, and even neglectful:

> *I have been to a few shelters […] they’re supposed to be geared toward the homeless person but it ends up being about the staff. And I found everywhere I went it was about their shift change, you know?*

Food quality

The provision of food – and in particular, the quality and availability of food – was the shelter service that was most often discussed by participants. Many times, the overall quality of a shelter seemed to be measured by its food – good or bad, not enough, unhealthy, or bland.

Crowding

Crowding in shelters was one quality issue that was described numerous times. Many people spoke about the difficulties associated with sleeping in a dormitory room with as many as 80 other people:

> *…Just (a) lack of privacy, if you are feeling a certain way being able to go off by yourself […]You can’t go anywhere and – excuse the expression – but go and pick your nose in private.*

Day-time closure of shelters

A great many shelter users spoke about the day-time closure of most shelters and the negative impact it has on health and self-determination. Many people spoke about being “kicked out” and “killing time” until they were allowed back in: “It doesn’t matter if it’s snowing like a blizzard and cold as hell or if it’s pouring like down, out you go no matter what, even Christmas day.”

Impact of shelters on mental health

While some participants described a positive shift in their mental health in a shelter, many participants recalled a decline in their mental health during their shelter stays. For many participants, going to the shelter was a last resort and there was an associated sense of disbelief and disheartenment upon their arrival: “I think a person like me who has always been working and very proud of myself, (having) raised three children, being in a shelter is one of the lowest points of my life.“

A number of study participants spoke about their stay at a shelter as a time of deepening depression – increased stress levels, loss of sleep, and an overall sense that staying at the shelter "made things worse." One participant who has a history of depression described her first stay in the shelter system as a "completely different experience": "…Although I've had problems with depression before, this kind of made – it seemed to break something in me."

In terms of following medication regimes while in shelters, participants indicated that, at some shelters, residents are asked to hand in their medication to staff upon arrival. Some participants expressed concerns about their medication being stolen while in shelters and about being given the wrong medication by the staff.

Impact of shelters on physical health

In addition to their mental health problems, participants are often contending with physical health issues. These represent a variety of chronic physical health conditions, including Hepatitis C and epilepsy, as well as debilitating injuries.

Being "kicked out" of the shelter during the day exacerbated existing health conditions for some participants, who felt it was almost impossible to get permission for the bed rest they felt they needed:

> *With epilepsy you must have proper rest, relaxation, nutrition and medication, and sleep, proper sleep to keep yourself stable […] I started having seizures again more frequent […] I think that was due to the stress, being put on the street from the shelter and first thing in the morning, out in the winter, out in the rain, out in the hot sun, and you weren't allowed to come back til 5:30 in the evening. So, it was a long day.*

In addition to being on the street all day, overcrowding, poor nutrition, and a lack of cleanliness in shelters were all factors that participants associated with a decline in their physical health while staying in shelters. In particular, the inability to get a good night's sleep was one of participants' major concerns, as for the following participant:

> *I have been in shelters where there is as many as twenty women in a dorm setting, so you have 20 beds and you have to listen to that one snore, and that one fart […] or that one have a nightmare and wake up screaming and it's really hard to get a good night sleep sometimes.*

Many participants spoke about self-medicating using sleeping pills or alcohol as "the only way to get a proper sleep."

C) Social Supports While Homeless

Several participants discussed having different kinds of social supports in their lives, whether it was from friends, family, acquaintances or the friendship of companion animals.

Instrumental Support while Homeless

Some participants discussed the importance of instrumental support through friends while homeless or living on the street and that friends would help with survival through providing food, money, information on resources or advice, as one participant described: "Right so, sometimes like help me with food and, and thankfully those always have been there some friends they come and going like, comes and go, friends comes and go…" One participant discussed the value of friends who were helpful in navigating the drug scene and related survival:

> *And they were just so you know, supportive of me and they said nope, we won't let you know, next time you come we will kill you if you ask for drugs because you know what drugs around here is really bad you know?*

Another participant indicated that unconditional support from a friend was key in making some changes in her life and getting her back in touch with her son:

> *And then by the grace of God one day I got a phone call from my son's godmother who's been my friend for over 20 years, she delivered my son and uh, she said I, your son needs you and I need you to come, I said I have no money and she said don't worry about it just bring what you have and I gave them the address and 45 minutes later by GPS they found me on the street dirty, homeless {Crying} hungry and sick but they found me and then when I got to that house you know, I got myself together and I seen my son.*

"Real" Vs. "Drug" Friends

A number of participants distinguished between people who were "real friends" that they could count on and from whom they could derive consistent support, versus "drug friends", as one participant described:

> *…These are like real friends, good friends, friends that's there um, friends that's there for me you know, friends that's there for me, friends that will help me and friends that will you know, take care of me if I need, yeah if I need something or I need help you know, if I need help or something like that […] I keep in touch with even today, yeah, even today still.*

"Drug friends" were friends or acquaintances with whom they used drugs and who typically moved in and out of their lives and were less reliable and often untrustworthy. Some participants discussed a desire or need to separate themselves from "drug friends" who are well entrenched in the drug scene in order to begin to control their own drug use and move towards recovery. As one participant said:

> *… Most of the people I know, I`ve been down, downtown for 35 years in the same neighbourhood I know all the people like, I mean they're my friends so long and the bad habits they have I just don't want to fall back that way you know?*

Support in Recovery

Some noted the importance of consistent support from peers or friends during recovery from mental health and/or substance use issues. Support from peers was viewed as valuable in the process of healing because they could relate to their experiences and challenges dealing with mental health and substance use. They felt that it was important to be able to talk to someone about their experiences who had "been there". Some discussed the importance that counselors be peers as that shared experience enhances their credibility and understanding of the struggles related to mental health and substance use problems and the treatment/recovery process:

> *Just being there, listening and talking, and you know, some of the, the counselors that were there […] they were actually you know, um, they've been there. They've been there, they weren't fucking from the text book […] And they weren't from the text book, I mean some of them were but I didn't have to listen to them, right? [...] it was like {Snoring noises}, like come wake me up when you're done […]*

One participant described mutual acceptance between peers as beneficial:

> *I later found an organization […] through one of the, the gentlemen in the shelter… which was very beneficial for me because they could relate and identify with my illness…accept it too you know, and I accepted them for their illnesses too.*

Self-help treatment groups such as Cocaine Anonymous and Alcoholics Anonymous were sought out by many participants and peer sponsors in these groups were valued. One participant discussed his sponsor in Cocaine Anonymous as important for building confidence in his own recovery:

> *I've got a sponsor that's working with me I've got, I've got a lot of, I am really, really building my safety net and I, I went to a Cocaine Anonymous convention and I, I met a guy there a, about 10, 10 or 15 years younger than me and this guy has recovered you know, completely recovered and I thought you know what, if this guy can do it I know I can do it.*

Support from Service Providers

Some participants talked about receiving social supports from service providers, in particular counselors and social workers. Participants in the intervention arms spoke about the support they were receiving from their 'At Home/Chez Soi' service providers. As one moderate needs participant indicated:

> *I got [my worker] to help me if I, if I ever need something different she, she, she can get in touch me with me.*
> Interviewer: And how did you, how did you link up with her?
> *Well, through you guys.*

For more about mental health service providers, see *Mental Health Services*.

The Friendship of Companion Animals

A number of participants valued the companionship of pets, and discussed the importance of dogs, cats and birds in their lives:

> *They go into shelters and then they're euthanized or whatever like you've got to find room for people with dogs because they're a companion and Louis was with, my dog's name Louis he was with me when I went through… I didn't tell you all my illnesses…*

Many discussed challenges with finding or keeping housing because they had a pet and often, shelters and landlords would not allow pets. Subsequently, these participants were faced with the decision to give up their companion animals or find new housing. As one participant explained:

> *I had a couple of cats that I actually, I had to give up again obviously because I couldn't take them across the border as soon as I, I had to say good-bye to them that's when I was just like okay, if I don't have them here, then I don't want to be here.*

Another participant lost his housing because his dog frightened his neighbours:

> *We moved into that apartment and it was a bachelor and the lady said oh my god, these dogs are big dogs, I thought you said they were little and we said you know what a Rottweiler looks like but for Rottweilers they were little and most of the older people they weren't scared of them […] but there was a couple of old bitties that had a problem and so she asked us to leave.*

Loss of Friendship and Support

Other participants talked about difficulty maintaining friendships while homeless. Many felt that they tended to lose friendships because friends would not continue to be supportive while participants were homeless or dealing with mental health and addiction issues. For some this translated into apprehension about the prospect of making friends:

> *I felt like, that maybe they won't like me. Like, because like, one, I don't have a place. I'm homeless and like I'm not making my house and making much money. Actually, I wasn't making money at all. Because like, my job, again, it was like a part-time. Sometimes they would call me, I'd go there. Other times, they don't call me, you know?*

Some implied that the inability to maintain friendships was due to a lack of respect related to an inability to keep housing and make money, or stigma towards people experiencing illness, mental health problems and addictions, or conflicts with the law: *"You really know your friends when you end up in jail or in a hospital and nobody comes to see you, thank you very much."*

For further discussion of stigma and discrimination in relationships, see *Experience of Mental Health Problems*.

