Mental Health Commission of Canada

Commission de la santé mentale du Canada

At Home/Chez Soi Research Demonstration Project
Winnipeg Baseline Consumer Narratives Report

University of Manitoba

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Winnipeg Baseline Consumer Narrative Report

I. Introduction

This report documents an overview of the baseline consumer narratives of the Mental Health Commission of Canada's At Home/Chez Soi project in Winnipeg. It reports on participants' oral accounts of precipitants of homelessness, life on the streets or in shelters and their experience of mental health and with mental health services. This report is the result of more than forty individual qualitative interviews with Winnipeg At Home/Chez Soi participants conducted by the Winnipeg project research coordinator, University of Manitoba graduate students, and a peer interviewer. The opinions expressed in the results section of this report are that of participants and thus are descriptive in nature and not intended to be an evaluative assessment.

II. Context

a. Site description

The research component of the Winnipeg demonstration project is co-led by the Institute of Urban Studies, University of Winnipeg and the Department of Psychiatry, University of Manitoba and is structured as follows:

- Site Coordination: Marcia Thomson and Project Consultant Carla Kematch;
- Co-Principal Investigators:
    - Dr. Jino Distasio, PhD, Associate Professor of Geography and Director of the Institute of Urban Studies, University of Winnipeg and
    - Dr. Jitender Sareen, MD, Professor of Psychiatry, Community Health Sciences and Psychology and Director of Research, Department of Psychiatry
- Research Coordinator: Corinne Isaak, MSc, Research Associate, Department of Psychiatry, University of Manitoba

Three teams in Winnipeg manage Service delivery. The Ma Mawi Wi Chi Itata Centre undertakes provision of the Intensive Case Management (ICM) intervention known as Wi Che Win (or "Walk with Me"), while the Mount Carmel Clinic (MCC) is responsible for implementing the Assertive Community Treatment (ACT) intervention. The Aboriginal Health and Wellness Centre offers the Ni-Apin Program as the site- specific (Third Arm) intervention component. The program is an ICM model with an additional day program and provides housing alternatives to its constituents at first point of entry into the program.

The Winnipeg Regional Health Authority (WRHA) coordinates housing procurement in association with Housing Plus and works with the Service Tem to identify appropriate housing. They also have an educational role with landlords in terms of Aboriginal Cultural Awareness and Mental Health First Aid.
The Project Leadership Team, (comprised of the Site Coordinators, Project Consultant, Co-

Principal Investigators, the Research Coordinator, Lead Service Providers, and the Housing Procurement Coordinator), provide overall management and coordination of the Winnipeg Project. The Advisory Committee helps to secure effective, holistic and effective partnerships across housing, service and health care sectors, while the Aboriginal Cultural Lens Committee ensure that Aboriginal perspectives are honoured and promoted. Persons with lived experience in mental health and in homelessness (PWLE) are represented in various roles of the Project, on the Advisory Committee, as staff of the lead service providers and as research interviewers. The inclusion of Aboriginal perspectives and of persons with lived experience in mental health and homelessness are considered integral to the Winnipeg Site (see Appendix 1) for a chart illustrating the structure of the Winnipeg Site).

b. Characteristics of the Homelessness Situation in Winnipeg Prior to Implementation

According the 2006 Census, Winnipeg is a community of 633,451 people, (337,465- male and 357,205-female) with a median age of 38.7. Winnipeg is home to Canada's largest urban Aboriginal population (68,385) with 32,480-male and 35,905-female persons self-identified during the 2006 Census. This growing urban Aboriginal population is also much younger with a median age of 24 compared to nearly 40 for non-Aboriginal persons (Census Canada, 2006).

Since 1991 there has been an overall decline in the vacancy rates for rental property in Winnipeg, going from 6.5 per cent to 1.1 per cent as of October 2009. Low vacancy rates in Winnipeg in both the public and private housing market have contributed to long waiting lists for those seeking affordable shelter. As a result, prospective landowners and managers in the public market have the power to be selective in tenant selection. Some property owners and managers may avoid renting to tenants who are considered marginalized due to perceived drug and alcohol use and mental health issues, or as a function of racism and systemic discrimination.

Approximately 40 per cent of the rental housing stock is located within Winnipeg's inner city where housing is older and increasingly in need of major repair. This has placed considerable pressure in the rental market with fewer options. The Core Housing Need in Winnipeg has been estimated at 10 per cent, meaning that these dwellings may be in need of repair, the household pays more than 30 per cent for shelter or the household is considered to be crowded (CMHC, 2008). Winnipeg's housing rental stock is decreasing while rents increase, eroding both affordability and availability. According to a 2009 report from Canada Mortgage and Housing, the average rent for a bachelor apartment was $447, $615 for a one-bedroom and $809 for a two-bedroom.

With the average rent at these rates, a single person on Employment and Income Assistance (EIA) with a budget of $320 per month, in order to rent an apartment (or $300 per month for accommodations in a rooming house) would have great difficulty obtaining shelter in Winnipeg. For a bachelor suite, this represents a shortfall of $147 per month for

shelter costs, which must inevitably be taken from other household budget areas.

Table 1: Private Apartment Average Rents: Winnipeg CMA							
Bachelor		**One Bedroom**		**Two Bedroom**		**Three Bedroom**	
Oct-08	Oct-09	Oct-08	Oct-09	Oct-08	Oct-09	Oct-08	Oct-09
464	**447**	**602**	**615**	**769**	**809**	**920**	**946**
Source: Rental Market Report Winnipeg CMA Fall 2009							

The wait lists for subsidized housing is also a key issue. The Manitoba Urban Native Housing Association reports that there is an overwhelming shortage of housing, with 2,300 persons on their wait lists (Distasio & Mulligan 2005).

Another key issue in Winnipeg is that there are an estimated 5,000 tenants in 1,000 rooming houses, with EIA paying approximately $825,000 in monthly rents (Distasio, Dudley & Maunder 2002). In addition, close to 1,000 persons live in residential hotels along the Main Street area of downtown Winnipeg (Distasio & Mulligan). While overall shelter beds have increased over the past several years, there remains no Aboriginal-owned and operated shelter. The last shelter operated by the Aboriginal community was the Neeginan Emergency Shelter. Currently, Winnipeg has the capacity for 500 shelter beds during the winter months.

Estimates of the homeless population in Winnipeg range from a minimum of 350 living on the streets, with a further 1,915 making use of shelters on a short-term or crisis basis (Ford 2009). One challenge associated with the Winnipeg At Home/Chez Soi research demonstration project is that there has never been a comprehensive and coordinated homeless count. A recent report published by one of the main shelters in the city (Main Street Project) indicates that of the 300 homeless adults surveyed, approximately 70 percent were male and overall, respondents were five times more likely to report being of Aboriginal descent than the general Winnipeg population (Main Street Project, 2011). This corresponds with a recent "point in time" count orchestrated by the Canadian Institute for Health Information, as shown in the chart below.

Table 2: Point in Time Estimate: Winnipeg, Manitoba		
Date of data collection	**Estimate**	**Gender, Age and Aboriginal Peoples**
Night of June 22, 2005	Emergency shelter users 125 (excludes those on the street and hidden homeless)	101 males (81%) 24 Female (19%) Aboriginal Peoples 77 (62%)
Source: *Improving the Health of Canadians 2007-08: Mental Health and Homelessness.* Canadian Institute for Health Information, Canadian Population Health Initiative. Ottawa, Ontario. P.10.		

c. Description of Service Delivery Environment ("care as usual") Prior to Implementation

The standard form of shelter for the homeless in Winnipeg falls under the category of Crisis and Transitional Housing. Main Street Project, the Salvation Army Booth Centre, and Siloam Mission offer crisis and transitional housing. Such shelter is short-term in nature (with stays of a few days to a few weeks), and is particularly intended for emergency use, with the goal of transitioning individuals back into the community into more permanent housing. Between the three facilities, 435 homeless individuals can be easily sheltered, with a maximum capacity of 500 under conditions of extreme cold.

