BMJ open

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Journal:	*BMJ Open*
Manuscript ID:	bmjopen-2013-004379
Article Type:	Research
Date Submitted by the Author:	01-Nov-2013
Complete List of Authors:	Kirst, Maritt; St. Michael's Hospital, Centre for Research on Inner City Health Zerger, Suzanne; St. Michael's Hospital, Centre for Research on Inner City Health Wise Harris, Deborah; St. Michael's Hospital, Centre for Research on Inner City Health Plenert, Erin; St. Michael's Hospital, Centre for Research on Inner City Health Stergiopoulos, Vicky; St. Michael's Hospital, Centre for Research on Inner City Health
Primary Subject Heading:	Mental health
Secondary Subject Heading:	Health services research, Mental health, Qualitative research
Keywords:	Quality in health care < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Adult psychiatry < PSYCHIATRY, PUBLIC HEALTH, QUALITATIVE RESEARCH

The promise of recovery: Narratives of hope from participants in a Housing First intervention in Toronto, Canada

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Keywords: Homelessness, Housing First, mental illness, hope, recovery

Word count: 4,640

Abstract

Objectives: Hope is widely embraced as an important factor in the recovery process. The role of housing in inspiring hope and facilitating recovery has been explored with homeless populations, but is not well-understood. This study explores the importance of housing to hopes for recovery among participants in the Toronto site of a multi-site Housing First randomized controlled trial in Canada. 'Housing First' is an intervention which places individuals experiencing homelessness and mental illness into permanent independent housing first - without prerequisites for sobriety and treatment - and offers flexible access to supportive health services.

Design: In-depth interviews were conducted with a subsample of participants from a larger Housing First randomized controlled trial.

Setting: The research took place in Toronto, Canada.

Participants: Sixty participants in the larger trial (36 from the Housing First group and 24 from the Treatment as Usual group) took part in in-depth interviews.

Method: Participants for the in-depth interviews were purposively selected from the larger trial sample in Toronto and participated in an interview at the beginning of the study (baseline). Data from the baseline interviews were analyzed using the constant comparative method derived from grounded theory methods.

Results: Participants' narratives show clear visualization of goals for recovery, and emphasize that housing is an integral factor that can facilitate hope and support dimensions of recovery. However, some participants had difficulty adjusting to housing, and were concerned about feeling socially isolated, which could have negative implications for hopefulness and recovery.

Conclusions: Housing First interventions should explicitly incorporate hope-inspiring, recovery-oriented approaches, and support participants while adjusting to housing in order to sustain hopefulness.

Article Summary

Strengths and Limitations of this Study

- Limitations of the study include that these findings reflect the experiences of individuals experiencing homelessness and mental health issues and thus do not necessarily generalize across all homeless populations
- Strengths include that findings contribute to existing research in this area showing that housing, and specifically Housing First programs can foster hope in achieving recovery for individuals experiencing homelessness and mental illness
- The study has emphasized that housing alone is not sufficient to support recovery, but that Housing First and other programs need to explicitly integrate hope-inspiring, recovery-oriented approaches

INTRODUCTION

Homelessness is a growing problem in Canada, with approximately 200,000 individuals experiencing homelessness each year [1]. In Toronto, Canada's largest city, the estimated homeless population has grown from 4,969 in 2006 to 5,219 in 2013 [2]. Research has shown that the prevalence of mental health and substance use problems is higher among homeless individuals than in the general population, and that homeless individuals often have complex service needs [3-5]. As a result, interventions that transition homeless individuals with serious mental health issues into housing and support their complex mental health needs have been developed and implemented, primarily in the United States [6, 7].

Related to prior histories of trauma, loss, illness and impoverishment that are often prevalent among homeless individuals with serious mental health issues, this population often experiences a loss of hope [8]. Hope has been called the "bedrock" of recovery [9], defined as how people "manage their mental illness and/or addiction and their residual effects to claim or reclaim their lives in the community" [10]. The current Canadian Mental Health Strategy identifies hope as one of the key principles upon which recovery is built [11], and the U.S. Substance Abuse and Mental Health Services Administration's new definition of recovery from mental illness and substance use disorders calls hope the catalyst of the recovery process [12].

While widely embraced for its role as both a trigger and a "maintaining factor" in the recovery process, hope remains a difficult concept when translating into strategies and interventions. A recent systematic review of recovery literature named hope and optimism about the future as one of the dimensions of the recovery process with the most "proximal relevance to clinical research and practice" [13] (p.449), yet development of interventions that mental health clinicians can employ to rekindle and sustain hope for persons in recovery is in early stages. For example, researchers reviewing hope-

inspiring interventions for people with mental disorders identified numerous recovery-oriented interventions with hope as a secondary outcome, but indicated that no successful interventions specifically focused on increasing hope [14]. These authors concluded that interventions with the greatest impact on increasing hope relied on multi-dimensional hope concepts, and those narrowly focused – such as only on goal setting and achievement – were ineffective. They also identified five promising elements for inclusion in interventions: i) collaborative strategies for illness management, ii) focus on fostering relationships with service providers and others outside the mental health system; iii) facilitating peer connections and support; iv) helping clients form and pursue realistic goals; and v) supporting multiple positive factors such as self-esteem, self-efficacy, spirituality and well-being, identifying this last element as one most neglected in clinical practice [14].

Homelessness and Hope

Homelessness interferes with these and other elements key to recovery: for example, it complicates illness management and medication maintenance, erodes self-control and self-esteem, and engenders mistrust and self-isolation[15, 16]. Indeed, some have declared homelessness "the antithesis of recovery" [17] (p.69). Qualitative studies which have studied hope with persons experiencing homelessness, including children, street youth, women and families, veterans, and shelter residents, all share the common theme that powerlessness associated with the experience of homelessness has a destructive impact on self-esteem and hope [8, 15, 16, 18-20]. An interesting exception to this was one of the few quantitative studies measuring hope with homeless persons, in this case participants in a consumer-run mental health services program, which found a positive association between homelessness and hope [21].While all of these researchers agree development of hope-inspiring interventions that address the complexity of homelessness is important and possible, and some

progress has been made with homeless women and families, the "how" of inspiring hope remains elusive – especially for single, chronically homeless adults [22-24].

The Role of Housing

The role of housing in inspiring hope and facilitating recovery has been explored with homeless populations, though it is not well-understood. 'Housing First' is an intervention for individuals experiencing homelessness and mental illness which places individuals into permanent independent housing first - without prerequisites for sobriety and treatment - and offers flexible access to supportive health services [25]. Research on this intervention has consistently found that placing individuals in housing first does not affect ability to maintain housing, has no deleterious effects on recovery and has led to improved mental health outcomes [26, 27].While housing creates critical stability to facilitate the recovery process, its role and importance is otherwise unclear; one qualitative study found newly housed Housing First participants only "partially attained" core elements of recovery, including hope and social connections, once housed [28].

This study contributes to this body of literature by exploring the importance of housing to hopes for recovery from the perspective of chronically homeless adults with mental illness. The study draws on data from in-depth qualitative interviews with participants from the Toronto, Ontario site of the multi-site 'At Home/Chez Soi' Project in Canada.

METHODS

The 'At Home/Chez Soi' study is a randomized controlled trial that evaluates the effectiveness of a 'Housing First' approach to improving the lives of individuals who experience both homelessness and mental illness. The project was implemented across five cities in Canada – Moncton, Montreal, Toronto, Winnipeg and Vancouver – and received federal funding for three years.

'At Home/Chez Soi' project participants in Toronto were randomized to one of two Housing First interventions based on level of mental health service need, or to a 'Treatment as Usual' arm. High needs participants (N=197) were randomized to an Assertive Community Treatment (ACT) arm or Treatment as Usual, while moderate needs participants (N=378) were randomized to an Intensive Case Management (ICM) arm or Treatment as Usual. Moderate needs participants who identified as ethnoracial and were randomized to the intervention were further provided with the option to participate in an ethnoracial-intensive case management intervention (ER-ICM; specific to the Toronto site of the project). Participants in the Housing First interventions received a rent supplement and housing of their choice, and mental health service supports according to their level of need. Participants in the 'Treatment as Usual' arm received information materials about services available in the community but no direct services. Study participants were classified as high or moderate need using an algorithm described in Goering et al. that draws from Section 3 of the Ontario Standards for ACT teams [3].

Participants completed a series of surveys at specific time intervals to assess the effects of the housing first intervention on such outcomes as mental health, substance use, social functioning, community integration, and criminal justice system involvement. A subsample of 60 participants took part in in-depth qualitative interviews at the beginning of the study (baseline).