As discussed earlier, a number of participants noted the loss of an intimate partner as very difficult, and the repercussions this had for mental health and/or substance use issues:

> *And yeah, so when I broke up with her it was like who do I talk to about it because I was really angry right, you know, I couldn't talk to my mother, didn't have no so called good friends and the one guy who I really, really trusted […] he was really cool back then he was cool, and I went down and I said […] I've got a problem man we've got to talk right?*

> *[…] and that was the fucking biggest mistake ever did, I went down his basement and never left for a couple of days, never fucking left […] that's when I started doing some hard drugs.*

General Lack of Support/Preference for Social Isolation while Homeless

Similarly, some participants discussed difficulty making friends while homeless and a general lack of support during this time of their lives. Some also said that because of bad or disappointing experiences with relationships in the past, they are reluctant to try to make friends and prefer to "keep to themselves" or to be alone:

> *I don't know, probably because I can, I don't know what to look for in a friendship now, if it should be long lasting or short, short, short or long relationships probably like even myself now like I don't need that, like I don't need to feel isolated either, [but] I am still happy on my own.*

D) Experience of Mental Health Problems

Early Experiences

Some participants experienced mental health problems at an early age, while others' experiences emerged in adulthood. Many described symptoms emerging gradually over time. This participant had difficulties with school and work as a young adult due to the occurrence of paranoia: "No, I dropped out [of school] because I couldn't concentrate anymore. I was driving taxi and… I got paranoid. I thought the radio was reading my mind or something."

A number of participants discussed that their early experiences with mental health problems emerged in relation to traumatic events including abuse and violence:

> *I know that things wasn't right, I knew but my father will make you think it's you…now, after years and years of really trying to understand why I can't… If he had just let me be and be a father instead of an alcoholic and a gigolo and, and molest me you know, all of that I wouldn't have developed the things.*

Some participants discussed that despite early signs, they did not seek out help due to fear, confusion or lack of personal awareness of the issue. This participant described that it was others that made note of his/her early issues, but that he/she did not receive a diagnosis until adulthood:

> *And obviously like I can remember when I was younger people would say "oh you've got issues", or you've got mental problems and it's {Sighs} I used to laugh at it but obviously there is something there ...maybe there is…I was diagnosed in 2003 with severe depression, I have been on these meds for about 8 years so.*

Some participants who began to experience mental health issues at an early age were connected to treatment through schools and/or parents:

> *I experienced mental health issues back when I…was being raised by my mom actually yeah, it's been since I was a little kid yeah…unfortunately, well I had a child psychologist when I was in school and that's all I really remember about that.*

Concurrent Mental Health, Substance Use and Addictions

For a great many participants, their life stories are fundamentally linked with substance use and addictions. It is therefore difficult to talk about participants' mental health problems without also discussing issues that participants have with substance use. A significant number of participants have used or continue to use a range of substances including alcohol, street drugs (including marijuana and cocaine), over-the-counter painkillers, opiates, and benzodiazepines. In the case of alcohol and marijuana, several participants have been using since their youth, one participant from as early as 9 years old. Some participants also indicate that they have or have had a gambling addiction.

Some participants perceive their substance use as having precipitated or exacerbated their mental health problems. One participant described the onset of his mental health difficulties as a direct result of using: "…after I started using drugs like marijuana and I started drinking then I just became very psychotic. Like it all escalated since then…"

Self-medicating

Many participants described using substances as a coping strategy to deal with mental health difficulties and to relieve stress. Some participants are using or have used substances to cope with the loss of significant relationships, due to death, loss of custody and relationship breakdown. One participant described how he uses substances in lieu of psychiatric medications: "I no longer use the prescriptions, they actually took it off the market, the Zyprexa…I kind of solved the problem myself. I use alcohol. Alcohol and over-the-counter drugs."

Mental Health and Life Problems

Suicidality

A considerable number of participants described struggling with suicidal thoughts, and many have attempted suicide. For some, suicidal ideation persists and affects them every day, as one participant noted: "It's always in my mind, right?" Other participants see their "suicidal tendencies" as part of their mental health problems. For example, one participant described feeling suicidal: "When I hear the voices, I want to kill myself you know?" Some participants connected their wish to commit suicide to the difficulties of living:

> *You know […] sooner or later I am just going to cut life short and it's getting to, it's getting to that point because I said you know, every which way I turn it's, it's, there's always an obstacle.*

Conflict with the law

Many participants have come into conflict with the law. Participants who have served time in prison are sometimes jailed due to issues related to substance use. As one participant noted, "I know a lot of my federal time was due to my addiction to crack and cocaine and because I do robberies and stuff to feed by habits […]"

For other participants, conflict with the law is precipitated by their mental health problems. One participant explained: "the worse my disease gets the more desperate I become and […] the more chances and risks I take." Another participant mixed alcohol with psychiatric medication, with negative results:

> *My charges always came back because of my alcoholism and I didn't realize that [the] medication that I take, you're not supposed to mix alcohol with that. So I would black out, wouldn't know what I was doing and do crazy shit […]*

When participants have come into contact with police, some have experienced harassment due to discrimination based on race or ethnicity. Some report police violence and having been "beaten up" by police. Many participants have had mental health crises in which police are called to intervene. Most often, participants who have been in mental health crisis describe being directed by police into the mental health system, rather than into the criminal justice system.

Mental health, losing housing and homelessness

Participants frequently associated concurrent substance use and a cascade of consequences – such as conflict with landlords, loss of employment, and the inability to pay rent – with loss of housing. Here a participant describes the factors that led to his homelessness:

> *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.*

As discussed previously, some participants describe having lost their housing due to being hospitalized for mental health problems.

Participants describe how being homeless has negatively impacted their mental health. Homelessness is strongly associated with causing depression and anxiety, and acutely so during the winter months. For this participant, having mental health problems intensifies the difficulties of being homeless:

> *It's, it's been getting easier, I guess easier every day on the streets, sometimes it gets harder [...] sometimes because, just because it's just the mental thing that makes it harder. It gets easier but the mental thing is always […] it makes it a challenge every day, it gets harder and harder.*

Homelessness also had an impact on some participants' ability to get treatment for their mental health problems. One participant explained: "The streets are affecting me because I am not getting proper treatment."

Employment and mental health

For many participants, their mental health problems mean that they are no longer able to work. Some participants explained how, due to the nature of their specific jobs, their poor mental health no longer made work possible: "I used to work, I can't work because the voices…I lose my concentration, I have a forklift job […]"

Many participants voluntarily left their places of employment having become unable to continue to perform their normal duties. Similarly, some participants dropped out of school due to mental health difficulties, and in at least one case, due to the side effects of medication: "[…] I had to drop out of school […] because the medication made me drowsy when I was in class and so I would be sleeping in class so I had to drop out."

One participant who had continued to work while in a shelter found the stress of being homeless eroded his ability to remain employed: "[…] the stress from not having stable housing got very high for me; I was showing up late to work so I wasn't able to hold onto the job so I had to quit the job as well." Some participants identified their work experiences as stressful and causing "burn out", and as therefore contributing to mental health problems.

Relationships and mental health

Many reported that family relationships are strained by participants' mental health and substance use issues. For some participants, family support has been contingent on the participant seeking and continuing treatment for mental health and/or substance use. As one participant explained: "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."

Participants also describe how the loss of important relationships has had a negative impact on their mental health. For several participants, the death of their mother is connected to the onset of mental health difficulties, as for this participant: "[I] kind of got lost when my mother died, she died…and 1995, 94, I have been lost since, in and out of psych hospitals, psychiatric hospital for 2 ½ years." Separation from children and the loss of custody also made mental health problems worse for some participants. One participant struggled with suicidality upon losing custody of his daughter: "I kind of felt like I had meaning when I had her, had custody of her and when I lost her I didn't have no, I didn't think I had nothing left to live for I guess you could say."

As discussed earlier, some participants identified negative partner relationships – and the breakdown of positive ones – as contributing to the decline of their mental health. One participant went "downhill" when his girlfriend left, feeling that he had "lost the world." Other participants experienced partner abuse which had a detrimental impact on their mental health.

Stigma and discrimination

There is a strong sense among participants that having a mental health issue is stigmatizing. For some participants, stigma or fear of discrimination prevented them from seeking help and treatment. One participant resisted applying for disability assistance because of stigma:

> *I never got on disability till 10 years later because when you're, even though you're diagnosed doesn't necessarily mean you're going to go and get help and, and, and there is that stigma that's attached to it […] yeah, there's, there's a, because it says, it says*

> *sort of mental health[…] of it all you kind of want to have a tendency to want to sweep it under the carpet you know, you don't really want to have to deal with it, you've got enough shit going on without having realized […] mental illness or talking about it.*

Some participants experienced discrimination by family members due to their mental health problems. Family members sometimes distance themselves from participants, or are wary of contact with them. Many participants also perceived that stigma results in fear among and isolation from their friends and community.