In addition, there are emergency and transitional shelters geared towards providing services to particular populations, such as women or youth needing protection from dangerous home environments. Women's facilities include Ikwe-Widdjitiwin, Osborne House, Salvation Army - Women's Services, Alpha House Project, and the Native Women's Transition Centre. Homeless youth are served by MacDonald Youth Services, the Main Street Project, Ndinwemaaganag Endaawaad, and the Neeginan Emergency Shelter.

However, there are major gaps in service provision. In 2007, Leskiw and Associates investigated service use and availability among Aboriginal people in Winnipeg and found that, while there are a number of services for adult women there is a lack of similar services for adult males (Leskiw & Associates, 2007). This is a particular problem in Winnipeg as the 2001 Community Plan on Homelessness and Housing pointed out; adult males represent a constituency of "high need" that are frequent users of emergency shelter, and who often have addictions issues. Moreover, the Plan indicated that Aboriginal males experiencing mental illness often seek emergency, transitional, and supportive housing in contrast to permanent housing. In general, the report concluded that among the most under-served populations were individuals with mental illness (Social Planning council of Winnipeg, 2001).

The Winnipeg Regional Health Authority (WRHA) provides general services for individuals with mental health issues. Supportive Housing (with on-site support staff) and Supported Housing (case management provided to residents who need supports) are also available in Winnipeg through the Winnipeg Regional Health Authority's Mental Health Program. The WRHA also operates mental health residential care facilities through its Community (Supported) Living and Community Mental Health programs. In addition, the WRHA offers a Program of Assertive Community Treatment (PACT), which is an outreach oriented, comprehensive community treatment, rehabilitation, and support service designed to meet the needs of people with severe and persistent mental illness. The service is provided to participants in their homes, at work, and in community settings but does not assist with the provision of housing for these individuals. The Province of Manitoba also funds the "ALL Aboard" strategy, which include housing facilities with community-based supports provided by multi-disciplinary teams.

To some extent then, housing is integrated into the delivery of mental health services in Winnipeg. However, there is clearly a lack of such services for homeless individuals with mental health issues.

III. Methodology

a. Description of the sample (demographics)

The Winnipeg site participant sample **totals** 513 participants (8 of whom are deceased since enrolment). Nearly 64 percent of participants are male, 35 percent are female with the remainder identifying as "other" or transsexual. Seventy percent of participants identified as Aboriginal (includes First Nations, Inuit, Métis, status and non-status as well as Indigenous outside of Canada). These patterns are also reflected in the sample of the 45 participants who took part to date in baseline qualitative interviews as detailed in Table 3 below.

ii. Data Collection

The National Qualitative Research Team, in collaboration with qualitative researchers from the 5 sites, developed the Baseline Consumer Narrative Interview Guide which was used to explore; 1) pathways into homelessness, 2) Life on the street/in shelters, 3) experiences of mental health issues and with mental health services and 4) High, Low and Turning Point stories (national level analysis). Field notes were taken to record interview length, relevant background/context, location of interview and the climate of the interview (comfort level, nonverbal behaviours etc). Interviews were conducted at shelters, project service team and referral source offices. Interviews were between 40 and 90 minutes in duration and were audio recorded and transcribed verbatim.

iii. Description of coding/analysis process

The main objectives of the analysis were to identify themes according to the topics asked about in the interview guide (see Appendix 2). The approach to data analysis involved constant comparative analysis as applied in grounded theory and other analytic approaches.

Open coding was used, primarily which involved identifying and giving provisional labels (codes) to seemingly similar sections of data that re-occur, and/or which appeared to be emerging as significant issues or themes. In addition, thematic coding was used, which involved developing more firm categories, and involved going back to re-code data, grouping them according to the emerging themes.

Table 3: Demographics Winnipeg Qualitative participants

Item	Number of participants n (%)
Age	
Mean	45
Range	21-57
Sex	
Male	30 (69%)
Female	13 (29%)
Transsexual	1
Ethnicity	
Aboriginal	32 (71.1%)
White	8
Mixed	1
Asian (includes East Indian)	1
Other	2
Marital Status	
Married/cohabitating	0
Single, never married	28 (62.2)
Separated	6 (13.3)
Divorced	8 (17.8)
Widowed	3 (6.7)
Children under 18 years old	
0	25 (55.6)
1-2	11(24.4)
3-4	5 (11.1)
>4	4(8.9)
Housing Status at Intake	
Absolutely Homeless	25 (55.5)
Precariously Housed	20 (44.4)

iv. Description of how the quality of the data was established

In addition to what has already been described regarding sample selection, measures were taken to ensure that the sample reflected the general Winnipeg site as well as the general homeless population in Winnipeg both in ethnicity and sex. For example, the majority of qualitative participants are of Aboriginal descent and the representation of female participants in the qualitative sample is also similar to the site and local populations.

The site research coordinator conducted the interviews as well as several graduate students and a peer interviewer. Under the supervision of the research coordinator, new interviewers first observed experienced interviewers, and then conducted interviews themselves. Feedback was given to new interviewers both immediately after the interview as well as after the interview had been transcribed and reviewed by the research coordinator.

The interview supervisor (research coordinator) ensured the quality of the interviews by reviewing a sample of five interviews (one from each of the five groups [High Need Treatment as Usual, Moderate Need Treatment as Usual, High Need ACT, Moderate Need ICM or Moderate Need ICM Aboriginal]). A member of the national qualitative team also reviewed the audio and transcript files and provided feedback. In addition, several of the interviews (audio files) have been reviewed and approved by the site Co-Principle Investigators. The main topics/questions of the interview guide were asked with appropriate probes on key issues raised by participants. The recordings are clear and generally easy to understand.

Interviews were transcribed according to the MHCC guidelines and confirmed for accuracy by the research coordinator (and participant if necessary). Feedback was provided when necessary for clarification and correction. Digital recordings of participant narratives are being stored on a secure, yet easily accessible repository.

IV. Findings

a. Pathways into and experiences of homelessness: A narrative of disconnections

The Winnipeg At Home/Chez Soi participants conveyed a kind of trajectory as to their pathways into homelessness. The start point was typically a disconnect from key relationships, community or supports. The fracture may have been due to mental illness, personal, or family trauma or a feeling of discrimination. This was often coupled with or was the beginning of substance use perhaps for self-medication or coping, which in turn exacerbated their mental illness and negatively affected their relationships and their ability to maintain stable housing. resulting in a cycle of long-time recurrent homelessness.

<u>Addictions and Relationships</u>

One of the most prominent reasons participants gave for becoming homeless was related to alcohol and substance abuse/dependence (alcohol, crack cocaine, marijuana, solvent use, crystal meth, pills). Alcohol and substance use may have been a coping mechanism used to deal with their mental illness and/or history of trauma.

> "That's when I started drinking [16 years old]. And then I never stayed at home, just always house parties, fights. And the drugs came in and yea, hit my rock bottom a few times"

> "When I came back [to the city] and I started going out again, I just ended up finding, people, and then that's when I started on that and then of course you get into the wrong people, started doing the harder drugs and then that's when my mom kicked me out of her place."
>
> "First became homeless? Was uh through getting kicked out of places for smoking pot and crack and drinking alcohol"

Participants also spoke of unhealthy or broken relationships in combination with alcohol and substance abuse/dependence and physical/sexual abuse as a reason for becoming homeless.