Data Collection

Participants in the baseline qualitative interviews were selected by sampling every 10th participant randomized to each study arm. These interviews were conducted with 36 participants from the Intervention group (12 from the ACT intervention, 12 from the ICM and 12 from the ER-ICM intervention), and 24 from the Treatment as Usual group (12 with high needs and 12 with moderate needs). Interviews were conducted by a group of three research staff between March 2010 and June 2011. 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 were also asked to complete a brief demographic form. 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

Qualitative interview data were analyzed with a coding process involving the constant comparative technique derived from grounded theory methods [29]. Data were coded into common categories based on similar content, and then emerging categories were compared with previous categories. The analysts then transformed codes into higher-level categories by analyzing and grouping similar codes into conceptual categories, using the constant comparative method of analysis [30]. Eventually, broader categories were reduced to a set of higher-level themes. To ensure reliability during this process, the analysts double-coded six interview transcripts, and met regularly to compare the accuracy of their codes and worked by consensus to refine discrepancies. There was a high degree of consensus in the coding, with slight differences in the wording of codes. Discrepancies in coding were discussed and resolved in consultation with the original interviewer and a qualitative research supervisor. Descriptive statistics were calculated on the demographic data using SAS software.

RESULTS

Sample Characteristics

Demographic information for the study sample is presented in Table 1. Sixty-seven percent of participants were male, 30% were female, and 2% identified as transgendered. Fifty-five percent of participants identified as members of an ethnoracial group, and seven percent of these participants identified as Aboriginal. Mean participant age was 41 years. Thirteen percent of participants completed grade 8 or less, and 37% had not completed high school. Twelve percent of participants reported having

been homeless for six months or less, and 32% reported having been homeless for six or more years. Forty percent of participants were identified as having a high need level, and 60% were identified as having moderate needs.

A number of study participants in the intervention arms were already housed through the 'At Home/Chez Soi' project at the time of the baseline in-depth interview, while other intervention participants were still waiting to be housed through the project. At the time of the interview, some study participants who had been randomized into the Treatment As Usual arm had obtained housing independently of the project through the private market or through various social housing organizations in the city. Thus, it is important to note that in the interviews, participants in the sample who were waiting for housing discussed anticipated benefits of housing for both their mental and physical well-being, while others in housing were noting benefits that may have already been experienced.

---Insert Table 1 here---

Hopes for Recovery

Regardless of whether the participants were randomized to the intervention groups or Treatment as Usual group, many had a clear vision for recovery and hoped to make many life changes as part of this process. For a number of participants, recovery was associated with the idea of starting over. For one participant in particular, being randomized to the intervention group in the 'At Home/Chez Soi' project 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…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.*

A number of participants expressed wanting to experience personal growth. One participant discussed 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."*

For many, dealing with substance use problems facilitated the recovery process. Without "getting clean", some participants felt that recovery and finding stability in life would not be possible:

> *There's a lot of people out there who would like to…get the help that I have gotten, right? But then due to this… addiction, a lot of them [are]… going to ruin it.*

Some also hoped to achieve self-acceptance as part of the recovery process. This participant explained that recovery involved accepting past experiences and finding self-worth:

> *…I guess part of that [recovery] would be to…learn to at least like myself or not hate myself um,…try and get well you know, trying to understand the different emotions about what happened in the past like you know, guilt or…and, and whatever all that, all those different emotions that come up from that…and being able to see some you know, like some worth in life.*

For a number of these participants, spirituality was central to the journey of recovery, and some felt that it gave them hope in the process.

> *I said, "I[was]…blinded for 35 years. If they had only invited me to the Bible, I wouldn't be…so dead. I would have at least had a fighting chance." But the Bible helped me a lot. Because the Bible gives you hopes. I don't know why other people read it, but…at least for me, that's what happened to me.*

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 […]".*

However, some participants discussed 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.*

Hope and Personal Goal-Setting

A number of participants expressed hope for future recovery through personal goal-setting. Goals included seeking education, employment and re-building relationships in the future. Many discussed wanting to get a job or to establish a career, as a way to support their future 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…*" .

Many participants discussed the desire to develop or re-establish positive, healthy relationships. Some hoped that they might meet a romantic partner, and 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 while homeless. This participant discussed 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.'*

Housing as a Condition for Realization of Hope for Future Recovery – Anticipated and Experienced Benefits

Housing as the First Step

Despite having well-defined hopes for future recovery, for most participants, becoming housed was key to the realization of these hopes. Many participants saw becoming housed as the first step in a move towards rebuilding their lives, and addressing broader notions of recovery:

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

> *Once I get an apartment and I see this doctor tomorrow I know this doctor is going to prescribe the right medication because my other doctor she is going to recommend what I need… and once I get an apartment I, I will go to the food bank, I will go buy groceries… As soon as I get an apartment I recover, I stop… I don't want to know nobody… I don't even want to have a cigarette inside. I just want to go outside and do my own thing… I might go back to work.*

Several participants associated stable housing with an increased sense of security, peace of mind and a decreased stress level, which in turn would allow them to focus on other life domains:

> *[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...*

Anticipated Benefits of Housing on Health and Well-Being

Many participants felt that their physical and mental health would improve with the stability that comes with housing:

> *Well, it [recovery] means having as few mania attacks as possible I don't think they'll stop entirely ever, having a few depression attacks as possible. Certainly getting my physical health back which is happening now because… I think mostly recovery has to do strangely enough with having permanent subsidized housing…*

For a number of participants in the intervention arms, the most significant shift related to moving from homelessness to housing was perceived to be the ability to stay in during the day and care for their health, as opposed to having to be out on the streets during the day in accordance with shelter policies. 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.*

Lack of sleep while homeless was another important factor that many participants discussed as negatively affecting their physical health. With stable housing, participants felt that they would be able

to get better, more consistent rest and engage in self-care. Another participant in the intervention group discussed the impact of being housed 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!'*

Another newly housed participant described that housing contributed to improved emotional well-being and facilitated planning for the future:

> *But in terms of emotional, you know, it's been a month…right now, I feel a lot better. I'm feeling better, you know? It is really that, thanks to this program, I think, uh…I start to…I'm starting to calculate and saying, "You know what? I think this is where I'd like to see myself some time", you know? I want to be here. I don't want to go back out there.*

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

Anticipated Independence and Control Associated with Housing

In addition to the health benefits of being housed, many participants anticipated a sense of independence and control associated with living on their own – especially after living 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 independence, was described by a number of participants: *"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 freedom and self-reliance – something they had not felt while they were homeless. 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.*

A number of participants who were newly housed discussed feeling more independent and self-sufficient, and generally having more control over their lives: *"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."*

Several participants discussed that an important part of maintaining stable housing was the ability to pay their rent regularly and on time. One participant described the ability to pay his own rent as a symbol of self-worth 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.*

Housing as a Precursor for Relationship Re-Building

A number of participants discussed 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, this participant 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."*

Stable housing also allowed a number of participants to regain or maintain relationships with their children. One participant spoke about her sons not being able to visit her when she was living in a shelter. Now housed, one of her sons is living with her and another son is able to visit whenever he likes. Others indicated the importance of being able to open up their homes to friends and potential romantic

partners, something that they were previously unable to do while homeless, either due to shelter rules or out of embarrassment. A number of participants also discussed valuing the companionship of pets, and expressed the desire to get a companion animal once housed. However, some expressed concern about their ability to have a pet while housed due to regulations preventing pet ownership in apartment buildings:

> *They [dogs] 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 named Louis, he was with me when I went through… I didn't tell you all my illnesses…*

Concerns about Housing: Issues that May Temper the Benefits

While most participants in the intervention arms of the project discussed the benefits of being housed, there was some concern around being isolated in their apartments and the potential effect this could have on their recovery:

> *So… I am excited but I am nervous, you know? Because I am institutionalized now, I have been in a shelter for 3 years, there is a lot of things I haven't had to do for myself you know? And I… am a little worried about the isolation so I am going to have [to] like take steps towards not being isolated, you know?*

One participant who had recently been housed noted a negative effect of being housed on his mental health: *"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 in one of the intervention arms who had recently been housed discussed not yet feeling comfortable in his new home due to 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 this participant that he considered giving up the apartment and leaving town.

Based on previous experiences with destructive relationships, several 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. As one participant said: "*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 many participants to be able to choose when and how much time they would spend with others, but this was another contributing factor to feelings of social isolation for some participants.