Some participants described discrimination in housing, employment and in social services. One participant described having lost housing due to harassment following his "attacks of mania." Another participant described facing discrimination while seeking employment due to his disability.

As participants contended with stigma and discrimination, many emphasized that having a mental health issue was beyond their control and was not their "fault". One participant described being "at the mercy of moods that you can't control." Many participants had childhood experiences of family mental health problems and concurrent substance use, leading some to understand their issues as "running in the family". In these ways, mental health problems were understood as beyond their control, and therefore not resulting from a personal defect or weakness.

Sense of self and well-being

Some participants reported how their mental health challenges and resulting lack of capacity affected their well-being, with personal frustration and shame eroding their sense of self. One participant who lost her job due to an injury and the subsequent onset of depression also dealt with a sense of failure associated with the loss of her capacity:

> *[…] I just felt really inadequate. I was sort of the rising star out of the children because I went to school, I went to college and I got a good job […] [My parents] didn't understand that I was injured and got depressed […]*

Some participants suggested that self-care, particularly eating and sleeping well, is essential for dealing with mental health problems. Knowing oneself and one's limits is another pathway to mental health for participants, as one participant explained:

> *I find I get stress easily […] I can feel myself when I'm kind of like being drained almost […] when my stress level is going up. After living with something for 15 years, you kind of know yourself. I watch myself, too, to see when I'm approaching certain limits.*

E) Mental Health and Social Services

Access to Mental Health Services

Many participants described having limited access to psychiatric care. Frequently, participants have found that psychiatric professionals are unavailable to them: "There was nobody that, that really helped me about [my depression], that dealt with it. There was no professionals. There was no help. Nobody ever asked." Other participants describe their experience with long waiting lists for psychiatrists.

Some participants reported seeing general practitioners for their mental health care:

> *[My family doctor] knew I was depressed, he, he was the one who told me that I was depressed, I didn't realize that […] you need to go on medication, you're very depressed. He's the one that told me like I was, I guess I just wasn't aware of it but he saw the signs and stuff.*

Sometimes general practitioners treat participants in collaboration with a consulting psychiatrist. Many participants are accessing general practitioners through walk-in clinics and community-based health centres that specifically serve people who are homeless. Participants also have some access to psychiatric care directly through certain shelters, but only continue to benefit from this service while they are staying in a given shelter.

Some participants in crisis are accessing mental health services through distress lines, crisis centres and emergency departments. Others have, or have had, access to social workers and counselors who have referred them to other mental health services, or have themselves provided some support and counseling. See *Treatment vs. Talk* below for elaboration.

Many participants have had multiple psychiatric hospitalizations and described having had access to psychiatrists while hospitalized. Sometimes inpatient psychiatrists have established treatment regimens that participants continued to follow once they have returned to the community.

Other participants spoke about not being able to access inpatient hospital services, either because they are denied admission or because psychiatric hospital services are no longer available in their community.

Quality of Mental Health Care

While many participants currently have limited access to psychiatrists, many have had experiences meeting with psychiatrists over the course of their mental health histories. These experiences range from very positive and helpful to very unsatisfactory. For those participants who have had positive experiences with psychiatrists, some expressed appreciation for the services they have received and speak of them in high esteem. As one participant summed up his experience with psychiatrists: "I am in debt[ed] to them."

Other participants described experiences in which psychiatrists have disappointed them or have treated them disrespectfully, as in one participant's story of a psychiatrist slamming his office door in the participant's face:

> *He 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 "blooo!" right in my face.*

Other participants describe their psychiatrists as having lacked compassion: “I don’t think he was into it because he really cared about the patient. I think it was more just a job and it was for the money.” Several participants also recounted how psychiatrists had pressured them to return to work.

While some participants described positive hospital experiences, others, and particularly those who have been involuntarily hospitalized, describe negative experiences in which they feel their rights have been denied. Some participants describe receiving or fearing the use of forced treatment, in particular the use of physical and chemical restraints, such as forced medication.

However, it is interesting to note that some participants described an improvement over time in the delivery of inpatient psychiatric services. Some participants pointed to the amalgamation of several mental health facilities into a single mental health and addictions centre as having had a positive impact on hospital care.

Several participants describe how multiple hospitalizations can lead to disjointed psychiatric treatment, expressing the need for consistent and coordinated care. As one participant put it:

> *I have probably seen like a good 15 to 20 different psychiatrists […] it’s just like all my charts are spread out through different hospital systems […] it’s really difficult to get one big picture of what’s going on […] So, if I had somebody that would actually follow me that would be very helpful I think.*

Cultural competency and discrimination in the mental health system

Some participants pointed to the importance of culturally and linguistically competent mental health services in terms of addressing the impact that racialized, sexual, and gender identities can have on mental health. One participant appreciated that her doctor was a compatriot: “The doctor’s been great because I have a doctor from my country. Yes, we speak the same language so […]” Participants who are members of the LGBTQ community have experienced discrimination in the mental health system. One participant identified hospital services as homophobic, pointing to the need for LGBTQ-competent and sensitive mental health services:

> *But [a particular hospital] is very discriminatory […] very homophobic some of the staff um, they tried to make the emergency room look “rainbowy” but they hide the flag […] so you actually have got to look or know where it is [Yeah] to find it […] I would say [it] is one of the worst hospitals I’d never go to it as far as homophobia, especially the emergency room.*

Mental Health Interventions

Medications and psychiatric care

Most participants are taking psychiatric medications as part of their treatment and find them helpful. However, some participants expressed concerns about severe side effects including tardive dyskenisia, extreme fatigue and weight gain.

Participants described their relationships with psychiatrists as being circumscribed by the prescription of medication, suggesting that the treatment they are receiving is limited. See the discussion on "Treatment vs. talk" for further elaboration of this theme. Several participants also expressed concern that psychiatrists are experimenting on them with medications and are "pill pushers":

> *I did have an appointment […] with a psychopharmacology unit and their suggestion was to add […] another medication to the cocktail and be like 'Okay, well maybe it's not working because you don't have the right one to make it work' and I was just like I am (a) frigging human test tube already, like I have an entire page full of medication that I have been on and haven't work[ed] so what exactly do you want to do?*

Some participants indicated satisfaction that psychiatrists adjust medications in response to participants' sharing their experience that the medications are ineffective. As one participant reported:

> *Like sometimes they don't prescribe the right pills right away and then it turns out that you're getting worse… I was smart enough to say to them look it, I haven't improved at all I mean can you please change my dosage or the type of pills that I am taking and a lot of evaluation and everything went into it.*

As with the above participant, being able to advocate for oneself is identified as an important part of ensuring effective treatment.

Services for people with concurrent substance use and mental health problems

Some participants with concurrent substance use and mental health problems are accessing addiction treatment services, including drug and alcohol rehabilitation services, "detox" services and self-help treatment groups. In addition, mental health services have helped a number of participants address their concurrent substance use and mental health problems. As one participant explained:

> *[the social worker at the psychiatric hospital] brought all of this mental health stuff to the forefront and got me all aware of It[…] [the] first one that made it very clear that I am concurrent, not only do I have to worry about my bipolar illness, I also have to worry about my substance use […]*

For several participants, reducing substance use has improved their mental health and their ability to follow psychiatric treatment. As one participant described it: "my mental health is controllable as long as I do what I'm supposed to doing [...][which means taking my medication] and staying abstinent from drugs and alcohol." Another participant spoke of the positive impact of psychiatric medications on his substance use: "when [my psychiatrist] was giving me my medication I stopped drinking."

In some cases, participants have been denied access to mental health services as a result of their substance use. As one participant described:

> *I ran into a good doctor but she cut me off […] she wouldn't prescribe my medication for the longest time […] she said you come in here intoxicated all the time I am not going to help you.*

Treatment vs. talk

Many participants characterized the need to talk and be listened to as important for their well-being. A few had the support of mental health professionals – social workers and counselors through social service agencies and through the Project – who fulfill this need. In addition to providing referrals to other mental health services, specifically to psychiatrists and general practitioners, some service providers offered participants the opportunity to talk and be listened to, as for the following participant:

> *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 uh, she listened to me so I felt you know? I was getting somewhere.*

Other 'workers' went above and beyond the expectations of their clients, as for one participant: "I was assigned a social worker, occasionally she would take me out for a meal […] Yeah, you know, and we became friends, chatted that sort of thing."

However, in terms of "treatment," particularly from psychiatrists, many participants speak critically about medication being the only mental health service that is available to them. One participant summed up what many participants shared: "But as far as mental health system [is concerned]… it's pretty shitty…I mean no therapy, no nothing, just take a pill and you'll be fine." Support in the form of "talk" constitutes a missing service from which many participants felt they would benefit. As one participant said:

> *So there was…no support, there was no "gee", you know, like somebody listening to me, I had some really terrible things that happened to you, perhaps you could, go to this counselor…[but] there was nothing.*

Many participants in both the Intervention groups and the Care as Usual group identified 'At Home/Chez Soi' research activities as providing worthwhile opportunities for them to talk about their life experiences. As one participant in the Care as Usual group said during the qualitative interview: "[…] talking with you right now, it's kind of like a therapy […] I don't have to feel alone […] it' good to talk, it's good to talk […]"

As discussed in *Support in Recovery* above, some participants identified the "talk" they do with others who share their experiences – their peers – as invaluable.