> "Yea it's usually drugs and alcohol. I would say that would be like 90 percent and 10 percent would probably be like interpersonal relationships, you know, living with a friend, get into a fight or you know, a girlfriend"
>
> "So it was my addictions that brought me down, and unhealthy relationships with men. That was because I trusted them, believed in them and they just like lied to me [laughs]. And, and then I, I shift-, I tried to take healthy relationship programs and then I did stick with it, so in the long run it didn't help because I went, I went back to the same. "
>
> "How did I lose my housing? I would just get up and leave. Go take my kids and get up and leave. I would just go [laughs] I, I would just up and pack everything up that I needed and, and I wou- would usually get beat up and I would be in Osborne Hou-, Osborne House with my kids. And then they would find me a place and I would start over again."
>
> " When I was growing up, up North in um; no when I was eleven actually. I'm from [rural community] I got sexually abused by my brother-in-law. [My worker] knows that and ah that's why, probably why I don't really wanna go back there. They know all about that."

One participant spoke about another issue perhaps related to detrimental relationships. He indicated that he was caring for other homeless people and letting them into his apartment, or having friends 'stay over' which would eventually lead to his eviction due to the activities of his guests. This issue also ties in with the discussion above related to the concept of disconnection leading to homelessness. Perhaps a fear of disconnection from others, and a need to stay connected prompted this participant to put the needs of others above his own.

Mental Health and Relationships

Several participants discussed their mental illness in combination with a number of interpersonal relationship issues with spouses, employers and landlords as a reason for becoming homeless.

> "My wife left I guess, well I know exactly when it was, June 7, 1999 actually, Cause I had gotten ill again So, it's a recurring illness for me. And after that really had nowhere to go and had no idea that the market was so bad, nobody on welfare really didn't have a lot of choices, so moved in with some friends for about 9 months, but they have some emotional and family problems to the point where uh they were arguing so much that it actually became violent … Yea, so I had to call the police and obviously I couldn't stay there any more and I was basically thrust out to the community and I became homeless"

Another participant spoke about his depression getting in the way of keeping steady employment. A few participants also spoke about mental health problems (anxiety) leading to anger, irritation, and aggression towards landlord or neighbours, which led to eviction.

Disconnection from Supports

In relation to becoming disconnected from key and supportive relationships, a number of participants indicated the reason for becoming homeless initially was due to new transitions and a subsequent disconnect from services and supports. For example, a participant spoke of the transition from First Nations community to the city. Others spoke of disengagement from either parents or the Child and Family Services (CFS) system when they became young adults. One participant spoke about being kicked out of his foster home at 18 years old, with a lack of skills, resources, and social supports.

> "I was living in foster homes. And it was okay in foster homes but after I was 18 they kicked me out and I was on my own they didn't teach me nothing. It was more like ah you know, you're 18 so get out and you know we don't want to know you anymore You know; that's (it's) too bad about, lots of people are like that in the foster homes. Like ah once you're 18 you're out the door and you're more like you don't know what to do they don't teach you anything"

> "I was kicked out of age 16 to live on my own. And at the time I was drinking alcohol and stuff and living on my own and, I spent the cheque and everything uh and I got put on the st-, out uh to my friends there on the street."

Another explanation participants gave for becoming homeless was due to being adopted as children into families of a different ethnicity and even different provinces and countries (for example the Sixties Scoop where Manitoba First Nations children were taken from their homes and adopted into American Caucasian families), again a disconnection from meaningful relationships and supports. Then as adults, in the process of making the

attempt to reconnect with their biological families, they become homeless because these family relationships were absent or could not be maintained and participants had no other supportive connections.

Barriers to obtaining/maintaining housing

Participants relayed a number of barriers in relation to obtaining and maintaining housing; both structural barriers related to tenancies as well as personal barriers such as perceived discrimination.

Structural Barriers

Issues such as the requirement for a lease co-signer, housing availability and rental costs on limited incomes were stated as barriers.

> "I've no means, no way of getting an apartment without getting a co-signer, but other than that, I'd be, I was willing and able to go out and get a place. Maybe find some work. Start off. But it never really carried on farther than that. Just the thought of getting out of there, or getting out of the [shelter] was in my head almost every day. I just eventually calmed down; it's been 11 years. I really don't see myself changing too much".

Participants also noted that finding affordable and desirable housing with a limited income contributed to their homelessness.

> "I think the main barrier was there's such limited housing for the amount that we were allowed. I mean 285 [dollars per month]! And umm if you want to live with bed bugs, umm crack heads umm people busting into your house…"

Personal Barriers

Another concern raised by participants in relation to homelessness was a perceived discrimination related to ethnicity. The feeling of being discriminated against may have led to lower self-esteem and perhaps to learned helplessness, reflective in the acceptance of poor practices of management and landlords .

> "Being aboriginal and homeless in Winnipeg sucks. [laugh] You know, I hate to say it but it-it's the truth. You can have three aboriginal homeless people and one white homeless person; and that white homeless person will get help before the other three. And they'll get a home before us, they'll get help before us, and you know, it's like people like to say it's not true but it happens every single day."

> "And that's the way that hotel is, it's management that does that and they treat Indians really bad over there."

Without supportive connections, structural and personal barriers played a sizeable role in preventing participants from obtaining housing. There was a sense of relinquishing the pursuit of finding housing as so many barriers seemed to repeatedly present themselves to participants, leaving them to feel they had no choice other than to remain homeless.

Homelessness as a choice

In contrast to the explanations for homelessness given above, several participants spoke about choosing to be homeless, enjoying the freedom and absence of responsibilities that this lifestyle brought:

> "I don't know, it probably just became a choice to be homeless I guess. It's just that I felt like I had a lot more freedom living on the outside, and I didn't have any responsibilities like paying rent or paying power or something like that. And ah and could just do anything I wanted to do. When living on the street is ah, it was a lot easier than living in a home, I guess that's how I chose to be homeless I guess."

> "The situation can't really be explained but I wanted to experience that lifestyle"
> *You wanted to experience what lifestyle?*
> "Ah the homelessness."
> *Oh okay can you think about why that might be?*
> "I just wanted to learn more about life. I still want to do that though "

One participant noted that parts of being homeless were a lot of fun.

> "I was having way too much fun and just kind of acting like a kid and people thought it was really strange, and it was, but you know, parts of it were actually a lot of fun."

Similarly, another participant noted that she felt good living on the street due to frequently using drugs and/or alcohol.

> "I felt like I was do-, like I was doing good I guess too cause I was getting high all the time I thought it was good"

While participants presented being homeless as their own choice, which provided independence and freedom from following a myriad of rules, they may have perceived their choice to be homeless as an alternative that provided freedom from going back to undesirable situations, fear of eviction/failure, following rules, and restrictions related to drug and alcohol use. In addition, if what they had known previously as 'normal' (having housing connected with multiple challenges) was not working for them, choosing to be homeless may be seen as a more desirable option.

b. Life on the streets or in a shelter

i. Typical day

Participants were asked about what a typical day was like while living on the streets or in shelters. Their accounts of life on the streets were characterized by stories of looking for and mastering means of survival for physical needs such as money, shelter, food and clothing, often trading one for the other to obtain what was needed in the moment. Descriptions of a typical day also included challenges regarding current relationships, mental health issues and efforts towards maintaining dignity and finding ways of coping with their situation.

<u>Survival - Addressing Physical Needs/Money-making Activities</u>

> "Let's see, what would I do in a day? I would make phone calls, if I wanted- If I really needed money I would go shopping. Meaning, I would, I would go and boost clothes and try to sell them. Yeah, um, what else? Just visit friends. Make sure I had a place to stay for the night."

Many participants spoke about spending a significant portion of their days walking and wandering about while collecting empty cans and bottles and panhandling to make money.