DISCUSSION and CONCLUSION

Study findings reflect that participants show considerable hope and optimism for recovery in the future. This hope was manifested in key self-management strategies of goal-setting, rebuilding self-esteem, and finding meaning through relationships and symbolism (e.g., the door key) [14]. Specifically, participants' perceptions of recovery are focused on hopes to regain control over their lives and a sense of independence after a period of powerlessness, achieve self-acceptance, rebuild and develop new relationships, as well as reclaim their lives in the community.

Participants' narratives show clear visualization of the role of housing in implementing these strategies, and emphasize that housing is an integral factor that can facilitate hope and support dimensions of recovery. Many felt that achieving the above-mentioned dimensions of recovery was dependent on housing, as a stable roof over their heads would alleviate the need to focus on survival concerns and provide them with the opportunity to instead concentrate on their recovery-oriented goals. These findings thus support theories of recovery and Housing First, in that actual and anticipated housing, without preconditions for "housing readiness", can stimulate hope, a key component in the recovery process [13, 14, 28].

This study clearly shows that housing is a necessary foundation from which to build hope, providing participants with control, independence, an opportunity to sleep, reflect, and care for their physical and mental health. It also reveals some critical areas in which housing is not, alone, sufficient for recovery, but could be strongly bolstered by interventions expressly aimed at building hope. The Housing First

model's emphasis on positive relationships with service providers, and client-driven goal-setting, are elements already known to be important bases for successful hope-building interventions [14] and this study identifies areas of focus with the greatest potential. For example, many of these participants considered housing an opportunity to repair lost or damaged relationships, and to build new healthy relationships, but were not always clear on how to actualize those hopes. While many participants desired to reduce or cease harmful substance use behaviors, and saw control over their housing as key, they needed help to overcome the social isolation that resulted from their turning away friends previously associated with substance use.

Study limitations include that these are findings on the experiences of individuals experiencing homelessness and mental health issues and thus do not necessarily generalize across all homeless populations.

Overall, these findings contribute to existing research in this area showing that housing, and specifically Housing First programs that provide housing and supports to homeless individuals with mental illness, can foster hope in achieving recovery [28]. However, housing alone is not sufficient to foster hope and support this population in moving forward in the recovery journey. In order to support the hope that is inspired by such interventions, these programs need to focus on assisting clients during the adjustment period while becoming newly housed to prevent and address social isolation. Furthermore, these programs should explicitly integrate hope-inspiring, recovery-oriented approaches [14], such as goal-setting, finding meaning, and implementing strategies to manage illness, build self-esteem, and (re)develop relationships.

Table 1. Sample Demographics (N=60)

	%
Gender	
Male	67%
Female	30%
Transgender	2%
Not Indicated	2%
Ethnoracial	
Yes	55%
No	45%
Age (mean)	41
Education Level	
Completed graduate school	3%
Completed university or business, trade, technical school	14 %
Some university or business, trade, technical school	11%
Completed high school	22%
Some high School, not completed	37%
Completed grade 8 or less	13%
Months Homeless in Lifetime	
≤ 6	12%
7 to 11	9%
12 to 23	15%
24 to 71	32%
≥ 72	32%

Contributors: MK and SZ drafted the manuscript. MK oversaw data collection and contributed to analysis; DWH and EP conducted interviews, data analysis and drafted thematic sections. VS supervised the research and critically reviewed the manuscript.

Funding Statement: This research was made possible through a financial contribution by Health Canada and was funded by the Mental Health Commission of Canada. The views expressed herein solely represent the authors.

Competing Interests: None to declare.

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The promise of recovery: Narratives of hope among homeless individuals with mental illness participating in a Housing First randomized controlled trial in Toronto, Canada

Journal:	*BMJ Open*
Manuscript ID:	bmjopen-2013-004379.R1
Article Type:	Research
Date Submitted by the Author:	07-Jan-2014
Complete List of Authors:	Kirst, Maritt; St. Michael's Hospital, Centre for Research on Inner City Health Zerger, Suzanne; St. Michael's Hospital, Centre for Research on Inner City Health Wise Harris, Deborah; St. Michael's Hospital, Centre for Research on Inner City Health Plenert, Erin; St. Michael's Hospital, Centre for Research on Inner City Health Stergiopoulos, Vicky; St. Michael's Hospital, Centre for Research on Inner City Health
Primary Subject Heading:	Mental health
Secondary Subject Heading:	Health services research, Mental health, Qualitative research
Keywords:	Quality in health care < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Adult psychiatry < PSYCHIATRY, PUBLIC HEALTH, QUALITATIVE RESEARCH

The promise of recovery: Narratives of hope among homeless individuals with mental illness participating in a Housing First randomized controlled trial in Toronto, Canada

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Keywords: Homelessness, Housing First, mental illness, hope, recovery

Word count: 4,640

Abstract

Objectives: Hope is widely embraced as an important factor in the recovery process. The role of housing in inspiring hope and facilitating recovery has been explored with homeless populations, but is not well-understood. This study explores perspectives on hopes for recovery and the role of housing on these hopes from the perspective of homeless adults experiencing mental illness participating in a multi-site Housing First randomized controlled trial in Canada. The study draws on data from in-depth qualitative interviews with participants from the Toronto, Ontario site of the'At Home/Chez Soi' Project.

Design: In-depth interviews were conducted with a subsample of participants from a larger Housing First randomized controlled trial.

Setting: The research took place in Toronto, Canada.

Participants: Sixty participants in the larger trial (36 from the Housing First group and 24 from the Treatment as Usual group) took part in in-depth interviews.

Method: Participants for the in-depth interviews were purposively selected from the larger trial sample in Toronto and participated in an interview at the beginning of the study (baseline). Data from the baseline interviews were analyzed using the constant comparative method derived from grounded theory methods.

Results: Participants' narratives show clear visualization of goals for recovery, and emphasize that housing is an integral factor that can facilitate hope and support dimensions of recovery. However, some participants had difficulty adjusting to housing, and were concerned about feeling socially isolated, which could have negative implications for hopefulness and recovery.

Conclusions: Housing First interventions should explicitly incorporate hope-inspiring, recovery-oriented approaches, and support participants while adjusting to housing in order to sustain hopefulness.

Article Summary

Strengths and Limitations of this Study

- L

  Limitations of the study include that these findings reflect the experiences of individuals experiencing homelessness and mental health issues at one point in time

- Strengths include that findings emerged from a large sample embedded within a larger randomized controlled trial. Findings contribute to existing research in this area by highlighting that housing can activate the mechanism of hope, through which recovery for individuals experiencing homelessness and mental illness can be pursued

- T

  The study has emphasized that housing alone is not sufficient to support recovery, but that given the important role of hope, Housing First and other housing programs need to explicitly integrate hope-inspiring, recovery-oriented approaches

INTRODUCTION

Homelessness is a growing problem in Canada, with approximately 200,000 individuals experiencing homelessness each year [1]. In Toronto, Canada's largest city, the estimated homeless population has grown from 4,969 in 2006 to 5,219 in 2013 [2]. Research has shown that the prevalence of mental health and substance use problems is higher among homeless individuals than in the general population, and that homeless individuals often have complex service needs [3-5]. As a result, interventions that transition homeless individuals with serious mental health issues into housing and support their complex mental health needs have been developed and implemented, primarily in the United States [6, 7].

Related to prior histories of trauma, loss, illness and impoverishment that are often prevalent among homeless individuals with serious mental health issues, this population often experiences a loss of hope [8]. Hope has been called the "bedrock" of recovery [9], defined as how people "manage their mental illness and/or addiction and their residual effects to claim or reclaim their lives in the community" [10]. The current Canadian Mental Health Strategy identifies hope as one of the key principles upon which recovery is built [11], and the U.S. Substance Abuse and Mental Health Services Administration's new definition of recovery from mental illness and substance use disorders calls hope the catalyst of the recovery process [12].

While widely embraced for its role as both a trigger and a "maintaining factor" in the recovery process, hope remains a difficult concept when translating into strategies and interventions. A recent systematic review of recovery literature named hope and optimism about the future as one of the dimensions of the recovery process with the most "proximal relevance to clinical research and practice" [13] (p.449), yet development of interventions that mental health clinicians can employ to rekindle and sustain hope for persons in recovery is in early stages. For example, researchers reviewing hope-

inspiring interventions for people with mental disorders identified numerous recovery-oriented interventions with hope as a secondary outcome, but indicated that no successful interventions specifically focused on increasing hope [14]. These authors concluded that interventions with the greatest impact on increasing hope relied on multi-dimensional hope concepts, and those narrowly focused – such as only on goal setting and achievement – were ineffective. They also identified five promising elements for inclusion in interventions: i) collaborative strategies for illness management, ii) focus on fostering relationships with service providers and others outside the mental health system; iii) facilitating peer connections and support; iv) helping clients form and pursue realistic goals; and v) supporting multiple positive factors such as self-esteem, self-efficacy, spirituality and well-being, identifying this last element as one most neglected in clinical practice [14].