Psychiatric diagnosis

Most participants described having received a psychiatric diagnosis, although some participants reject the diagnosis, feeling they have been misdiagnosed or wrongly diagnosed. Diagnosis poses a problem for some participants who feel that diagnosis leads directly to stigmatization and discrimination. One participant shared his diagnosis with his father and was subsequently rejected:

> *I let my dad know about that I got a diagnosis from the psychiatrist […] he hasn't phoned me and I have wrote him letters and he doesn't answer the phone […] I am scared to tell anybody that I have a problem with depression, you take medication for it […]*

Other participants see diagnosis as an important intervention because it is the first step toward receiving effective mental health services, and some social services. As one participant explained: "[the diagnosis] was hard to swallow but then it was actually a relief because then I knew what was wrong with me and I knew medication could keep me under control, right?" A psychiatric diagnosis is required in order to receive disability income support in Ontario. As one participant in one of the intervention groups noted: "[My At Home worker's] plan is to get me from OW to ODSP because he said that will be much better for me but the thing is […] I have to be properly diagnosed."

'At Home/Chez Soi' Mental Health and Housing Services

At baseline, several participants who have been housed through the Project identify this experience as an important turning point in their lives. Participants in the interventions arms have access to a number of services through the study, including mental health and housing services. Participants in both the high needs and moderate needs intervention arms identified the 'At Home/Chez Soi' project as a valuable source of both mental health services and housing services. Many participants found their Project workers supportive, not only in helping them to find housing, but also in providing ongoing support and mental health services. As one high needs' participant expressed:

> *[The 'At Home/Chez Soi' project staff] were great, they got me an apartment, they got me out of the shelter, bought me furniture, gave me everything I needed, they given me a doctor, a psychiatrist, nurses to assist me and doctor's appointments […] I have got my own nurse to talk to you know, so I, it's really, really good for me there […] Like thank God, the At Home Project saved me […]*

Some high needs participants describe their psychiatric services as having been disrupted by their participation in the Project. For one participant, no longer seeing her regular psychiatrist represented a loss: "I [had] a doctor from my country. We speak the same language […] he's been helpful […] now I have to change [to] the study doctor on the team for the study. So, I don't see him anymore."

Rent supplement

Participants in the intervention arms welcome the financial support – the rent supplement and allowance for furnishings – provided by the Project. Many participants, in each of the intervention arms and Care as Usual group, are accessing income support programs through Ontario Disability Support Plan (ODSP), Ontario Works (OW) and the Canada Pension Plan (CPP) and have those income supports inadequate to house themselves. Participants also identified the absence of affordable and subsidized housing as significant obstacles to housing. They pointed to lengthy social housing lists. As one participant who had been housed through the Project recounted: "I applied [for Metro Housing] ten years back and I have not heard from them."

Sustainability of the Project

Some participants in the intervention arms expressed concern that their housing will terminate in 2013 when the project ends, leaving them “to find our own way again.” One participant worried that the absence of other social housing will mean he will once again be homeless at the end of the Project:

> *I am still on Toronto Communities waiting list […] and I’d really like to get subsidized housing. I think that’s a point that’s always in the back of my mind because if 2013 rolls around and these people don’t extend the subsidy then I am going to have to pay market rent and that’s tough, and that’s a worrying that’s always there […]”*

Waiting for housing

Participants in the housed group described experiencing insecurity and concern while waiting for their housing: “[…] it took almost two months [to get a place]. I was getting a little bit desperate, you know, after a while […] every day [you wait] becomes a lot. It becomes heavy [...]”

Randomization

Among participants in the Care as Usual Group, the experience of not being assigned to the housing cohort is a negative one, creating feelings ranging from disappointment to anger and depression. Some participants who were randomized as “Care as Usual” seem to have strengthened themselves against failure by having kept their expectations low. Other participants expressed a belief that the selection process is not a random one but rather that it is designed to exclude specific groups:

> *I just think [the process is] fixed, I am sorry, maybe […] I am way out of my league but I just totally think that’s why [no] trans [got] accepted, considering they did enough trans in interviews. Like what’s up with that? Every time a trans pushed the button, rejected. It’s not right. It’s not right.*

E) Anticipated Impact of Housing

A number of study participants in the intervention arms were already housed at the time of the interview, while others were still anticipating receiving housing through the ‘At Home/Chez Soi’ project within the near future. Three study participants, who had been randomized into the Care As Usual arm of the project, had been housed through various social housing organizations external to the Project at the time of the interview. When asked about the advantages of being housed, many participants discussed the anticipated benefits of housing for both their mental and physical well-being.

Anticipated Effects of Housing on Mental Health

A number of the participants in the intervention arms of the ‘At Home/Chez Soi’ project spoke about the value of having stable housing:

> *(The housing is) there for a couple of years so […] it lends a little stability at least to your life for a short period of time and enables you to get some things done […] Because when you’ve been through the shelter system as I have you realize the value of stability[...]*

Stable housing, for a large number of participants, was perceived to be associated with an increased sense of security and peace of mind and a decreased stress level. Many participants felt as though their mental health would improve with housing. Participants who were newly housed at the time of the interviews spoke about feeling more independent and self-sufficient, and having more control: “Now at least I can clean my house the way I want it […] That’s important to me, I can run my house the way I want it.”

While most participants in the intervention arms spoke about the benefits of being housed, there was some concern around being isolated in their apartments and the potential effect this could have on their mental health. One participant who had recently been housed said: “I don’t do very much anymore. I have been staying right in my apartment. I haven’t been feeling good, like, mentally I guess you can say.” Another participant who had also been housed by the Project at the time of the interview spoke about the drastic shift from being surrounded by other people, in a shelter or in jail, to living alone: “Even if I am in jail, I am not alone […] there is nothing wrong with the house, you know, it’s me, I have to change that thinking.” At times, living alone was so overwhelming for the above participant that he considered giving up the apartment and leaving town.

Anticipated Effects of Housing on Physical Health

As noted in ‘Life in a shelter’ section of the report, many participants spoke about the physical impact of living in a shelter, in particular the physical stresses associated with spending long days on the streets killing time. For many participants in the intervention arms, the most apparent shift related to moving from homelessness to housing was the ability to stay in during the day and care for their health. One participant who was housed at the time of the interview noted an immediate effect on his physical health:

> *I feel a lot better because I don't have to go running […] When I got kicked out (of the shelter) I had to walk around and it was really hard on my knees and feet. So it's a lot better now.*

Sleep, or the lack of sleep, was another important factor affecting many participants' physical health. With stable housing, participants felt that they would be able to get better, more consistent rest. Again, one participant who was housed by the Project at the time of interview spoke about the impact on his overall well-being:

> *I feel different, you know? I feel more, more together, yeah. I sleep until sometimes 9:30, 10 o'clock. And I'm like, 'Oh my God, this is great. I can actually sleep!'*

For some study participants, access to a proper kitchen and the ability to cook their own food and eat when they were hungry represented important health and nutritional benefits of housing, in addition to providing welcome freedoms.

Anticipated Freedoms and Control Associated with Housing

In addition to the health benefits of being housed, many participants spoke about a sense of freedom and control associated with living on their own – especially after being on the streets or in a shelter:

> *Home to me is the best, it's your home, you own everything that's in there, you have your own key, you have your freedom to go in and out, you know? You have your own shower, you can cook, you can do whatever in there.*

The door key, as a symbol of this freedom, was described in a number of different interviews: "I pray every day that I would get somewhere to go on my own again, you know? That I can put my own key and turn it myself." For many participants, having their own key represented a renewed sense of independence and self-reliance – something they had not felt while they were living in a shelter. As one participant explained:

> *Home is like your own place, your own rules, you know? You wake up and […] you can do whatever you want, no one can tell you anything because it's your own place.*

As another participant stated, being housed and having his own space "gave me the freedom to work on myself and to get my life back together." Many participants saw getting housing as the first step in a move towards rebuilding their lives. A number of participants spoke about wanting to re-establish relationships once they were in stable housing. One participant talked about how difficult it was to maintain relationships with his family while he was living on the streets:

> *When you're out there, you don't have a family. You can't […] Where are you going to receive them? Who wants a person who hasn't taken a shower for three or four days?*

Newly housed, the participant above was proud to invite his brother over and could now take the first step toward rebuilding this relationship: "I have a place where I can receive him. That's an important thing. So I can have a family again."

Living in the shelters also affected participants' ability to maintain relationships with their children. One female participant spoke about her sons not being able to visit her in the women's shelter. Now housed, her one son is living with her and her other son is able to visit whenever he likes.

Others spoke about the importance of being able to open up their homes to friends and potential romantic partners, something that they weren't able to do while living on the streets or in shelters – either due to shelter rules or out of embarrassment.