> "I get up at about seven o'clock, jump on my bike, first thing I go in is a back alley, look for empties, look for a pop can or something I could sell to um, you know get some money"

> "I would walk around look for beer cans and pan handling and… Stuff. Not eating proper. Eating from the garbage."

> "Yeah, I'd just walk around, once in a while, you know, do the odd narcotic, but sometimes you get caught up in it so. I don't know. Like, us-, like you usually didn't really affect, but like we would just chum around basically. And, we'd get like, Smoke like pot together, just walk around the city looking for cigarette butts, buggin people for change and stuff like that. That was another way of feeding myself, was pan handling. Yeah, I mean, I could make, I used to be able to make like 40 bucks in less than an hour."

Some participants spoke of volunteering, doing work, or trading items for food or shelter.

> "And I used to volunteer at [mission]. So when I volunteered there they'd always give me food, extra food. So uh that's why I stayed there for a long time Because of that, If they clothed me and they fed me and, and they treated me good"

Participants' comments reflected the need for not only survival but meaningful activity which would keep them occupied and meet their needs of the day.

Finding shelter for the night

A significant part of participants' days were spent thinking about and procuring shelter for the night. Participants described a variety of places where they were able sleep. Accounts relayed ever-changing strategies and challenges of securing shelter or a safe place to sleep. Several participants also reported not sleeping and walking around all night. The weather was also a common theme throughout interviews due to the extremities in Winnipeg weather, affecting participants' planned sleeping arrangements, which were sometimes dictated by existing structural barriers such as available shelter spaces.

> "It was very difficult to find a place to sleep because of the weather. Missions were always full unless you lined up at 7:30 at night and I just wasn't going to do that on most cases or it was just too far away, didn't have bus fare So it was extremely difficult in that sense."

For some participants, survival meant adapting their hygiene practices to the amenities available to them or learning new skills for obtaining sleep for the night.

> "Oh, uh depended on the weather. Very often I would sleep on the ground by a fire, but unfortunately the fire would go out at 5:00 in the morning. I'd be covered in soot, my hair was just terrible I, I had quite long hair and I, eventually I had to shave it all off because I couldn't find a place to, to clean it. You know, and so, yep bouncing between the mission, parks, and under bridges essentially was where I was sleeping. There was no option."

> "I hung out pretty much anything that was open 24 hours, I'd be in there… there's quite a few of us who actually teach ourselves to learn how to sleep with the lights on so that way if we go to an open 24 hour Wal-Mart, then we can, if we need to we can go into the bathroom and sleep.

For some participants finding an acceptable place to sleep was connected with their need for or their sense of security and privacy and implied a desire for seeking isolation.

> "One night when it was warmer I slept at the corner of Logan and Salter. There's a big patch of open land there and there's a great big tree standing in the corner and its big enough to where I could put the blankets I was on and it would cover me so nobody could see me and come and bother me while I was sleeping".

> "In the summertime I would just, like sleep on a bench and just, And then, to get away I would go along the river and just sit around in the bush because I wanted to

> be alone. I felt safe because no one was really around and when I grew up, I remember seeing the bush. And as kid, I used to go in the bush all the time. And get away from all the abuse…and all the pain. And I felt safe in the bush, listening to the birds and the rabbits. Seeing the rabbits and stuff made me happy."

One participant who did not drink any alcohol described that this was a disadvantage when sleeping on the street.

> "I don't drink so which is, its actually that's one of the reasons that you can't sleep when you're homeless because if you don't drink, you don't sleep. Everybody else would sleep. I'd be up all night because it's too cold and I'm sober, just sitting there shivering."

Several women discussed the realities of living on the street and how at times, trading sex for shelter was required in order to obtain shelter and the personal stress that came with this.

> "I been staying with, with, with a guy right now and like I have to sleep with him to stay there you know what I mean like I'm, I'm, I'm very high risk, I have been for like 10 years eh in the trade so Um, you know but he doesn't hurt me and, and it's a safe place to stay "

> "well it's really, a really, really, really, it's a really horrible feeling not knowing where your gonna like stay the night and its horrible to think about what you've got to do in order to have some place to stay and- It's the worst feeling that there is. "

<u>Obtaining Food</u>

Many participants discussed the challenges and also the options for obtaining food during the times they were living on the streets or in shelters. One participant described that there are many opportunities for finding food in Winnipeg particularly if they had knowledge of when and where to go, while others expressed the opposite.

> "Sunday, the hotdog stand here, you can't starve in Winnipeg, there's always a place to eat, you can never go hungry here, yea, I found that out, Sunday, get, Sunday's are the best day of the week. There's so many places to eat, there's churches, sandwich van, hot dog stand, there's everywhere you know Sunday, Sunday is the best day if you're homeless. You're hunger, never go hungry on Sunday, Sunday is a day you look forward to."

> "The hardest days of the week are Saturday and Sunday. Saturday mainly after 2 because [shelter] is shutdown after 2. … And Sunday is the worst because none, nothing is open. So we're just walking around all day."

Other participants indicated that although food was available, it was difficult to obtain healthy food or to find a place to cook their food.

> "Healthy food wasn't uh easy thing to get a hold of, the junk food, the pop, the, that was kind of more accessible, um than the healthy food. I was just kind of lived on junk most of the time"

> "Going into garbages and stuff to eat"

> "You know, just at soup lines. Yeah, because there's no place to cook it you know. Cuz most of the time I eat everything raw, like you know just grab a can of Klik meat and open it up, throw the can away and start eating it."

The type and amount of food available to participants seemed to be connected with their 'inside' knowledge of both where and when to get food. If they did not have this inside knowledge they would resort to eating junk food or discarded food from garbage cans, again relating to the ongoing theme of disconnectedness.

Relationships

The theme of disconnection emerged again in relation to how participants would spend their days. Some spoke of isolation, disconnect, alienation from friends, family, neighbours and supports.

> "I sit in my room all day. Well since, since its cold out I just stay in my room all day. I don't do anything. I don't even try to phone and like to phone for an apartment or something (like). Just relying on living here I guess until, as long as I could. I'm mostly by myself. Well, I've talked to a few people here but I don't, I'm not really a people person. I'm just a loner by myself."

> "I think I - like once I went to see a friend, but I totally shut myself off or being by myself. Or they didn't want to hang around with because I din-, I didn't take a shower or nothing."

> "It was sort of hopeless, it was hopeless actually."

A number of participants described the need to keep other homeless people at a distance, whereas others discussed caring for and being cared for by other homeless people. For example, one participant noted that he would watch out for his friends' safety and well-being.

> "And I would actually take my clothes and cover them up and that's how my, all my clothes got ruined cause it was just brutally cold one night and… raining and everything so I was covering them all up"

For others, there seemed to be a 'love/hate' relationship with their street community, loyalties flip flopping from day to day and 'friend' to 'friend', portraying a sense of distrust, lack of meaningful connections and meeting their survival need of the day.

Mental Health Issues

Some participants described not knowing what a typical day was like due to mental health issues or drug/alcohol use and self-medication interfering with memory of events. At the same time, participants described a desire for normalcy, maintaining dignity and self-respect.

> "Well that's difficult to tell because unfortunately when you're in mania you really don't maintain a lot of your memory and especially the sequence of events is very difficult to recall. But, yea essentially trying to find the essentials of life and still trying to enjoy myself to whatever extent I could."

> "I'd stay at the [shelter] and that once in awhile, but, at that time I was too scared to yea, to stay there, Yea, that's why it's a psychological problem... That would be not, not being able to sit still, like all this moving. And uh panic attacks. In the past."

Self-Medicating - 'Saving Face' and Coping

> "My day would usually start at night time after I had woken up. With a hangover um, I would get up, turn my vehicle on, get some warmth, warm up. I'd have a wet facecloth with me all the time, wash up, put the makeup on, put your happy [frank] face on, go out and "hey how's it going?"