Homelessness and Hope

Homelessness interferes with these and other elements key to recovery: for example, it complicates illness management and medication maintenance, erodes self-control and self-esteem, and engenders mistrust and self-isolation[15, 16]. Indeed, some have declared homelessness "the antithesis of recovery" [17] (p.69). Qualitative studies which have studied hope with persons experiencing homelessness, including children, street youth, women and families, veterans, and shelter residents, all share the common theme that powerlessness associated with the experience of homelessness has a destructive impact on self-esteem and hope [8, 15, 16, 18-20]. An interesting exception to this was one of the few quantitative studies measuring hope with homeless persons, in this case participants in a consumer-run mental health services program, which found a positive association between homelessness and hope [21].While all of these researchers agree development of hope-inspiring interventions that address the complexity of homelessness is important and possible, and some

progress has been made with homeless women and families, the "how" of inspiring hope remains elusive – especially for single, chronically homeless adults [22-24].

The Role of Housing

The role of housing in inspiring hope and facilitating recovery has been explored with homeless populations, though it is not well-understood. 'Housing First' is an intervention for individuals experiencing homelessness and mental illness which places individuals into permanent independent housing first - without prerequisites for sobriety and treatment - and offers flexible access to supportive health services [25]. Research on this intervention has consistently found that placing individuals in housing first does not negatively affect ability to maintain housing, has no deleterious effects on recovery and has led to improved mental health outcomes [26, 27].While housing creates critical stability to facilitate the recovery process, its role and importance is otherwise unclear; one qualitative study found newly housed Housing First participants only "partially attained" core elements of recovery, including hope and social connections, once housed [28].

This study contributes to this body of literature by exploring the importance of housing to hopes for recovery from the perspective of chronically homeless adults with mental illness. The study draws on data from in-depth qualitative interviews with participants from the Toronto, Ontario site of the multi-site 'At Home/Chez Soi' Project in Canada.

METHODS

The 'At Home/Chez Soi' study is a randomized controlled trial (RCT) that evaluates the effectiveness of a 'Housing First' approach to improving the lives of individuals who experience both homelessness and mental illness. The project was implemented across five cities in Canada – Moncton, Montreal, Toronto, Winnipeg and Vancouver – and received federal funding for three years.

'At Home/Chez Soi' project participants in Toronto were randomized to one of two Housing First interventions based on level of mental health service need, or to a 'Treatment as Usual' arm. High needs participants (N=197) were randomized to an Assertive Community Treatment (ACT) arm or Treatment as Usual, while moderate needs participants (N=378) were randomized to an Intensive Case Management (ICM) arm or Treatment as Usual. Moderate needs participants who identified as ethnoracial and were randomized to the intervention were further provided with the option to participate in an ethnoracial-intensive case management intervention (ER-ICM; specific to the Toronto site of the project). Participants in the Housing First interventions received a rent supplement and housing of their choice, and mental health service supports according to their level of need. Participants in the 'Treatment as Usual' arm received information materials about services available in the community but no direct services. Study participants were classified as high or moderate need using an algorithm described in Goering et al. that draws from Section 3 of the Ontario Standards for ACT teams [3].

Participants completed a series of surveys at specific time intervals to assess the effects of the housing first intervention on such outcomes as mental health, substance use, social functioning, community integration, and criminal justice system involvement. A subsample of 60 participants took part in in-depth qualitative interviews at the beginning of the study (baseline).

Data Collection

Participants in the baseline qualitative interviews were selected from the larger RCT sample by sampling every 10th participant randomized to each study arm. This approach was taken to facilitate sampling across the larger RCT sample. Purposive sampling was also employed in order achieve representation across gender and ethnicity. Eighty three participants were invited to participate in the interview by the study recruitment staff, and 23 participants either declined to participate, or it was not possible to schedule an interview with them. Sixty participants agreed to participate, andinterviews were conducted with 36 participants from the Intervention group (12 from the ACT intervention, 12 from the

ICM and 12 from the ER-ICM intervention), and 24 from the Treatment as Usual group (12 with high needs and 12 with moderate needs). Interviews were conducted by three research staff, including one peer researcher, with training in conducting in-depth interviews, between March 2010 and June 2011. All participants provided written, informed consent to participate, and agreed to have the interviews audio-recorded. Interviews were semi-structured, and asked questions on history of homelessness and mental health issues, daily activities, experiences with mental health and social services, and hopes for the future. Interviews were took place in a location that was convenient for the participant, typically the project office or conducted ranged from approximately 45 minutes to 1.5 hours in length. Interview participants were also asked to complete a brief demographic form. 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

Qualitative interview data were analyzed with a coding process involving the constant comparative technique derived from grounded theory methods [29]. Sensitizing questions regarding hope for the future and the related role of housing in hopes for the future guided the coding process [30]. Data were coded into common categories based on similar content, and then emerging categories were compared with previous categories. The analysts then transformed codes into higher-level categories by analyzing and grouping similar codes into conceptual categories, using the constant comparative method of analysis [30]. Eventually, broader categories were reduced to a set of higher-level themes. To ensure reliability during this process, the analysts double-coded six interview transcripts, and met regularly to compare the accuracy of their codes and worked by consensus to refine discrepancies. There was a high degree of consensus in the coding, with slight differences in the wording of codes. Discrepancies in coding were discussed and resolved in consultation with the original

interviewer and a qualitative research supervisor. Descriptive statistics were calculated on the demographic data using SAS software.

RESULTS

Sample Characteristics

Demographic information for the study sample is presented in Table 1. Sixty-seven percent of participants were male, 30% were female, and 2% identified as transgendered. Fifty-five percent of participants identified as members of an ethnoracial group, and seven percent of these participants identified as Aboriginal. Mean participant age was 41 years. Thirteen percent of participants completed grade 8 or less, and 37% had not completed high school. Twelve percent of participants reported having been homeless for six months or less, and 32% reported having been homeless for six or more years. Forty percent of participants were identified as having a high need level, and 60% were identified as having moderate needs.

Thirtystudy participants in the intervention arms were newly housed through the 'At Home/Chez Soi' project at the time of the baseline in-depth interview, while five intervention participants were still waiting to be housed through the project. At the time of the interview, 11 study participants who had been randomized into the Treatment As Usual arm had obtained housing independently of the project through the private market or through various social housing organizations in the cityThus, participants were either newlyhoused (within a month or two) through the project or independently, were about to receive housing through the project, or were aspiring to be housed (unhoused TAU participants), and were reflecting on hopes for the future as well as anticipated benefits and challenges associated with being housed. As a result, we do not treat TAU participants as an explicit comparison group in the analysis.

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---Insert Table 1 here---

Hopes for Recovery

Many participants had a vision for recovery and hoped to make life changes as part of this process. For a number of participants, recovery was associated with the idea of starting over. For one participant in particular, being randomized to the intervention group in the 'At Home/Chez Soi' project 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…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. (Female participant, ACT, housed)*

A number of participants expressed wanting to experience personal growth. One participant discussed 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." (Male participant, ER-ICM, unhoused)*

For many, dealing with substance use problems facilitated the recovery process. Without "getting clean", some participants felt that recovery and finding stability in life would not be possible:

> *There's a lot of people out there who would like to…get the help that I have gotten, right? But then due to this… addiction, a lot of them [are]… going to ruin it. (Male participant, ER-ICM, housed)*

Some also hoped to achieve self-acceptance as part of the recovery process. This participant explained that recovery involved accepting past experiences and finding self-worth:

> *…I guess part of that [recovery] would be to…learn to at least like myself or not hate myself um,…try and get well you know, trying to understand the different emotions about what happened in the past like you know, guilt or…and, and whatever all that, all those different emotions that come up from that…and being able to see some you know, like some worth in life. (Female participant, TAU, unhoused)*

However, some participants discussed 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. (Female participant, ACT, housed)*

Hope and Personal Goal-Setting

A number of participants expressed hope for future recovery through personal goal-setting. Goals included seeking education, employment and re-building relationships in the future. Many discussed wanting to get a job or to establish a career, as a way to support their future and to rebuild their self-esteem.

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…" (Female participant, ACT, housed).*

Many participants discussed the desire to develop or re-establish positive, healthy relationships. Some hoped that they might meet a romantic partner, and 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."(Female participant, ICM, housed).* Other participants were more focused on rebuilding relationships that were lost or damaged during their time while homeless.