At the same time, many participants discussed being very selective about who they would invite over – if anyone at all – in order to maintain their current housing and limit the potential for any disturbances: "A few guys pop over but there is only a select few that know where I live. I like to keep it that way." Overall, it was invaluable for participants to be able to choose when and how much time they would spend with others.

When asked about their hopes for the future, most participants who were not housed spoke about the desire to get off the streets and find stable housing – somewhere with a kitchen and a place to lay their head. As one participant said:

> *It's the homelessness that I don't care for. I want to be back in a home […] I don't want to have to head to the subway to get some sleep, I want to go home and go to my bed in order to get some sleep.*

An important part of maintaining stable housing was the ability to pay rent regularly and on time. One participant spoke about paying his own rent as a symbol of independence and self-sufficiency:

> *I want to be able to pay my own rent that's what I want to change, I want to get a job and pay my own rent, man. Feel like a somebody, you know? Right now I don't feel like a somebody, you know? I don't.*

When asked about their vision for ideal housing, many participants mentioned the importance of privacy and safety. One participant stated: "Home means a lot. You have your own place and you feel secure as long as you pay your rent. And you work, you work towards, you know, making it safer." Another participant described his vision: "I like to have my own space, my own private area where I can do what I want and you know, then maybe, maybe I could get my life back together […]" The above quote emphasizes the fact that many participants see housing as only the first step towards getting their lives back on track. Essentially, many participants felt that housing was key to achieving a variety of future goals.

G) Other Hopes for the Future

Vision for Recovery

The role of housing

When asked about their vision and thoughts about recovery or healing, many participants spoke about the interconnectedness of factors that they associated with their own recovery. For many participants, their current housing situation was their biggest concern – "home is everything" and, therefore, was the first thing that would have to be addressed before they could conceive of broader notions of recovery and healing. Other forms of recovery were seen to depend on getting stable housing:

> *A place to live and then from there I can start doing my things, like getting better and going out. Getting into routine. Finding a job, getting the training for something else.*

Mental health

Acceptance of mental health problems and accessing the proper supports – whether mental health services or medication – were also considered to be important parts of the recovery or healing process. One participant articulated that accepting his/her mental health diagnosis was an important part of the recovery process:

> *I think I am going to recover one day or at least be like myself as a bigger person, school, career, enough to say I feel comfortable with my mental diagnosis and stuff like that you know, I hope.*

Substance use and addiction

Addressing substance use and addiction issues was another significant part of participants' recovery process. A number of participants spoke about self-help treatment meetings and peer support received therein as an important part of their journey towards healing.

Especially for those participants who are dealing with substance use and addiction issues, the concept of recovery can be a daily struggle and they often see it as a lifelong journey.

A sense of hope and spirituality

For a number of participants, recovery was associated with the idea of starting over. For one participant in particular, being accepted into the 'At Home/Chez Soi' study was an opportunity to begin a new life:

> *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 of my life in 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.*

Yet, even for those participants who have been randomized into the intervention arm of the study, there is a recognition that recovery starts from within: “It has to start with me obviously, like the outside world can do all that they can but if I am not willing to stop there is not anything they can do.”

For some participants, the motivation behind the work of recovery also had to come from within – one participant spoke about the desire to feel proud of himself again: “I want to be proud of me. I used to be really proud of me, I’m not all that proud of me right now.” Others spoke about simply believing that something better was meant to come their way.

For a number of participants, the faith required to embark on the journey of recovery came out of a strong spiritual or religious belief. Some participants recalled that religion and spirituality were always part of their lives, while others connected or reconnected to their faith as part of the healing process:

> *How I got out is just praying, you know, just believing. You’ve got to believe in yourself and you’ve got to believe that there is a better way than what you’re doing …*

Overall, the impression was that recovery or healing was a day-to-day challenge:

> *All I really have is today and that’s what I’m going to do is just stay in the present and not really worry about yesterday and not ready to focus on tomorrow. Whatever is going to come will have to come, it’s just taking it one day at a time and things are getting so much better … so much more quickly than I could have imagined…*

Work and school

Beyond finding and maintaining proper housing, many participants also discussed the importance of education and employment in their future. Many participants spoke about wanting to get a job or to establish themselves in a career, as a way to ensure financial security and independence and to rebuild their self-esteem:

> *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.*

Returning to school or pursuing further education and training was also an important aspect of participants’ vision for their future: “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…”

In discussions about the future, a number of participants spoke about the barriers that they would need to overcome in order to establish the kind of life they would like for themselves:

> *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.*

A number of participants have taken their experiences of life on the streets and have turned them around, using their personal expertise of homelessness and mental health as motivation to help others: "Now that I am in a home and I see people on the streets and I just want to help them, I just want to do something to help them, you know?"

Develop or re-establish relationships

When considering their futures, many participants spoke about the desire to develop or re-establish positive, healthy relationships. Some participants hoped that they might meet a romantic partner. Other participants discussed wanting to get married and have a family: "I still want to get married. I still want to have another child. I still want to live."

Other participants were more focused on rebuilding relationships that were lost or damaged during their time on the streets or in a shelter. One participant spoke about wanting to establish a relationship with the child that she had to give up:

> *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.'*

As discussed earlier, many participants felt that having access to stable housing would be instrumental in developing relationships and re-connecting with family and friends.

CROSS-CUTTING THEMES

The data point to a number of key themes that affect pathways into homelessness, the experience of homelessness and, for some, the way out of homelessness into housing. It is clear that the causes of, responses to, and solutions for those experiencing homelessness and severe mental health problems are not solely dependent on individuals; rather it is the nature of the physical and social context and environment that seems to have the greatest impact.

Environmental factors that influenced all stages of the experience of homelessness included stigma and discrimination; access to housing; social supports; health services; availability and access to resources and conditions that fulfill basic needs (e.g. good food, safety, sleep); and access to work and education. These environmental factors and conditions influenced the health, well-being and self-esteem of the person, ultimately shaping a vision for the future.

Stigma and Discrimination

The impact of stigma and discrimination has been well documented (Angermeyer & Dietrich, 2006; Schomerus & Angermeyer, 2008; Thornicroft, 2006) and many people living with mental health problems have reported that the effects of stigma are more harmful than the mental health problems themselves. For people who are both homeless and living with mental health problems, the effects are severe. Participants spoke about experiencing discrimination based on mental health status, ethnoracial background and sexual orientation, and the sources of these stigmatizing experiences were in their families, in the shelters, and on the streets. Stigma towards mental health problems prevented some from seeking treatment, and for others, created barriers to accessing treatment. Many described experiencing discrimination that limited opportunities for work, education and housing. Furthermore, stigma is often internalized by those who are consistently exposed to it and accordingly, some study participants expressed shame and embarrassment regarding their situations. The consequences – isolation, poor self-esteem and poor mental health – create monumental challenges to recovery and a promising future. These findings suggest that efforts directed at minimizing stigma are important considerations for program planning and research. Education of shelter staff and the public at large may reduce stigma and contribute to more accessible treatment and life opportunities. Currently, the Mental Health Commission of Canada is promoting anti-stigma awareness in its Opening Minds initiative but a focus on homelessness is not included.

Access to Housing

Interviewees who were housed by the 'At Home/Chez Soi' Project reported that housing provided a stable foundation from which to rebuild their lives. Some described a sense of isolation that accompanied their new housing status, but for the most part the emphasis was on the improvements in their health and quality of life that they began to experience and anticipate. Even after having been housed for only a short period at the time of data collection, participants in the intervention arms described an 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. The provision of housing can have a wide-ranging impact on health, quality of life and life roles, and is an important area to track in the long term in order to determine its effects and relationship to these outcomes.

Social Supports

Research has shown that a lack of social support can be a key factor contributing to homelessness, and that the presence of social supports is important for recovery and in moving forward through the adversities of life for homeless individuals and those with serious mental health problems (Hwang, Kirst, Chiu et al. 2010; McCorkle, Rogers, Dunn et al., 2008; Cohen & Thomas, 1985).

Descriptions of social supports pervaded the interview data. Social support was cited as a factor that prevented homelessness and similarly, the lack of social support was cited as a factor that contributed to homelessness. Importance was attributed to many forms of social support, including peer support, support from service providers, instrumental support and companionship of animals. With regards to friends and peers, some spoke of the isolation and difficulty maintaining friendships while homeless as well as the caution that was needed in befriending others who were in the same situation. A few individuals did have support from peers, which was described as extremely helpful.

Mental Health and Social Services

With regards to support from mental health professionals, participants spoke about limited access to services and supports while homeless. Many reported that when psychiatric services were available, they tended to be medication-focused and the opportunity to 'talk' was missing. In terms of quality, participants had a range of experiences with psychiatrists, from extremely positive to very negative. The participants who had experiences with other mental health service providers, including counselors and social workers, tended to be satisfied, and even pleased, with these services. The need for support services such as case management, drop-in centres, social clubs, counseling, treatment services and peer support services is reflected by these data and the impact of such services on housing tenure, mental health and quality of life is an important line of inquiry.

Many participants had accessed inpatient mental health services, and some expressed concern that multiple hospitalizations led to disjointed health care. Several participants spoke about their distress about forced treatment while in hospital.