> "What I did a lot was I just walked around. [Laughing] I did a lot of walking. I walk along the river, get together with people. The thing was ah for me was getting high, getting high, so I didn't have to feel anything. It didn't seem as serious when I, you're high."

Participants' days consisted of surviving in the moment and meeting their day to day needs for shelter, food and money and coping with their circumstances. Despite many obstacles including mental illness and lack of connection with supports, participants exhibited a high degree of resourcefulness and resiliency, attempting to navigate the existing systems and deal with their situation as best they knew how.

ii. Support, services and community organizations

Participants mentioned a wide variety of community organizations and services that they frequented, including shelters, meal programs, and community support agencies.

<u>Shelters/Meal Programs</u>
Varying opinions were given on the support of the various shelters. Some indicated that certain shelter staff and services were very caring and helpful, for example, "It's the staff there who I can talk to" while others felt the same shelter was not meeting their needs. Again, this may speak to the lack of meaningful connections for participants. Those who felt shelter staff were supportive may have established supportive relationships with them while for others, positive relationships with shelter staff may not have existed or may have been broken. A number of barriers such as shelter/meal program hours, vacancy and transportation are also evident.

> "When [Shelter], you go there you get one plate and let's just say it couldn't feed a squirrel"

> "There was some opportunity to use uh the shelters, although they were extremely full. There were food kitchens, but you had to get there by certain times and it was very difficult walking to them because I was carrying this huge bag"

Although particular shelters were frequently used and mentioned, participants criticized certain organizations for the atmosphere, the price participants had to pay to access services and the sense that once a person stayed there, it was impossible to escape.

> "Least helpful? [Shelter], they don't help nobody, you have to pay everything you do"

> " that place is hell on earth… you see nothing but drugs and alcohol and… All kinds of stuff in front of that place, around that place, even inside that place, oh yea I've seen multiple fights, one guy got killed outside for not giving someone a smoke"

> "It's like once you're in this and, I've heard more than one person say this, that once you're in the [Shelter] building and you live there, it's hard to get out of there"

Most of the comments above convey dissatisfaction with the services and supports offered by community shelters and a feeling of being trapped in the life of shelter use. At the same time, participants indicated regular use of these services, perhaps believing there were no other options or choices for them at this point in their lives.

Social/Government Services

Some participants expressed a lack of trust in governmental support, health care (medical), and social workers. There was a perception that they are on opposite sides- feeling there was disrespect, stigma against homeless people. For example,

> "You stay away from those". I mean because if you're home, homeless people, we're looked down upon. You know? It doesn't, they just see the outer shell, they don't see the person, they don't see you as a person they see you as a thing. 'get out of my way you're, you're nothing but a nuisance.' They forget that we're human beings, ya know. It's like we're pieces of garbage, just kick us aside. And after getting treated like that for awhile [crying], you start to feel that way. And then you get defiant, they you get hateful, you know and then you just kinda withdraw from the world; and that's how you find your own little niche, I like to get high and that got me through my day, and screw the world hah because the world doesn't want me."

Another concern that was raised was navigating resources and not knowing how to get appropriate help and what services were available coupled with the perception of discrimination or stigmatization.

> "So a lot of us don't even- you know when you get to that point on the street you just give up cuz you know you're not gonna get the help and you're goon have to go through hell just to get help… It's like whenever I was ready to deal with an outside agency I would have to mentally prepare myself, you know. If I'm gonna be treated disrespectful I gotta how am I gonna stop that? Are they going to be condescending, how do I get over that and how do I get over just putting up with the BS that they're gonna give me to get the help without getting pissed off and walking out before I get the help. [laughing] And then how many more hoops am I gonna have to jump through to keep getting the help if I need it you know."

Some participants however, did speak of helpful interactions they had with community agencies or services. The connection this participant had made with a supportive worker in the community played a significant role in navigating the required systems and getting the help they needed.

> "Most recently like uh the guy centre, no I mean the [Centre] That's how they helped me to get uh my, my IDs and stuff again and go back on welfare. I didn't have patience to do it (incomp) problem, that's why I went homeless."

Responses from participants regarding support and community services are centred around the existence of or lack of supportive and meaningful relationships. It is evident that positive connections and supportive services are critical to assisting individuals in both navigating services as well as providing a stepping stone to move beyond their current circumstances.

iii. Vision for Housing for the Future

Participants' visions for future housing reflected themes of safety and security, independence (including living alone) and having a 'sanctuary', a place to rest and relax.

Safety, Security and Relaxation

Most participants spoke of their desire for safety and security in places other than where they were currently staying. However, several participants indicated that they found the shelters to be the safest place for them, perhaps because they felt they needed additional supports at this point in their lives to obtain a safe living environment.

> "I wouldn't wanna live anywhere else cause I know that's, there's a lot of stuff will happen on the street Yea so I'd wanna live here [shelter] I just think it's the safest place, for me right now"

> "A place, a safe place to st- to live. Somewhere safe like where you don't have to worry about someone busting your door down or, or kicking through your door because it's been busted down so many times that they can see if you're home or not [laughs]. Security system I guess."

> "Ideal vision? Safe. Secure."

> "like a sanctuary I could be somewhere relaxed. Being on the streets after awhile [can be] nerve wrecking"

Desire for Independence

Participants expressed the desire to both live independently, making their own decisions and schedules as well as living on their own and not allowing friends or acquaintances to visit.

> "So I could stay home and sleep as mu-, much as I want [laughs]. Yea and do your cooking… Whenever you want. I'm not telling nobody where I'm moving So that's my problem is…I never told anybody that way I just tell them "well I'll be staying over there" they're looking for a place to drink or…That's why I don't tell nobody. Just keep it to myself"

> "Yea, live on my own. No roommates"

> "I'd live on my own Like have a, like one of those button operated doors, (incomp) your own key, yea Where no one could get in And not bring certain friends to my place when I get it"

The participants' desire for independence and living by themselves may stem from a history of negative outcomes they had experienced when they did allow others into their homes. Also, the desire for privacy and being left alone and able to relax is likely to be opposite of their experiences whilst living on the streets or in crowded shelters where they would continually be expected to share spaces and to interact with others.

Desired Location and Future Plans

Visions for future housing varied significantly among participants, possibly reflecting the current level of stability and wellness they perceived themselves to be at. In terms of desired living location and future plans, some participants indicated they felt most comfortable remaining in the inner city core area where they knew how to find supports and felt there was no fear of discrimination and were content staying at a shelter or with their current housing obtained through the *At Home/Chez Soi* project. Others, however described a 'white picket fence' aspiration of living in the suburbs or in the country, reconnecting with their families and finding employment or furthering their education. Still others relayed a desire to be of assistance to others and to develop a facility outside the city which they could use as a hostel or rehabilitation centre.

> "I would like to live, well I don't really know; all I know is downtown, central Winnipeg. I know there's other spots, but then the further you get out then, then more you have to deal with 'Oh you're in the wrong part a town, shouldn't you be downtown?"
>
> "My ideal place, I wanna get married, I wanna have the white picket fence, I want a career, I want all the goody thi-, good things"
>
> "I would envision a nice beautiful log home in the country, possibly even a rehab centre for uh people of my age and up, our maturity, 45 and up, 50 and up"

Some participants seem to be at a place in their lives where they are ready to take the risk of moving beyond what they have known or perhaps returning to previous lifestyles, while others wished to remain with what they've known and are comfortable with, not yet ready to take risks. Those who wished to remain in shelters may for example, feel a sense of safety there that they are not able to currently secure for themselves elsewhere.

iv. Life on the Streets or in a Shelter

The Hardest Part

When participants were asked what the hardest part of being homeless was, they relayed a number issues ranging from addressing physical needs such as food, shelter and

maintaining hygiene and controlling additions, to the need for a place of privacy and relaxation.