Housing as a Condition for Realization of Hope for Future Recovery – Anticipated and Experienced Benefits

Housing as the First Step

Despite having well-defined hopes for future recovery, for most participants, becoming housed was key to the realization of these hopes. Many participants saw becoming housed as the first step in a move towards rebuilding their lives, and addressing broader notions of recovery:

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

> *Once I get an apartment and I see this doctor tomorrow I know this doctor is going to prescribe the right medication because my other doctor she is going to recommend what I need… and once I get an apartment I, I will go to the food bank, I will go buy groceries… As soon as I get an apartment I recover, I stop… I don't want to know nobody… I don't even want to have a cigarette inside. I just want to go outside and do my own thing… I might go back to work. (Male participant, ACT, housed)*

Several participants associated stable housing with an increased sense of security, peace of mind and a decreased stress level, which in turn would allow them to focus on other life domains:

> *[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...(Female participant, ER-ICM, housed)*

Anticipated Independence and Control Associated with Housing

Many participants anticipated a sense of independence and control associated with living on their own – especially after living 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. (Femal participant, ER-ICM, housed)*

The door key, as a symbol of this independence, was described by a number of participants: *"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." (Male participant, ER-ICM, unhoused).* For many participants, having their own key represented a renewed sense of freedom and self-reliance – something they had not felt while they were homeless. 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. (Male participant, ICM, housed)*

A number of participants who were newly housed discussed feeling more independent and self-sufficient, and generally having more control over their lives: *"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." (Female participant, ER-ICM, housed)

Several participants discussed that an important part of maintaining stable housing was the ability to pay their rent regularly and on time. One participant described the ability to pay his own rent as a symbol of self-worth 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. (Male participant, ER-ICM, housed)*

Anticipated Benefits of Housing on Health and Well-Being

A sense of control and security anticipated to accompany housing was also central to the achievement of other hopes, for example improvements to health and well-being. Many participants felt that their physical and mental health would improve with the security and stability that comes with housing:

> *Well, it [recovery] means having as few mania attacks as possible I don't think they'll stop entirely ever, having a few depression attacks as possible. Certainly getting my physical health back which is happening now because… I think mostly recovery has to do strangely enough with having permanent subsidized housing… (Female participant, ER-ICM, housed)*

For a number of participants in the intervention arms, the most significant shift related to moving from homelessness to housing was perceived to be the ability to stay in during the day and care for their health, as opposed to having to be out on the streets during the day in accordance with shelter policies. 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. (Male participant, ACT, housed)*

Lack of sleep while homeless was another important factor that many participants discussed as negatively affecting their physical health. With stable housing, participants felt that they would be able to get better, more consistent rest and engage in self-care. Another participant in the intervention group discussed the impact of being housed 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!' (Male participant, ER-ICM, housed)*

This participant described that housing contributed to improved emotional well-being and facilitated hopes for the future:

> *But in terms of emotional, you know, it's been a month…right now, I feel a lot better. I'm feeling better, you know? It is really that, thanks to this program, I think, uh…I start to…I'm starting to calculate and saying, "You know what? I think this is where I'd like to see myself some time", you know? I want to be here. I don't want to go back out there.*

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

Housing as a Precursor for Relationship Re-Building

A number of participants hoped 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? (Male participant, ER-ICM, housed)*

Newly housed, this participant 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."*

Stable housing also allowed a number of participants to regain or maintain relationships with their children. One participant spoke about her sons not being able to visit her when she was living in a shelter. Now housed, one of her sons is living with her and another son is able to visit whenever he likes. Others indicated the importance of being able to open up their homes to friends and potential romantic partners, something that they were previously unable to do while homeless, either due to shelter rules or out of embarrassment. A number of participants also discussed valuing the companionship of pets, and four expressed the desire to get a companion animal once housed. However, some expressed concern about their ability to have a pet while housed due to regulations preventing pet ownership in apartment buildings:

> *They [dogs] 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 named Louis, he was with me when I went through… I didn't tell you all my illnesses… (Female participant, TAU, housed)*

Concerns about Housing: Issues that May Temper the Benefits

While most participants in the intervention arms of the project discussed the benefits of being housed, there was some concern around being isolated in their apartments and the potential effect this could have on their recovery:

> *So… I am excited but I am nervous, you know? Because I am institutionalized now, I have been in a shelter for 3 years, there is a lot of things I haven't had to do for myself you know? And I… am a little worried about the isolation so I am going to have [to] like take steps towards not being isolated, you know? (Female participant, ICM, housed)*

One participant who had recently been housed noted a negative effect of being housed on his mental health: *"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" (Male participant, ICM, housed). Another participant in one of the intervention arms who had recently been housed discussed not yet feeling comfortable in his new home due to 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."* (Male participant, ACT, housed). At times, living alone was so overwhelming for this participant that he considered giving up the apartment and leaving town.

Based on previous experiences with destructive relationships, several 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. As one participant said: "*A few guys pop over but there is only a select few that know where I live. I like to keep it that way."* (Male participant, ICM, housed). Overall, it was invaluable for many participants to be able to choose when and how much time they would spend with others, but this was another contributing factor to feelings of social isolation for some participants.

DISCUSSION and CONCLUSION

Study findings reflect that participants show considerable hope and optimism for recovery in the future. This hope was manifested in key self-management strategies of goal-setting, rebuilding self-esteem, and finding meaning through relationships and symbolism (e.g., the door key) [14]. Specifically, participants' perceptions of recovery are focused on hopes to regain control over their lives and a sense of independence after a period of powerlessness, which would facilitate achieving self-acceptance, rebuilding and developing new relationships, as well as help them to reclaim their lives in the community. These findings regarding hope for future recovery echo results from other research in this area [31-33].

Participants' narratives show clear visualization of the role of housing in implementing these strategies, and emphasize that housing is an integral factor that can facilitate hope and support dimensions of recovery. The majority felt that achieving the above-mentioned dimensions of recovery was dependent on housing, as a stable roof over their heads would alleviate the need to focus on survival concerns, and this combined with an anticipated increased sense of independence and security that housing would bring, would provide them with the opportunity to instead concentrate on their recovery-oriented goals. This study further confirms that housing is an important foundation from which to build and act upon hope, providing participants with hopes for experiences of control, independence, and security and an opportunity to sleep, reflect, and care for their physical and mental health. These findings support the notion of increased ontological security, reflecting an increased sense of security, safety and predictability that can be enhanced by permanent housing, which has been noted in research on Housing First interventions with homeless individuals with serious mental illness [28, 32]. These findings expand on this research by connecting the importance of increased ontological security to hope-building and recovery processes in that the receipt of actual, but also anticipated housing, can stimulate a sense of ontological security which can further build and support action on hope, a key component in the recovery process [13, 14, 28].

The study also reveals some critical areas in which housing is not, alone, sufficient for recovery, but could be strongly bolstered by interventions expressly aimed at building and acting on hope. The Housing First model's emphasis on positive relationships with service providers, and client-driven goal-setting, are elements already known to be important bases for successful hope-building interventions [14] and this study identifies areas of focus with the greatest potential. For example, many of these participants considered housing an opportunity to repair lost or damaged relationships, and to build new healthy relationships, but were not always clear on how to actualize those hopes. While many participants desired to reduce or cease harmful substance use behaviors, and saw control over their

housing as key, they needed help to overcome the social isolation that resulted from their turning away friends previously associated with substance use.

Study limitations include that these findings reflect point in time observations and do not explore long-term impacts of housing on hopefulness and recovery trajectories among study participants. However, longitudinal analysis of the data in this area is currently ongoing.

Overall, these findings contribute to existing research in this area by showing how hope, housing and recovery are connected in a large sample of homeless individuals experiencing mental illness participating in a Housing First RCT. Specifically, findings support that anticipated and actual housing, facilitated through the mechanism of Housing First programs that provide housing and supports to this population can foster hope for increased ontological security and achievement of other recovery-oriented goals [28]. However, housing alone is not sufficient to foster hope and support this population in moving forward in the recovery journey. In order to support the hope that is inspired by such interventions, these programs need to focus on assisting clients during the adjustment period while becoming newly housed to prevent and address social isolation. Furthermore, these programs should explicitly integrate hope-inspiring, recovery-oriented approaches [14], such as goal-setting, finding meaning, and implementing strategies to manage illness, build self-esteem, and (re)develop relationships.