Not surprisingly, our data reflects that the work of being homeless involves finding resources that will meet one's basic needs, and that this task was not always easy. Control over food and diet, cleanliness, safety and sleep were identified as important issues that were often difficult to achieve. For many, the perceived danger of the streets and shelters prevented them from sleeping or taking care of themselves. These challenges had a negative impact on the health and self-esteem of participants.

Access to Work and Education

The issue of work and education was raised by many participants. Some attributed homelessness to loss of work, while others reported that loss of work resulted from being homeless. Mental health problems also contributed to many participants' leaving their jobs. People in this study expressed the desire to contribute to society and to maximize their potential through work and education. Although work was associated with stress for some, it was frequently a goal of participants. People remained in large part hopeful that they would be able to access training or work at some point in their futures, and this was particularly true for those who had been housed. Much research points to the benefits of work for people living with mental health problems as well as the importance attached to work as a part of the recovery process (Kirsh, 2001; Krupa, 2004). Thus, the implementation and evaluation of supported employment services for newly housed or homeless individuals is an area that should be carefully considered as part of this study, given vocational supports offered through the 'At Home' project.

Self Management

In addition to the environmental or contextual factors listed above, there were a number of issues related to self management that are noteworthy. Interviewees recognized that their circumstances reflected the intersection of contextual factors and their own mental health, physical health and self-esteem. The issue of substance use was discussed by many; for some it contributed to homelessness while for others it was a coping strategy while living on the streets. Substance use was reported to have led to conflicts with the law, as well as with family and friends. People felt that peer support and housing were helpful in dealing with their substance use issues.

CONCLUSION

In sum, the data reveal that people who have experienced homelessness and mental health problems often struggle with issues of survival, safety, isolation and addiction, yet have not given up hope for the future; some expressed desires that included work, education and family. Many were insightful about their circumstances and had a sense of what they needed in order to move on. Underlying their hope for the future and for recovery is a strong sense of resiliency.

For the most part, people who participated in the interviews wanted to feel proud and reclaim a sense of dignity that they had lost. The impact of housing on the achievement of these goals will be important to track over the 18 months that follow.

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APPENDIX A: CONTEXT

Site Description

There is a large pool of longstanding services available to individuals experiencing homelessness in Toronto, including supportive and alternative housing, emergency shelters, drop-ins, integrated street outreach services, housing help and eviction prevention services, and meal programs funded through three levels of government and the charitable sector. Also included in the homelessness service landscape are the City of Toronto's Streets to Homes program which began in 2005 and focuses on moving homeless individuals living outdoors into permanent housing (Toronto Shelter Support and Housing Administration, 2009).

A sizeable mental health service network serving homeless and housed individuals in Toronto is 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 ethnoracial agencies, amongst other services.

Despite this, people who are homeless and living with mental health problems often face barriers to service access and end up using emergency room and inpatient hospitalizations for their care (Canadian Institutes of Health Research. Reducing Health Disparities & Promoting Equity for Vulnerable Populations. 2002). Existing mental health services often lack the resources or are unable to combine the basket of services and supports needed to address their needs, especially at higher levels of care (Stergiopoulos, Dewa, Durbin, Chau, Svoboda, 2010). Service fragmentation and lack of options for consumer choice often make it difficult to engage those with the most complex needs.

As part of the 'At Home/Chez Soi' project, the Toronto Site is testing the following three approaches:

Housing First-Assertive Community Treatment

The ACT intervention was originally planned to serve 100 high needs participants. The team approach to providing clinical supports and services is key feature of the model, aiming to deliver recovery-oriented support, treatment and rehabilitation. Another important feature of the model includes peer support provided through a peer specialist. The ACT team also comprises social workers, psychiatrists, psychiatric nurses, job development specialists, and a primary care physician. All participants are provided with continuous support and assessment. Participants have access to a team member or crisis support services 7 days per week, 24 hours per day.

Housing First-Intensive Case Management

The Housing First/Intensive Case Management Team (ICM) utilizes a one to one service model for 100 moderate needs participants who are randomized to this intervention. ICM is a coordinated approach to comprehensive client-centered services. Each study participant is matched with a Case Manager, who works with each participant to develop a service plan that meets the individual’s needs and is acceptable to him/her. Together they work on achieving goals that are important to the client through any of the following functions: outreach, assessment, skills teaching, network development, linking to resources, individual advocacy and crisis support. Service takes place in the community, typically at the location of choice for the participant. Case managers provide support services for participants 5 days a week, 8 hours per day, with after-hours crisis support as needed.

Housing First-Ethnoracial Intensive Case Management

The third arm of the Toronto project is an Ethnoracial Intensive Case Management (ER-ICM) program designed to meet the needs of homeless people with mental health problems from ethnoracial groups. This model provides the same basic support services as the regular ICM model but emphasizes a holistic approach to mental health care that recognizes the interdependence of spiritual, emotional, mental, physical, social, economic, cultural, linguistic and broader aspects of life in working with clients with severe mental health problems. Participants randomized to the intervention arm, who are eligible for ICM, and who identify as a member of an ethnoracial group, are given the choice to participate in the ER-ICM intervention arm. Programs and initiatives that integrate peer support, skills building, social and recreational activities, support groups, alternative and complementary therapies, art and music therapy, creative expressions, community kitchen, individual support and community outreach are available to participants in this intervention group. Assisting participants to build their support networks, including working with their family and friends is a main goal of this model. The ER-ICM service is provided from 8am- 8pm Monday to Friday and on weekends as needed. Aside from the ability of case managers to speak a second language, translation and interpretation services are purchased as needed.

Characteristics of the Homelessness Situation

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

As demonstrated by the Street Needs Assessment, on any given night, there are more than 5,000 homeless people in Toronto. About 79% of them are living in shelters, 8% on the street, 4% in health care or treatment facilities, and 6% in correctional facilities (Toronto Shelter Support and Housing Administration, 2009).

Between one-fourth to one-third of homeless individuals in Toronto have a serious mental health problem such as schizophrenia, major depressive disorder, or bipolar affective disorder. A 2007 survey by Street Health found that about 35% of homeless people in Toronto reported a prior diagnosis of a mental health condition and 25% reported a combination of mental health and substance use problems (i.e. a concurrent disorder). Within the current system, a large proportion of these individuals do not receive the proper level of care for their mental health problems (Toronto Shelter Support and Housing Administration, 2006).

Mortality among homeless people in Canada is much higher than among the general Canadian population, and many unexpected deaths among homeless people in Canada are related to mental disorders and suicides (Hwang SW, Wilkins R, Tjepkem, O'Campo, Dunn, 2009). The average homeless person in Toronto will die before the age of 50 (ibid).

Based on the Street Needs Assessment conducted by the City of Toronto in 2006, the unmet need for specialized mental health services among homeless individuals in the Toronto area is significant and a large proportion of homeless people with mental health problems do not receive the proper level of care. Furthermore, immigrants, who make up about one third of homeless people in Toronto, in particular face significant barriers (e.g. racism, language barriers and stigma) to accessing mental health services (Access Alliance Multicultural Community Health Centre, 2005).

Homelessness in Toronto: Description of Care as Usual

Clients suffering from serious mental health problems and homelessness access the treatment system in Toronto through many different entry points: inpatient and outpatient clinical services, peer support, crisis services, intensive case management, Assertive Community Treatment, supportive housing, vocational programming, street outreach programs, drop-in services and shelters.

While the service landscape in Toronto is typically characterized as having a wealth of available mental health services, it is estimated that only 25-50% of those eligible for services actually receive them. Although this may in part be attributed to a lack of capacity, it is also influenced by the absence of coordination amongst the existing services. There are ongoing efforts to develop a centralized access point for certain community services including case management, ACT, and supportive housing.

Many individuals who have serious mental health problems will be homeless at one time or another. Some are homeless repeatedly, and a small percentage is homeless for long periods of time. Many will end up in an inpatient mental health unit, at which time they may be referred for community-based services such as ACT, case management or supportive housing. There are, however, long waiting lists for most community-based services, which prevent the majority of individuals from accessing them on an immediate basis. Others will access a shelter or a drop-in that provides or has access to specialized services for mental health clients, such as Seaton House or Sistering, and will be connected to ongoing community services that way. The mobile crisis services that form a network across the city play an important role in engaging with consumers while they are in crisis and connecting them to services where possible. These programs are increasingly recognizing the importance of establishing a presence in hospital emergency departments so that individuals who are not going to be admitted can be engaged, thereby shortening their wait in emergency.

There are approximately 4405 supportive housing units in Toronto specifically designated for individuals with serious mental health problems. The great majority of these are permanent housing with anything from an hour a week to 24 hours a day of support. Additionally there are many units available through what is referred to as the "alternative housing providers", a group of providers who house individuals with a variety of health and social issues.