> "The hardest part about living on the street, it's not knowing where your next meal is or where, where you're gonna sleep and… You just, you know and, and for me it was addictions. It was hard."

> "Sometimes uh, when you were staying at the mission you had uh facilities there which was good. You know I would go into a Laundromat to do my clothes whenever possible but for the most part, no because you know I wasn't aware of the fact that they had shower facilities at a couple of places, but I, really had no place to, to bathe or anything so I was quite dirty most of the time."

> "The hardest thing? Was probably just wanting some privacy. Cause I just needed some alone time you know? And I just never could relax and be alone for any length of time."

<u>What kept you going?</u>

When asked what kept them going from one day to the next, participants described a variety of important motivators, such as being able to connect with their children, spirituality and personal beliefs as well as meaningful activities and a sense of hopefulness.

> "I guess, I always looked forwards to the weekends because that's when I get to see my kids. I guess they are basically what's really kept me going…So its basically just that and just wanting to, having this hope that I will, um, get something going soon and be able to be with them again."

> "Most of all I think about my kids."

> "I don't believe in suicide! I don't know. I'm just, I've never been a, able to completely give up. What kept me going? I, I guess what kept me going is I didn't have a choice. I couldn't will myself to die; otherwise I would a just laid down and curled up in a ball and say 'I'm done'. But I couldn't I, you know that isn't an option and killing myself wasn't an option. So I jus- I just didn't have a choice, you gotta just keep going. And hope for, hopefully that a you know, …that a good things will come your way."

> "Music I guess, the CD player helped a lot when I was on the street. I found one. Music, rock, rock music I like, I like all kinds of classical, techno Yea dance. Yea it was very helpful."

> My spirit, spiritual awakening. Yea, my relationships, God as I know him…I got a good friend who's a chaplain. And I've had some pretty amazing things happen in my life and um, so I would say, and I don't know if it's called Christianity I just, Godliness."

Participants spoke of challenges to obtaining basic needs like food, clothing, shelter and also privacy as being the hardest part of being homeless and living with mental illness. These are fundamental biological and physiological requirements typically not being met for participants but assumed for all humans and are often taken by granted by those of us who are fortunate to be able to meet these needs on a daily basis. Yet, participants displayed a tremendous spirit of strength and resiliency and were able to access some of their internal motivators and beliefs as well as their desires to re-establish and maintain relationships with their children which is what kept them going day to day.

c. Experiences of mental health issues and mental health services:

i. Mental health issues

Many participants discussed that the development or worsening of their mental health problems in the course of their homelessness, was especially difficult for them, as they did not know what was happening to them, why they were feeling the ways they did, or what they should do about it. This lack of mental health literacy meant that participants and their family and friends were not able to detect what the issues were, did not know about symptoms, nor did they know what to do about them or how or where to get help until much later in life.

One participant noted that he developed Agoraphobia living in shelters and did not want to leave his room. Increases in mania and depression and not being able to identify these issues as mental illnesses were also linked with becoming homeless.

> "And because I was in mania I really didn't understand, I don't know (incomp) didn't understand, but uh wasn't doing as much as I probably should have been doing to try and find appropriate housing. Because I really didn't know where to turn."

> "[It] Wasn't right, hearing things that people weren't saying."
> *Okay, so can you, like how old were you or when did that start happening?*
> *"*Sixteen, seventeen it started up. Yea I used to suffer a lot, now I'm doing good now. Like uh, I guess I didn't really know too much about it at the time, but now I can see it."

> "Yes, especially the psychological problem, like it's like a few people said, you think you're dying, but you're not, not at all"

> "And I didn't know I had an anx-, an anx-, anxiety disorder and I didn't know what was going on with me and kept asking my mom "did you drink with me."

> "Cause I never, I didn't know where it came from, before I even got [educated] I didn't even know what depression was."

This lack of mental health literacy on the part of the participant in addition to their family, friends, or broader support network left participants feeling alienated and alone. Disconnection from family, friends, and supports was both a precipitory factor to the development or worsening of mental health problems, as well as a consequence of not understanding what the problem was, and how to be of the most help to the participant.

> "My family wasn't dealing with it in the way that they should have been. But you know in their defence, you know they, people they just didn't know that much about it."

> "I think some of them are scared or someone didn't know too much about it."

Some spoke of using alcohol and drugs to self medicate in order to cope with mental health problems (ease pain, numb, decrease anxiety).

> "Actually marijuana helps with the depression and also with the ADHD right, cause that's what I have ADHD, FAS, uh CKY, XYZ, you know, I'm like every letter of the alphabet, but it helps calm me down"

In contrast, some participants denied ever experiencing any mental health problems or seeking mental health services, suggesting that living with mental illness was just part of how they had always navigated through life, or perhaps displaying a lack of insight into or knowledge of their mental illness.

ii. Mental health services

<u>Medications</u>
Several participants expressed caution or resistance to taking pharmacological treatments and discussed the side effects of medications they had taken.

> "I don't know, I don't want to pop some wacko pill that's, you know, you know leave me comatose."

> "…And bad experience from uh side effects and the pill they were giving me too."

> "So yea, and, and, and, and, and a little while later I started feeling holy smokes, I'm like I'm going crazy here because that, that, that pill, whatever I took, did something to my, my mind, I felt like I was losing it."

> " Yea, will not take medication cause all that did to me was make me hallucinate like…"

Support from Mental Health professionals

Participants discussed pharmacological treatment as often being the first line of treatment offered, with little or no follow-up or continued mental health or social support.

> "He did this, 'oh, just take these, you'll be okay'."

> "And I've had no help, they give me pills and nobody will even pay for my pills"

The scepticism of participants around taking medications for mental illness may be due to a lack of connection with their mental health caregiver. It may also be a reaction to the perceived lack of engagement of prescribers with them and also lack of understanding about the medication and being able to discuss their concerns regarding side effects with a mental health professional. In addition, participants from non-Western, non-Caucasian ethnicities may be suspicious of 'western medicine' as they may not trust the system or the professional who work within it.

Another individual relayed the experience of having and then losing a mental health worker and the fall out of not having that support and consequently losing housing.

> "I used to have a community mental health worker. Uh, Used to. When I was in [the] Hospital, they gave me a community mental health worker. And after, after being uh, through several group homes, my, well- my mental health worker sort of gave up on me, which wasn't too good. So, I was always getting kicked out for some reason or something else would happen, and I'd get the blame, or …I'd just have a manic attack and call the police. "

Many participants discussed not trusting health supports/medical professionals (alienating/abandoning). Mental health professionals were often characterized as invalidating - not thinking anything was wrong left a few participants feeling confused and alone. For example, "I tried, I tried but they said there was nothing wrong with me." Other participants described feeling blamed for being in the position they were in. They termed this "blaming the victim."

Some participants described that they were more inclined to see an elder, healing with spirituality rather than take a medication or visit a mental health professional. One participant who was seen at a Counselling Centre noted that the counsellor was of different

cultural background and of different gender, and as such she felt like he did not understand her.

> "The one man that I was seeing for counselling, I did all the talking and I never, the sense that I got from him was he, he just wasn't getting me. I think I went three times and I quit going. I said he doesn't understand; because, he you know it was like 'Well this is what I did'. Well yeah you're white, I'm Indian, I can't just go through the steps that you go through and get you know where you're at. It's just not gonna happen!"

The quotes above and below speak to the need of participants to form connections with others - a point that continues throughout the analysis. Participant comments also illustrate a point that several participants made about a preference and desire for an alternative type of treatment, to see a counsellor whom they could trust, who shared their same cultural background and cultural practices and was also of the same gender.