Table 1. Sample Demographics (N=60)

	%
Gender	
Male	67%
Female	30%
Transgender	2%
Not Indicated	2%
Ethnoracial	
Yes	55%
No	45%
Age (mean)	41
Education Level	
Completed graduate school	3%
Completed university or business, trade, technical school	14 %
Some university or business, trade, technical school	11%
Completed high school	22%
Some high School, not completed	37%
Completed grade 8 or less	13%
Months Homeless in Lifetime	
≤ 6	12%
7 to 11	9%
12 to 23	15%
24 to 71	32%
≥ 72	32%

Funding Statement: This research was made possible through a financial contribution by Health Canada and funded by the Mental Health Commission of Canada. The views expressed herein solely represent the authors.

Contributors: MK and SZ drafted the manuscript. MK oversaw data collection and contributed to analysis; DWH and EP conducted interviews, data analysis and drafted thematic sections. VS supervised the research and critically reviewed the manuscript.

Competing Interests: None to declare.

Data Sharing Statement: No additional data available.

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The promise of recovery: Narratives of hope among homeless individuals with mental illness participating in a Housing First randomized controlled trial ~~from participants in a Housing First intervention~~ in Toronto, Canada

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Keywords: Homelessness, Housing First, mental illness, hope, recovery

Word count: 4,640

Abstract

Objectives: Hope is widely embraced as an important factor in the recovery process. The role of housing in inspiring hope and facilitating recovery has been explored with homeless populations, but is not well-understood. This study explores perspectives on ~~the importance of housing to~~ hopes for recovery and the role of housing on these hopes from the perspective of homeless adults experiencing mental illness participating~~among participants~~ in ~~the Toronto site of~~ a multi-site Housing First randomized controlled trial in Canada. The study draws on data from in-depth qualitative interviews with participants from the Toronto, Ontario site of the'At Home/Chez Soi' Project.

~~'Housing First' is an intervention which places individuals experiencing homelessness and mental illness into permanent independent housing first - without prerequisites for sobriety and treatment - and offers flexible access to supportive health services.~~

Design: In-depth interviews were conducted with a subsample of participants from a larger Housing First randomized controlled trial.

Setting: The research took place in Toronto, Canada.

Participants: Sixty participants in the larger trial (36 from the Housing First group and 24 from the Treatment as Usual group) took part in in-depth interviews.

Method: Participants for the in-depth interviews were purposively selected from the larger trial sample in Toronto and participated in an interview at the beginning of the study (baseline). Data from the baseline interviews were analyzed using the constant comparative method derived from grounded theory methods.

Results: Participants' narratives show clear visualization of goals for recovery, and emphasize that housing is an integral factor that can facilitate hope and support dimensions of recovery. However,

some participants had difficulty adjusting to housing, and were concerned about feeling socially isolated, which could have negative implications for hopefulness and recovery.

Conclusions: Housing First interventions should explicitly incorporate hope-inspiring, recovery-oriented approaches, and support participants while adjusting to housing in order to sustain hopefulness.

Article Summary

Strengths and Limitations of this Study

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- Limitations of the study include that these findings reflect the experiences of individuals experiencing homelessness and mental health issues at one point in time ~~and thus do not necessarily generalize across all homeless populations~~
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- Strengths include that findings emerged from a large sample embedded within a larger randomized controlled trial. Findings contribute to existing research in this area by highlighting ~~showing~~ that housing can activate the mechanism of hope, through which ~~, and specifically Housing First programs can foster hope in achieving~~ recovery for individuals experiencing homelessness and mental illness can be pursued
- T
- The study has emphasized that housing alone is not sufficient to support recovery, but that given the important role of hope, Housing First and other housing programs need to explicitly integrate hope-inspiring, recovery-oriented approaches

INTRODUCTION

Homelessness is a growing problem in Canada, with approximately 200,000 individuals experiencing homelessness each year [1]. In Toronto, Canada's largest city, the estimated homeless population has grown from 4,969 in 2006 to 5,219 in 2013 [2]. Research has shown that the prevalence of mental health and substance use problems is higher among homeless individuals than in the general population, and that homeless individuals often have complex service needs [3-5]. As a result, interventions that transition homeless individuals with serious mental health issues into housing and support their complex mental health needs have been developed and implemented, primarily in the United States [6, 7].

Related to prior histories of trauma, loss, illness and impoverishment that are often prevalent among homeless individuals with serious mental health issues, this population often experiences a loss of hope [8]. Hope has been called the "bedrock" of recovery [9], defined as how people "manage their mental illness and/or addiction and their residual effects to claim or reclaim their lives in the community" [10]. The current Canadian Mental Health Strategy identifies hope as one of the key principles upon which recovery is built [11], and the U.S. Substance Abuse and Mental Health Services Administration's new definition of recovery from mental illness and substance use disorders calls hope the catalyst of the recovery process [12].

While widely embraced for its role as both a trigger and a "maintaining factor" in the recovery process, hope remains a difficult concept when translating into strategies and interventions. A recent systematic review of recovery literature named hope and optimism about the future as one of the dimensions of the recovery process with the most "proximal relevance to clinical research and practice" [13] (p.449), yet development of interventions that mental health clinicians can employ to rekindle and sustain hope for persons in recovery is in early stages. For example, researchers reviewing hope-

inspiring interventions for people with mental disorders identified numerous recovery-oriented interventions with hope as a secondary outcome, but indicated that no successful interventions specifically focused on increasing hope [14]. These authors concluded that interventions with the greatest impact on increasing hope relied on multi-dimensional hope concepts, and those narrowly focused – such as only on goal setting and achievement – were ineffective. They also identified five promising elements for inclusion in interventions: i) collaborative strategies for illness management, ii) focus on fostering relationships with service providers and others outside the mental health system; iii) facilitating peer connections and support; iv) helping clients form and pursue realistic goals; and v) supporting multiple positive factors such as self-esteem, self-efficacy, spirituality and well-being, identifying this last element as one most neglected in clinical practice [14].

Homelessness and Hope

Homelessness interferes with these and other elements key to recovery: for example, it complicates illness management and medication maintenance, erodes self-control and self-esteem, and engenders mistrust and self-isolation[15, 16]. Indeed, some have declared homelessness "the antithesis of recovery" [17] (p.69). Qualitative studies which have studied hope with persons experiencing homelessness, including children, street youth, women and families, veterans, and shelter residents, all share the common theme that powerlessness associated with the experience of homelessness has a destructive impact on self-esteem and hope [8, 15, 16, 18-20]. An interesting exception to this was one of the few quantitative studies measuring hope with homeless persons, in this case participants in a consumer-run mental health services program, which found a positive association between homelessness and hope [21].While all of these researchers agree development of hope-inspiring interventions that address the complexity of homelessness is important and possible, and some

progress has been made with homeless women and families, the "how" of inspiring hope remains elusive – especially for single, chronically homeless adults [22-24].

The Role of Housing

The role of housing in inspiring hope and facilitating recovery has been explored with homeless populations, though it is not well-understood. 'Housing First' is an intervention for individuals experiencing homelessness and mental illness which places individuals into permanent independent housing first - without prerequisites for sobriety and treatment - and offers flexible access to supportive health services [25]. Research on this intervention has consistently found that placing individuals in housing first does not negatively affect ability to maintain housing, has no deleterious effects on recovery and has led to improved mental health outcomes [26, 27].While housing creates critical stability to facilitate the recovery process, its role and importance is otherwise unclear; one qualitative study found newly housed Housing First participants only "partially attained" core elements of recovery, including hope and social connections, once housed [28].

This study contributes to this body of literature by exploring the importance of housing to hopes for recovery from the perspective of chronically homeless adults with mental illness. The study draws on data from in-depth qualitative interviews with participants from the Toronto, Ontario site of the multi-site 'At Home/Chez Soi' Project in Canada.

METHODS

The 'At Home/Chez Soi' study is a randomized controlled trial (RCT) that evaluates the effectiveness of a 'Housing First' approach to improving the lives of individuals who experience both homelessness and mental illness. The project was implemented across five cities in Canada – Moncton, Montreal, Toronto, Winnipeg and Vancouver – and received federal funding for three years.

'At Home/Chez Soi' project participants in Toronto were randomized to one of two Housing First interventions based on level of mental health service need, or to a 'Treatment as Usual' arm. High needs participants (N=197) were randomized to an Assertive Community Treatment (ACT) arm or Treatment as Usual, while moderate needs participants (N=378) were randomized to an Intensive Case Management (ICM) arm or Treatment as Usual. Moderate needs participants who identified as ethnoracial and were randomized to the intervention were further provided with the option to participate in an ethnoracial-intensive case management intervention (ER-ICM; specific to the Toronto site of the project). Participants in the Housing First interventions received a rent supplement and housing of their choice, and mental health service supports according to their level of need. Participants in the 'Treatment as Usual' arm received information materials about services available in the community but no direct services. Study participants were classified as high or moderate need using an algorithm described in Goering et al. that draws from Section 3 of the Ontario Standards for ACT teams [3].