Over the past 10 years, several initiatives have been developed and funded by the Ontario Ministry of Health and Long-Term Care to better support those with greater challenges to successfully find and keep housing. The Mental Health Homeless Initiative of 2000 to 2002 provided about 1395 additional units of supportive housing (primarily existing housing, mostly scattered units with support) in Toronto for homeless individuals who have mental health problems. More recently, the Mental Health and Justice Initiative has added about 500 units of supportive housing, using a similar model of attaching supports and head leases to scattered units. These units are only available to homeless individuals with mental health problems who have recent involvement with the criminal justice system, and referral sources are specific to the justice system. Although these initiatives clearly had an impact on the identified populations, the permanent nature of the housing creates capacity issues once the units are filled.

Those individuals who remain on the street are engaged through services that provide an outreach component as well as through a network of drop-ins. Through Streets to Homes and its partner agencies, the individuals on the street are served through Intensive Case Management. Some Ministry of Health funded resources in street outreach and at drop-in centres also exist.

The Streets to Homes (S2H) initiative in Toronto, which includes both city staff and contracted providers, is mandated to seek out and engage individuals who are living rough on the street and assist them to find housing. S2H uses Intensive Case Management and a Housing First philosophy, engaging, referring and supporting the individual once they are housed. The city also funds a Mobile Multi-disciplinary Outreach Team (M-DOT) that takes referrals from S2H and its providers to work with those whose mental health problems and/or addiction issue are preventing the individual from engaging in a discussion about housing. The program has similarities to an ACT team in its multi-disciplinary approach but is relatively short term in duration, linking clients to other programs for follow-up once they are housed.

Community Health Centres

Three downtown Community Health Centres (CHCs) – Parkdale in West Downtown, Queen West in Central Toronto and Regent Park in Southeast Toronto – receive $6 million a year in addition to their annual funding to hire staff (doctors, nurses, nurse practitioners, social workers, outreach workers) to work specifically with people who are homeless, and to coordinate services among CHCs for people who are homeless. Regent Park and Queen West CHC have an integrated approach to services, with clinical and outreach staff paid through the homeless funding, developing work plans together, meeting monthly and making recommendations to management. Queen West has created a forum of service providers in its area to enhance local services for the homeless. The CHCs are present on community and city networks related to the health, and related, issues of the homeless.

Unfortunately, the Ministry focused its attention on the problem of homelessness in the central core of Toronto but did not provide resources for the agencies to work with clients in the east end of the City, particularly Scarborough.

Drop-In Centres with On-site Medical and Psychiatric Services

Most drop-ins have very limited resources for providing psychiatric or medical supports to their homeless service users living with serious mental health problems. The smaller drop-ins provide a safe space for social engagement and for accessing a broad range of necessities such as food, clothing, telephones, computers, laundry and showers. These drop-ins will have a small staff team to provide assistance in accessing care through referrals, eviction prevention supports and advocacy and, perhaps, an on-site nurse on occasion (i.e. from once every two weeks to one day per week). In some of the medium-sized drop-ins there will be a few specialist staff providing housing placement and maintenance supports.

A few larger drop-ins in Toronto, primarily those with Ministry of Health funding (of which there are six), have the resources to provide more extensive medical and case management supports to their homeless clients living with serious mental health problems. In these drop-ins, the largest staff team may have a few case managers (e.g., one of the largest has a mental health case manager, one addiction counselor and 2.5 trustee case management staff). Others may have housing support staff (e.g., one of the largest has 4 housing staff) to provide addictions, housing and mental health supports to the large number of people – 150 to 300/day depending on the location – coming in each day. These drop-ins also have limited but more extensive medical supports: one drop-in has a dental clinic; a number of drop-ins have a nurse on-site 1-4 days/week; one has a Concurrent Disorders Clinician on-site one day per week; another five currently have, through recent partnerships with St. Michael's Inner City Health, psychiatrists on-site one to two days per week, providing up to 5 hours per week of short-term care and psychiatric assessments for ODSP applications. In one drop-in working with Inner City Health Associates (ICH), for example, mental health staff in partnership with ICH and Ontario Works staff has been assisting participants to complete up to four ODSP applications per week, with the psychiatrist also providing short-term psychiatric care to 1-4 of the previously assessed individuals per week.

The few medical and case management staff in drop-in settings are often extremely busy and covering an unusually broad range of clinical needs. Thus, for example, the nurse working in one drop-in sees an average of fifteen individuals in a three-hour time period, with the work ranging from cleaning and bandaging wounds to mental health nursing. In almost all cases, while the case management and housing supports are part of the internal staff teams, the medical clinicians are from partner organizations like the Central Care Access Centre (CCAC) for nurses or ICH for psychiatrists or family doctors (of whom there are approximately 65).

The challenge is that those resources can be very precarious. Some drop-ins have experienced a regular turn over in nursing staff. Thus, in the very best resourced drop-ins, participants may be able to access some medical services (primarily nursing, with very limited availability of psychiatric care or other clinicians), housing placement and maintenance staff, an addiction counselor and case management staff, though these staff will often be working with much larger numbers of individuals than one would find in the case loads of staff working in traditional case management settings in other Community Mental Health programs.

Supportive and Alternative Housing

In the late 1970s into the early 1990s in Ontario, a number of unique non-profit organizations began to develop, own and operate housing with support for people who were considered to be in "deep core need" because they are economically disadvantaged and marginalized. Two streams of organizations responded to the need for safe, secure, permanent and affordable housing. One stream became known as "alternative housing providers", and the other became known as “supportive housing providers”. These providers act as landlord, property manager and support agency. The difference between them is the degree of support provided, the funding source (with alternative housing it is the City of Toronto, and for supportive housing it is the Ministry of Health and Long Term Care for bricks and mortar and the Toronto Central LHIN for support), and the additional key eligibility characteristics defining who is selected for the housing with support opportunity.

Alternative housing tenants are defined less by their clinical diagnosis than they are by their homeless status. Tenants are referred directly from the streets, from shelters, hospitals and correctional facilities. Supportive housing tenants are defined by clinical diagnosis and the intensity of support required (high, medium, low) and which is provided directly by the supportive housing provider. High support typically means 24 by 7 staff presence and homemaking/meals on-site. Staff presence on-sites and other services offered determine medium and low support. Tenants are also referred from psychiatric institutions, hospitals, correctional facilities, shelters and the streets.

Alternative and supportive housing take a number of forms including self contained apartments and private rooms in shared accommodation where kitchens, bathrooms, living rooms and kitchens are common. In some cases primarily in the boarding home segment of supportive housing, bedrooms may be shared as well. Units or apartments are located within buildings typically owned by both types of non-profit providers who are responsible for property management as well as support services. Affordability is through rent-geared-to-income subsidies administered by alternative and supportive housing providers. Alternative and supportive housing providers may also have rent supplements to access scattered or blocks of apartments in the private market rental sector. In this instance, case management services may fulfill the role of supportive housing provider managing the relationship with the private sector landlord.

The alternative housing providers’ tenants are a diverse group, but are predominately single adults with low incomes who may live with mental health problems or addictions, or other social or health issues which present barriers to finding and maintaining stable housing. The supportive housing providers’ tenants are diverse as well, with low incomes. They are predominantly single adults, have similar social or health issues affecting housing stability but must have a mental health diagnosis and may also live with addictions. In some instances supportive housing providers also house couples and families with children as long as one member of the household meets the mental health/diagnosis criterion.

Alternative housing support services include; housing stabilization, eviction prevention, crisis intervention, referrals regarding income supports, employment and health care, including addictions and mental health services; and assistance with budgeting, homemaking, community living and personal care; conflict mediation and community development.

Supportive housing support services include functions of case management within a recovery framework and commitment to consumer choice housing stabilization, eviction prevention, crisis intervention, referrals regarding income supports, employment, primary health care and intensive clinical care, and assistance with life skills related to budgeting, homemaking, community living and personal care, conflict mediation and community development. Some supportive housing services include meals. Because of the complex needs of supportive housing tenants they have access to a flexible array of support services within and without the housing setting. Some may be clients of ACCT and have access to support staff of the supportive housing provider. Use of support programs and services is not a condition of tenancy however the alternative and supportive housing providers are able to respond quickly to emerging issues and crises because their staff are available.

Ethnoracial Services Include:

- Access Alliance, a community health centre for immigrants and refugees;
- Across Boundaries, a mental health centre for people of colour;
- The Canadian Mental Health Association, offering a variety of cross-cultural initiatives;
- COSTI Immigrant Services, an agency offering educational, social, and employment services to immigrants;
- Hong Fook, a mental health association serving the Cambodian, Chinese, Korean, and Vietnamese communities;
- Mount Sinai Hospital, home to an ACT team serving the SE Asian, Tamil, Aboriginal and Black communities;
- Sistering, a drop-in centre serving low-income women from various ethnoracial groups;
- Sojourn House, the largest refugee shelter in Toronto, offering a variety of services and supports.

APPENDIX B: Quality of Data Collection and Data Analysis

Baseline Consumer Narratives

Sample Selection

Description of process for selecting sample, including changes made along the way

The original study protocol called for a subset of 50 participants (20 from the intervention arm-of which 10 were from the high needs group and 10 from the moderate needs group; 20 from the Care as Usual group and 10 from the ethnoracial intervention group) to be systematically selected from the larger study group (stratified by gender and other characteristics) and to be invited to participate in two in-depth qualitative interviews (the first within one month of entering the study and the second at 18 months.)