> [What was missing]"A connection with uh, aboriginal another aboriginal, feeling like someone that's like me, you know. Being able to talk to someone who will understand what I talk about that I trust and you know, that comfort feeling, comfortable feeling."

Several participants noted that they had seen several different counsellors and psychologists in their lifetimes, and that it would be nice not to have to re-tell their story, and to see one consistent therapist or counsellor over time, expressing a desire for long-term, meaningful and supportive connection.

For example, one participant explained:

> "It would be nice to have, like I would go into counselling, but it would be nice to have a counsellor in an office where I can continuously see him for a year or two years um not being a guinea-, guinea pig at uh the other hospitals you know Uh where you get a counsellor for six weeks and then all of the sudden you got someone else and… You know, but yea definitely one person that you can consistently trust and build a bond with and you don't find yourself constantly repeating your, your life to. And yea I mean speaking to people and you, you jump in from basically what's has happened ten years ago to what's happening a week ago to you know what happened three months ago. So it's hard to get everything out and, and clear and people really can't get a better understanding of it unless you're actually with that person and, for long term."

In contrast, others spoke of having mental health workers, counsellors, nurses, and psychiatrists with whom they had or were having positive interactions and some had established that trusted, long-term connection desired and expressed by others.

> "I got a mental health worker, I just got one. Finally, yea I seen her about three weeks ago. She's, uh I got an appointment with her March 5."
>
> "Yea I seen the nurses and doctors. Get on, Get medicine. Uh let's see, then after I went to see a doc- a psychiatrist And I started in to seeing him and medicines and stuff. Been like uh three four times I guess inside the hospital. Yea, good experiences."
>
> "This place here's been helping me for such a long time now. I kind of connected and grew, uh, trust with them? I built trust with them? They built the trust with me. It took a long time, but it's happening now."

Another participant shared how getting a formal mental health diagnosis from a psychiatrist while in a penitentiary was extremely helpful for him in understanding his mental illness.

> "Once I finally got diagnosed, that was just all what I'm feeling like, ha, not I'm right, but you know I'm right. Yea, it's like all the pieces of the puzzle…you know add up. So now, now it's like, it's time to start the new puzzle you know like, now with the knowledge you have you go from the 150 piece to the 600 piece."

Participants' stories of interactions with mental health services and supports echo the cross-cutting theme of the value of meaningful and supportive connections. For those who perceived they did not have meaningful or helpful interactions with mental health professions, their mental health issues continued to be a daily challenge and participants seemed unsettled, whereas those who had been given a formal diagnosis and were feeling support from their mental health worker had much more positive outlooks on their situation even if they continued to have limited options for housing.

V. Conclusion

a. *Cross-cutting themes or issues*

Throughout the various segments of the interviews a number of key themes or issues emerged. One of the main issues shared by participants was that of substance use, abuse, or dependence. It was connected with dysfunctional relationships, mental illness, as well as obtaining or maintaining stable housing. In addition, mental illness was conveyed as playing a role in losing housing, addictions, and detrimental relationships. Associated with both of these issues was the overarching theme of connectedness. For most it was a lack of connectedness from family, friends, community or health and social support systems and even self. In conjunction with the disconnect from or mistrust of health and social service, participants expressed the desire to pursue other avenues of support more closely

connected with their culture. Another key issue expressed was that of a lack of mental health literacy amongst the participants as well as their families and friends, many did not understand that they had a mental illness nor how to deal with it. This was exacerbated by a lack of knowledge about how and where to seek treatment. Many of the Winnipeg participants also spoke of feeling discrimination in relation to having a mental illness, being homeless, being of Aboriginal descent, or a "compounded" discrimination from being included in all three stigmatized groups. Despite all this however, there was a keen demonstration of strength, resilience, and resourcefulness conveyed by participants.

b. Reflections and lessons learned

The Winnipeg At Home/Chez Soi participants conveyed a kind of trajectory as to their pathways into homelessness. The start point was typically a disconnect from key relationships, community or supports. The fracture may have been due to mental illness, personal, or family trauma or a feeling of discrimination. This was often coupled with or was the beginning of substance use perhaps for self-medication or coping, which in turn exacerbated their mental illness and negatively affected their relationships and their ability to maintain stable housing. It would seem that these three key issues – lack of connections, mental illness, and substance use – might together create a barrier to improving the quality and stability of participants' lives. Considering Maslow's Hierarchy of Needs (Figure 1) (Maslow, 1954), we see – and can understand intuitively – that those who are homeless, have lost their connections with supports and positive relationships, and are living with a mental illness do not have the basic three levels of needs met according to Maslow (Biological and Physiological, Safety Needs, Belongingness and Love Needs) and thus do not typically have much motivation for continual betterment. Another view would be through the four quadrants of the Aboriginal Medicine Wheel (Figure 2) which represents harmony and connections and where the attainment of balance is met by being well in the mental, physical, spiritual, and emotional aspects of life. Participants provided numerous indications and explanations of how some of these aspects of their lives were out of balance.

While participants demonstrate tremendous resiliency and strength, at the same time it would appear that for most, their basic needs are not being met and their lives were chaotic and out of balance at the time of the baseline interviews. These observations seem obvious and yet the issue of mental health and homelessness remains a significant concern in Winnipeg and in Canada. Individuals in these situations, thus far, were not able to manage obtaining their essential needs with their own efforts and so require substantial assistance and support in order to regain balance in their lives and to have their basic needs met. While the Winnipeg At Home/Chez Soi project has made great strides in addressing the needs of the project intervention participants, tapping into their existing strength and resilient spirit of participants may be the first step in reconnecting participants with community and supporting them in their journey to well being.

ACKNOWLEDGMENTS

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Figure 1: Maslow's Hierarchy of Needs

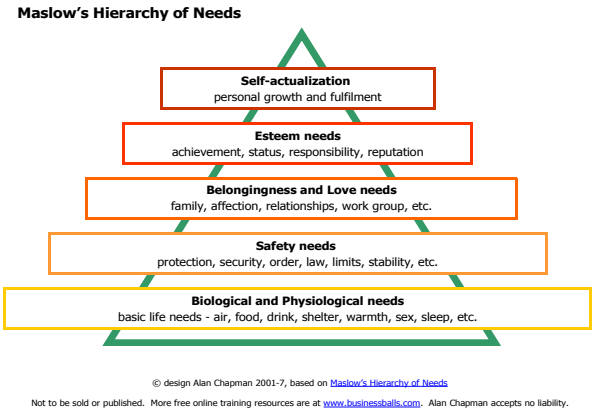
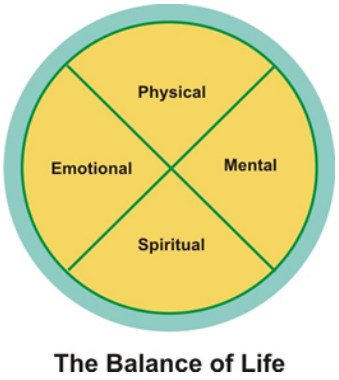