Participants completed a series of surveys at specific time intervals to assess the effects of the housing first intervention on such outcomes as mental health, substance use, social functioning, community integration, and criminal justice system involvement. A subsample of 60 participants took part in in-depth qualitative interviews at the beginning of the study (baseline).

Data Collection

Participants in the baseline qualitative interviews were selected from the larger RCT sample by sampling every 10th participant randomized to each study arm. This approach was taken to facilitate sampling across the larger RCT sample. Purposive sampling was also employed in order achieve representation across gender and ethnicity. Eighty three participants were invited to participate in the interview by the study recruitment staff, and 23 participants either declined to participate, or it was not possible to schedule an interview with them. Sixty participants agreed to participate, and

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~~ntation across the larger RCT sample. These~~ interviews were conducted with 36 participants from the Intervention group (12 from the ACT intervention, 12 from the ICM and 12 from the ER-ICM intervention), and 24 from the Treatment as Usual group (12 with high needs and 12 with moderate needs). Interviews were conducted by ~~a group of~~ three research staff, including one peer researcher, with training in conducting in-depth interviews, between March 2010 and June 2011. All participants provided written, informed consent to participate, and agreed to have the interviews audio-recorded. Interviews were semi-structured, and asked questions on history of homelessness and mental health issues, daily activities, experiences with mental health and social services, and hopes for the future. Interviews were took place in a location that was convenient for the participant, typically the project office or conducted ranged from approximately 45 minutes to 1.5 hours in length. Interview participants were also asked to complete a brief demographic form. 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

Qualitative interview data were analyzed with a coding process involving the constant comparative technique derived from grounded theory methods [29]. Sensitizing questions regarding hope for the future and the related role of housing in hopes for the future guided the coding process [30]. Data were coded into common categories based on similar content, and then emerging categories were compared with previous categories. The analysts then transformed codes into higher-level categories by analyzing and grouping similar codes into conceptual categories, using the constant comparative method of analysis [30]. Eventually, broader categories were reduced to a set of higher-level themes. To ensure reliability during this process, the analysts double-coded six interview transcripts, and met regularly to compare the accuracy of their codes and worked by consensus to refine discrepancies. There was a high degree of consensus in the coding, with slight differences in the wording

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of codes. Discrepancies in coding were discussed and resolved in consultation with the original interviewer and a qualitative research supervisor. Descriptive statistics were calculated on the demographic data using SAS software.

RESULTS

Sample Characteristics

Demographic information for the study sample is presented in Table 1. Sixty-seven percent of participants were male, 30% were female, and 2% identified as transgendered. Fifty-five percent of participants identified as members of an ethnoracial group, and seven percent of these participants identified as Aboriginal. Mean participant age was 41 years. Thirteen percent of participants completed grade 8 or less, and 37% had not completed high school. Twelve percent of participants reported having been homeless for six months or less, and 32% reported having been homeless for six or more years. Forty percent of participants were identified as having a high need level, and 60% were identified as having moderate needs.

Thirty~~A number of~~ study participants in the intervention arms were newly~~already~~ housed through the 'At Home/Chez Soi' project at the time of the baseline in-depth interview, while five~~other~~ intervention participants were still waiting to be housed through the project. At the time of the interview, 11~~some~~ study participants who had been randomized into the Treatment As Usual arm had obtained housing independently of the project through the private market or through various social housing organizations in the city~~. Given this fact, it was not possible to include the TAU participants as an explicit comparison group in the analysis.~~ Thus, participants were either newly-housed (within a month or two) through the project or independently, were about to receive housing through the project, or were aspiring to be housed (unhoused TAU participants), and were reflecting on hopes for the future as well as anticipated

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benefits and challenges associated with being housed. As a result, we do not treat TAU participants as an explicit comparison group in the analysis.

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~~Thus, it is important to note that in the interviews, participants in the sample who were waiting for housing discussed anticipated benefits of housing for both their mental and physical well-being, while others in housing were noting benefits that may have already been experienced~~.

---Insert Table 1 here---

Hopes for Recovery

~~Regardless of whether the participants were randomized to the intervention groups or Treatment as Usual group, m~~Many participants had a ~~clear~~ vision for recovery and hoped to make ~~many~~ life changes as part of this process. For a number of participants, recovery was associated with the idea of starting over. For one participant in particular, being randomized to the intervention group in the 'At Home/Chez Soi' project 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…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. (Female participant, ACT, housed)*

A number of participants expressed wanting to experience personal growth. One participant discussed 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." (Male participant, ER-ICM, unhoused)*

For many, dealing with substance use problems facilitated the recovery process. Without "getting clean", some participants felt that recovery and finding stability in life would not be possible:

> *There's a lot of people out there who would like to…get the help that I have gotten, right? But then due to this… addiction, a lot of them [are]… going to ruin it. (Male participant, ER-ICM, housed)*

Some also hoped to achieve self-acceptance as part of the recovery process. This participant explained that recovery involved accepting past experiences and finding self-worth:

> *…I guess part of that [recovery] would be to…learn to at least like myself or not hate myself um,…try and get well you know, trying to understand the different emotions about what happened in the past like you know, guilt or…and, and whatever all that, all those different emotions that come up from that…and being able to see some you know, like some worth in life. (Female participant, TAU, unhoused)*

~~For a number of these participants, spirituality was central to the journey of recovery, and some felt that it gave them hope in the process.~~

> ~~*I said, "I[was]…blinded for 35 years. If they had only invited me to the Bible, I wouldn't be…so dead. I would have at least had a fighting chance." But the Bible helped me a lot. Because the Bible gives you hopes. I don't know why other people read it, but…at least for me, that's what happened to me.*~~

~~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 […]*".~~

However, some participants discussed 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. (Female participant, ACT, housed)*

Hope and Personal Goal-Setting

A number of participants expressed hope for future recovery through personal goal-setting. Goals included seeking education, employment and re-building relationships in the future. Many discussed wanting to get a job or to establish a career, as a way to support their future 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…*" *(Female participant, ACT, housed)*.

Many participants discussed the desire to develop or re-establish positive, healthy relationships. Some hoped that they might meet a romantic partner, and 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."(Female participant, ICM, housed).* Other participants were more focused on rebuilding relationships that were lost or damaged during their time while homeless. ~~This participant discussed 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.'*~~

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Housing as a Condition for Realization of Hope for Future Recovery – Anticipated and Experienced Benefits

Housing as the First Step

Despite having well-defined hopes for future recovery, for most participants, becoming housed was key to the realization of these hopes. Many participants saw becoming housed as the first step in a move towards rebuilding their lives, and addressing broader notions of recovery:

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

> *Once I get an apartment and I see this doctor tomorrow I know this doctor is going to prescribe the right medication because my other doctor she is going to recommend what I need… and once I get an apartment I, I will go to the food bank, I will go buy groceries… As soon as I get an apartment I recover, I stop… I don't want to know nobody… I don't even want to have a cigarette inside. I just want to go outside and do my own thing… I might go back to work. (Male participant, ACT, housed)*

Several participants associated stable housing with an increased sense of security, peace of mind and a decreased stress level, which in turn would allow them to focus on other life domains:

> *[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...(Female participant, ER-ICM, housed)*

Anticipated Independence and Control Associated with Housing

Many participants anticipated a sense of independence and control associated with living on their own – especially after living 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. (Femal participant, ER-ICM, housed)*

The door key, as a symbol of this independence, was described by a number of participants: *"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." (Male participant, ER-ICM, unhoused).* For many participants, having their own key represented a renewed sense of freedom and self-reliance – something they had not felt while they were homeless. 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. (Male participant, ICM, housed)*

A number of participants who were newly housed discussed feeling more independent and self-sufficient, and generally having more control over their lives: *"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." (Female participant, ER-ICM, housed)*

Several participants discussed that an important part of maintaining stable housing was the ability to pay their rent regularly and on time. One participant described the ability to pay his own rent as a symbol of self-worth 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. (Male participant, ER-ICM, housed)*

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Anticipated Benefits of Housing on Health and Well-Being

An sense of control and security anticipated to accompany housing was also central to the achievement of other hopes, for example improvements to health and well-being. Many participants felt that their physical and mental health would improve with the security and stability that comes with housing:

> *Well, it [recovery] means having as few mania attacks as possible I don't think they'll stop entirely ever, having a few depression attacks as possible. Certainly getting my physical health back which is happening now because… I think mostly recovery has to do strangely enough with having permanent subsidized housing… (Female participant, ER-ICM, housed)*