Following consultation with the National Qualitative Research Team, the decision was made to oversample study participants in order to account for possible 'loss to follow-up' of study participants at 18 months. Six interviews were added for study participants in each of the respective intervention arms; and four interviews were added to the Care as Usual arm. A total of 60 participants were interviewed as part of the Toronto Site 'At Home/Chez Soi' baseline Consumer Narrative interviews.

Steps taken to ensure the sample reflects the local site's study population

Participants were selected using a systematic sampling approach of every 10th participant to be randomized to each study arm (high needs ACT; moderate needs ICM; ER-ICM; and Care as Usual). The sample was periodically assessed with regard to proportion of women and ethnoracial participants in each study arm, and adjusted in order to achieve the distribution in the table below, reflecting the distribution of study participants established in the overall study protocol.

Group	High-Needs ACT	Moderate-Needs ICM	ER-ICM	High-Needs Care as Usual	Moderate-Needs Care as Usual
Men	8	8	8	8	8
Women	2	2	2	2	2
Ethnoracial participants	3	3	--	3	3

The sampling frame was reviewed and adjusted four times in order to satisfy the distribution of participants that had been established by the sampling criteria. It should be noted that the decision to oversample participants for the baseline interviews was made well into the recruitment process at the Toronto Site. As such, the sampling criteria could not be appropriately adjusted to reflect the 10 participants added for this purpose.

Description of process for selecting purposeful sample

The qualitative data collection supervisor was responsible for selecting participants in Health Diary, based upon the above sampling criteria, who then communicated the Participant ID code of selected participants to the qualitative interviewers and a Follow-Up Contact Coordinator. Potential participants were contacted by phone or in-person and invited to participate in a narrative interview within one month of being randomized into the study.

A total of 151 participants were selected and contacted to participate in a narrative interview. Fifteen participants were identified "opportunistically". These interviews were scheduled with participants who came in contact with research staff as part of their involvement in other research activities for the study, including monthly 'call-ins', as well as other quantitative interviews for the 'At Home/Chez Soi' project. Five narrative interviews were completed in this way (4 HN TAU, and 1 ICM).

Four participants who were selected for a narrative interview could not be scheduled for an interview as they were flagged as representing safety concerns, or were identified as individuals who would not be able to participate in an interview due to acute physical or severe mental health problems. Other barriers to recruitment included participants failing to show up for scheduled interviews, and unsuccessful contact with a selected participant for a period significantly greater than 1 month after entering the study. The rate of recruitment was also influenced by the rate of participant recruitment into the overall study, as well as the randomization of participants into the intervention and control groups.

Interviewers

Description of interviewers

Interviews were conducted by three qualitative researchers at the Centre for Research on Inner City Health, including one male and two female staff members. One of the interviewers identified as a person with lived experience (PWLE) with mental health problems and the mental health system. As a "peer," this interviewer frequently inserted her personal experience into the narrative interview in an effort to engage participants and to put them at ease. This interviewer's familiarity with the mental health system contributed to her ability to probe participants' experience.

Another interviewer identified as ethnoracial and conducted the interviews with participants from the Third Intervention Arm. The decision to have an ethno-racial interviewer conduct these interviews was made in consultation with the service agency associated with the Third Intervention Arm and reflects the anti-racist and anti-oppression framework utilized by that model.

Interviews were conducted onsite, at the project office for the 'At Home/Chez Soi' project, and in participants' homes. All participants provided written informed consent to participate, and agreed to have the interviews audio-recorded.

Description of interviewer training

All three interviewers were required to have graduate-level training in qualitative research methods. Two of the interviewers had also participated in the Planning and Proposal Development study.

Research staff was provided with a 1.5 hour group training session, facilitated by the MHCC on interviewing techniques. The training predominantly involved discussion and role-play. While additional optional training was offered by the national team, research staff at the Toronto Site were not able to attend these sessions due lack of sufficient notification or scheduling conflict. Staff felt that they would have benefited from greater national and local support and direction on interviewing techniques, particularly with regards to asking participants to recount high, low, and turning point stories.

Locally, research staff was provided with manuals on qualitative interviewing techniques, the “AT HOME” Toronto Site Consumer Narrative Recruitment and Interview Protocol, and Procedures for Ensuring Participants’ Immediate Health and Safety & Interviewer Security and Safety. Research staffs were also offered additional training on crisis intervention through local partnerships with the Clinical Service Teams of the ‘At Home/Chez Soi’ project.

Research staff was provided with opportunities for informal training through monthly meetings of the local Qualitative Research Team. The Team consisted of the three research staff, as well as a qualitative supervisor and a co-investigator on the At Home Chez/Soi project. Staffs were encouraged to identify and problem-solve around issues ranging from the content and structure of the interview guides to strategies for interviewing participants who were difficult to engage.

Description of interviewer supervision

One of the three research staff was directly responsible for the day-to-day coordination activities for the Consumer Narrative research, ensuring adherence to research protocols and addressing procedural and safety issues. A qualitative research supervisor, who met regularly with interviewers to address emerging and ongoing issues, provided additional oversight and support.

The local Qualitative Research Team met one to two times per month to plan around and address issues relating to interviewing, data analysis, and report writing. Members of this team also reported monthly to a larger Research Working Group for the Toronto Site, ‘At Home/Chez Soi’ project; this group consists of principal investigators, other research staff from the Toronto Site, as well as members of the Toronto People with Lived Experience Caucus.

Quality of Interviews

Steps taken to ensure the overall quality of the interviews

Several steps were taken to ensure the overall quality of the interviews at the Toronto Site. Initially, both the qualitative supervisor, and later the research coordinator, listened to several interview audio recordings for accuracy and completion, and provided feedback to individual interviewers. This process was guided by documents on quality assurance in interviewing that were developed by the National Qualitative Research Team, and focused on several key elements of interviewing. These included: questioning, structuring of interviews, and appropriate use of probing.

Local research teams were also required to randomly select five interviews and corresponding transcripts and assess them based on a Quality Control for Narrative Interview Checklist produced by the National Team. Members of the National Qualitative Research Team also assessed selected interviews, and findings were compared as a method of standardizing quality assurance across all sites.

Transcriptions

Description of process for validating the accuracy of the transcriptions

Two independent contractors completed transcription for the Toronto Site Consumer Narrative Interviews. A second transcription service was added in order to ensure timely access to transcripts for the purpose of analysis. Each service was provided with direction on specific transcription requirements corresponding to guidelines developed by the National Qualitative Research Team.

The qualitative supervisor and research coordinator reviewed several initial transcripts for completion, accuracy, and adherence to the guidelines provided. As a result, the overall quality of the transcripts was deemed fairly high. While the quality of audio recording was high given the use of digital audio-recorders, there were a number of instances when some words were transcribed as inaudible. In certain instances, research staff was able to return to relevant sections of recordings and identify these missing words.

Involvement in Data Analysis

Description of who among the local research team was involved in data analysis

Two of the qualitative interviewers who conducted the study interviews coded all of the interview data using NVivo software. Members of the local Qualitative Research Team supported this process, with additional feedback from the larger Toronto Site Research Work Group.

Coding

Steps taken to facilitate decision-making throughout the coding process

As a reliability check during the coding process, the research staff double-coded 6 interview transcripts; they met regularly to compare the accuracy of their codes and worked by consensus to refine discrepancies. In general, there was a high degree of consensus in the coding, with only slight differences in the wording of codes, attributed to previous collaboration between interviewers coding together as part of the Planning and Proposal Development study. However, there were instances in the reading of the double-coded transcripts when each interviewer added codes that the other had not coded. Interviewers also identified difficulties in faithfully coding some participants' transcripts when the apparent clarity of the narrative was low—this was a particular issue for transcripts of participants demonstrating low insight into their mental health problems. These issues were discussed and resolved in consultation with the original interviewer and/or with a qualitative research supervisor.

Using the constant comparative method of analysis (Charmaz 1990), the interviewers then transformed codes into higher-level categories by analyzing and grouping similar codes into conceptual categories. A larger group of qualitative researchers from the team met on 5 occasions to discuss the emerging categories and to collectively reduce the categories to a smaller set of higher-level themes. Once a set of higher-level themes was developed, a meeting was convened of the larger qualitative team including the study principal investigators to get feedback and to ensure that the themes faithfully reflected the experiences of study participants.

Field Notes

Description of process for including field notes into data analysis

Field notes were recorded by the interviewers upon completion of each interview. Field notes were not explicitly used in data analysis; rather, these notes served to support quality assurance measures, and to assist interviewers in identifying and reflecting upon themes from the qualitative interviews.

Audit Trail

Description of process for documenting data, events and methodological decisions during each phase of the research

The recruitment of participants was tracked using an Excel spreadsheet. Field notes were organized and compiled into comprehensive documents. Interview transcripts were dated and uploaded to NVivo Software. All methodological decisions and key events were documented in meeting minutes that were circulated to members of the local Qualitative Research Team.