Figure 2: Medicine Wheel



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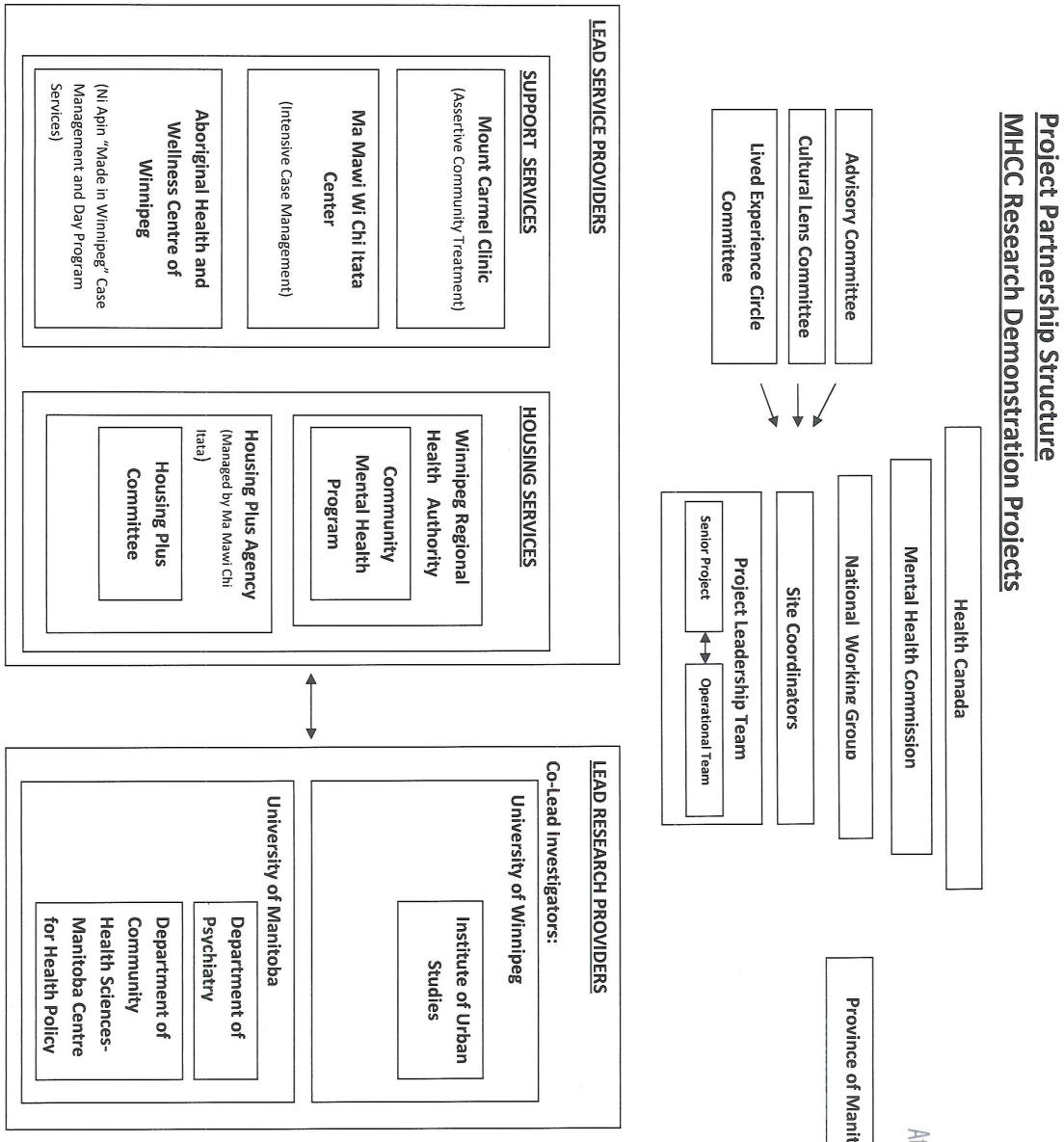
APPENDIX 1

PARTNERSHIP STRUCTURE OF WINNIPEG SITE AT HOME/CHEZ SOI PROJECT



APPENDIX 2

BASELINE CONSUMER NARRATIVE INTERVIEW GUIDE

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

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

Theme 1: Pathways into Homelessness (or Precarious Housing)

a. **Life before Homelessness**

Tell me please what life was like before you started living on the streets or in a shelter.

Tell me about the first house or apartment that you remember.

(probes: things that kept you housed prior to homelessness; things that kept you housed;)

b. **How the Person First Became Homeless**

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

c. **Recurrent Experiences of Homelessness**

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

d. **Most Recent Experience of Homelessness**

Tell me please about your most recent experience of becoming homeless.

(probes: how you found the housing your most recent housing; issues/experiences related to living on the streets or in a shelter; issues that prevented you from finding housing.)

Theme 2: Life on the Streets or in a Shelter

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

a. **Typical Day**

First of all, I'd like you to tell me about what your average day is like. For example, if yesterday was an average day, tell me about what your day was like.

(probes: where did you sleep, places visited, people met with, nature of encounters with people, etc.)

b. **Services, Supports, and Community Organizations**

Now, I'd like you to tell me about the services, supports, or community organizations that you have used while living on the streets or in a shelter.

(probes: what they're like; types of services/supports/community organizations found to be most helpful [e.g., services, family, friends, church]; types of services/supports found to be least helpful; sort of involvement in the community while living on the streets or in a shelter?)

c. **Experiences with Housing**

Now I'd like you to tell me more about your experiences with housing during the period of time when your housing situation has been unstable.

(probes: places lived [quality, safety, support]; relationships with landlords, superintendents or neighbours; experience of stigma, discrimination or other barriers in relation to services and housing; any positive experiences)

d. **Vision for Housing for the Future**

Now, I'd like you to talk about how you envision your housing situation in the future and how you might get there.

(probes: what does home mean to you; what would be an ideal housing situation [individual vs. shared living situations; landlord relationships; location; safety issues]; the kinds of challenges that would have to be addressed to allow you to achieve a more ideal housing situation);

Only for those in one of the housing interventions – What do you think of the "At Home" intervention project in which you will be involved?

(probes: hopes, fears, challenges)

e. **Life on the Streets or in a Shelter**

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

How has your life changed since you started living on the streets or in a shelter?

(probe re: feelings about oneself, relationships, family, friends, health, involvement in the community, poverty, stigma, addictions)

What has been *hardest* since living on the streets or in a shelter? (probe re: feelings about oneself, relationships, family, friends, work, health, involvement in the community, poverty, stigma, addictions);

What keeps you going?

(probe: what do you enjoy doing?)

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

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

a. **First Experiences**

First of all, please talk about when you first remember thinking that something was different, or that something was not quite right.

(probes: what life was like at that time; feelings about oneself, relationships, family, friends, physical health, involvement in the community, poverty, stigma, addictions)

b. **Experiences with the Mental Health System**

What have been your experiences with receiving help from the mental health system?

I'm interested in hearing about your experiences with the relationships that you've had with mental health professionals and service-providers.

(probes: first experiences; experience with mental health services and with mental health providers since that first time; current experiences; did services or providers meet needs; inadequate or unfair treatment; any changes or improvements needed)

c. **Recovery**

What would recovery (or healing) mean in your situation?

What kind of support would you need to realize this idea of recovery or healing?

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

In the final part of the interview, I'd like to ask you about some of the key moments in your life. So, I'm now going to ask you to highlight a high-point, a low-point, and a turning-point from your life. What would you like to start with? a high point, a low point, or a turning-point[1]?

a. **High Point Story**

I would like you to reflect on a high point in your life, what you might think of as the best moment in your life. It could be a moment or time in your life where you experienced very positive feelings, such as joy, excitement, happiness, or inner peace. Does an event or time like this come to mind? Describe it for me in detail. Make sure to tell me what led up to the scene, so that I can understand it in context. What happened in the scene? Where and when did it happen? Who was involved? What were you thinking and feeling in the event? Why is it an important event? What impact has this event had on who you are today?

b. **Low Point Story***;*
Think back over your entire life and try to remember a specific experience or event where you felt really low: it could involve emotions such as deep sadness, fear, strong anxiety, terror, despair, guilt, or shame. You might think of this as the worst moment in your life. Please describe this scene for me in detail. Again, tell me what led up to the scene, so that I can understand it in

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

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

c. **Turning Point Story**

In looking back on your life, are there any big "turning points" that come to mind? This could be times when you experienced an important change in your life.

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

Ending the Interview

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

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