For a number of participants in the intervention arms, the most significant shift related to moving from homelessness to housing was perceived to be the ability to stay in during the day and care for their health, as opposed to having to be out on the streets during the day in accordance with shelter policies. 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. (Male participant, ACT, housed)*

Lack of sleep while homeless was another important factor that many participants discussed as negatively affecting their physical health. With stable housing, participants felt that they would be able

to get better, more consistent rest and engage in self-care. Another participant in the intervention group discussed the impact of being housed 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!' (Male participant, ER-ICM, housed)*

~~Another newly housed~~This participant described that housing contributed to improved emotional well-being and facilitated hopes~~planning~~ for the future:

> *But in terms of emotional, you know, it's been a month…right now, I feel a lot better. I'm feeling better, you know? It is really that, thanks to this program, I think, uh…I start to…I'm starting to calculate and saying, "You know what? I think this is where I'd like to see myself some time", you know? I want to be here. I don't want to go back out there.*

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

~~*Anticipated Independence and Control Associated with Housing*~~

~~In addition to the health benefits of being housed, many participants anticipated a sense of independence and control associated with living on their own – especially after living 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 independence, was described by a number of participants: *"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~~

~~freedom and self-reliance – something they had not felt while they were homeless. 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.*~~

~~A number of participants who were newly housed discussed feeling more independent and self-sufficient, and generally having more control over their lives: *"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."*~~

~~Several participants discussed that an important part of maintaining stable housing was the ability to pay their rent regularly and on time. One participant described the ability to pay his own rent as a symbol of self-worth 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.*~~

Housing as a Precursor for Relationship Re-Building

A number of participants ~~discussed~~ hoped ~~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? (Male participant, ER-ICM, housed)*

Newly housed, this participant 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."*

Stable housing also allowed a number of participants to regain or maintain relationships with their children. One participant spoke about her sons not being able to visit her when she was living in a

shelter. Now housed, one of her sons is living with her and another son is able to visit whenever he likes. Others indicated the importance of being able to open up their homes to friends and potential romantic partners, something that they were previously unable to do while homeless, either due to shelter rules or out of embarrassment. A number of participants also discussed valuing the companionship of pets, and four expressed the desire to get a companion animal once housed. However, some expressed concern about their ability to have a pet while housed due to regulations preventing pet ownership in apartment buildings:

> *They [dogs] 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 named Louis, he was with me when I went through… I didn't tell you all my illnesses… (Female participant, TAU, housed)*

Concerns about Housing: Issues that May Temper the Benefits

While most participants in the intervention arms of the project discussed the benefits of being housed, there was some concern around being isolated in their apartments and the potential effect this could have on their recovery:

> *So… I am excited but I am nervous, you know? Because I am institutionalized now, I have been in a shelter for 3 years, there is a lot of things I haven't had to do for myself you know? And I… am a little worried about the isolation so I am going to have [to] like take steps towards not being isolated, you know? (Female participant, ICM, housed)*

One participant who had recently been housed noted a negative effect of being housed on his mental health: *"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."* (Male participant, ICM, housed). Another participant in one of the intervention arms who had recently been housed discussed not yet feeling comfortable in his new home due to 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*

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have to change that thinking." (Male participant, ACT, housed). At times, living alone was so overwhelming for this participant that he considered giving up the apartment and leaving town.

Based on previous experiences with destructive relationships, several 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. As one participant said: "*A few guys pop over but there is only a select few that know where I live. I like to keep it that way."* (Male participant, ICM, housed). Overall, it was invaluable for many participants to be able to choose when and how much time they would spend with others, but this was another contributing factor to feelings of social isolation for some participants.

DISCUSSION and CONCLUSION

Study findings reflect that participants show considerable hope and optimism for recovery in the future. This hope was manifested in key self-management strategies of goal-setting, rebuilding self-esteem, and finding meaning through relationships and symbolism (e.g., the door key) [14]. Specifically, participants' perceptions of recovery are focused on hopes to regain control over their lives and a sense of independence after a period of powerlessness, which would facilitate achieving~~achieve~~ self-acceptance, rebuilding and developing new relationships, as well as help them to reclaim their lives in the community. ~~[31, 32]~~ These findings regarding hope for future recovery echo results from other research in this area [31-33].

Participants' narratives show clear visualization of the role of housing in implementing these strategies, and emphasize that housing is an integral factor that can facilitate hope and support dimensions of recovery. The majority ~~Many~~ felt that achieving the above-mentioned dimensions of recovery was dependent on housing, as a stable roof over their heads would alleviate the need to focus on survival concerns, and this combined with an anticipated increased sense of independence and

security that housing would bring, would ~~and~~ provide them with the opportunity to instead concentrate on their recovery-oriented goals. ~~These findings~~ This study further confirms that housing is an important foundation from which to build and act upon hope, providing participants with hopes for experiences of control, independence, and security and an opportunity to sleep, reflect, and care for their physical and mental health. These findings support the notion of increased ontological security, reflecting an increased sense of security, safety and predictability that can be enhanced by permanent housing, which has been noted in research on Housing First interventions with homeless individuals with serious mental illness [28, 32]. These findings expand on this research by connecting the importance of increased ontological security to hope-building and recovery processes in that the receipt of actual, but also anticipated housing, can stimulate ~~a~~ a sense of ontological security which can further build and ~~also~~ support action on hope, a key component in the recovery process~~other s~~ [13, 14, 28].

~~thus support theories of recovery and Housing First, in that actual and anticipated housing, without preconditions for "housing readiness", can stimulate hope, a key component in the recovery process [13, 14, 28].~~

~~This study clearly shows that housing is a necessary foundation from which to build hope, providing participants with control, independence, an opportunity to sleep, reflect, and care for their physical and mental health.~~ The study ~~It~~ also reveals some critical areas in which housing is not, alone, sufficient for recovery, but could be strongly bolstered by interventions expressly aimed at building and acting on hope. The Housing First model's emphasis on positive relationships with service providers, and client-driven goal-setting, are elements already known to be important bases for successful hope-building interventions [14] and this study identifies areas of focus with the greatest potential. For example, many of these participants considered housing an opportunity to repair lost or damaged relationships, and to build new healthy relationships, but were not always clear on how to actualize those hopes. While many participants desired to reduce or cease harmful substance use behaviors, and saw control over their

housing as key, they needed help to overcome the social isolation that resulted from their turning away friends previously associated with substance use.

Study limitations include that these ~~are~~ findings reflect point in time observations and do not explore long-term impacts of housing on hopefulness and recovery trajectories among study participants. However, longitudinal analysis of the data in this area is currently ongoing.~~on the experiences of individuals experiencing homelessness and mental health issues and thus do not necessarily generalize across all homeless populations.~~

Overall, these findings contribute to existing research in this area by showing how hope, housing and recovery are connected in a large sample of homeless individuals experiencing mental illness participating in a Housing First RCT. Specifically, findings support that anticipated and actual housing, facilitated through the mechanism ~~and specifically~~ of Housing First programs that provide housing and supports to this population~~homeless individuals with mental illness,~~ can foster hope for increased ~~enhance~~ ontological security and achievement of other recovery-oriented goals~~foster hope in achieving recovery~~ [28]. However, housing alone is not sufficient to foster hope and support this population in moving forward in the recovery journey. In order to support the hope that is inspired by such interventions, these programs need to focus on assisting clients during the adjustment period while becoming newly housed to prevent and address social isolation. Furthermore, these programs should explicitly integrate hope-inspiring, recovery-oriented approaches [14], such as goal-setting, finding meaning, and implementing strategies to manage illness, build self-esteem, and (re)develop relationships.

Table 1. Sample Demographics (N=60)

	%
Gender	
Male	67%
Female	30%
Transgender	2%
Not Indicated	2%
Ethnoracial	
Yes	55%
No	45%
Age (mean)	41
Education Level	
Completed graduate school	3%
Completed university or business, trade, technical school	14 %
Some university or business, trade, technical school	11%
Completed high school	22%
Some high School, not completed	37%
Completed grade 8 or less	13%
Months Homeless in Lifetime	
≤ 6	12%
7 to 11	9%
12 to 23	15%
24 to 71	32%
≥ 72	32%

Contributors: MK and SZ drafted the manuscript. MK oversaw data collection and contributed to analysis; DWH and EP conducted interviews, data analysis and drafted thematic sections. VS supervised the research and critically reviewed the manuscript.

Funding Statement: This research was made possible through a financial contribution by Health Canada and funded by the Mental Health Commission of Canada. The views expressed herein solely represent the authors.

Competing Interests: None to declare.

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