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Journal:	<i>BMJ Open</i>
Manuscript ID:	bmjopen-2013-004379
Article Type:	Research
Date Submitted by the Author:	01-Nov-2013
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<b>Primary Subject Heading</b>:	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

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***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-

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3 inspiring interventions for people with mental disorders identified numerous recovery-oriented  
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5 interventions with hope as a secondary outcome, but indicated that no successful interventions  
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7 specifically focused on increasing hope [14]. These authors concluded that interventions with the  
8  
9 greatest impact on increasing hope relied on multi-dimensional hope concepts, and those narrowly  
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11 focused – such as only on goal setting and achievement – were ineffective. They also identified five  
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13 promising elements for inclusion in interventions: i) collaborative strategies for illness management, ii)  
14  
15 focus on fostering relationships with service providers and others outside the mental health system; iii)  
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17 facilitating peer connections and support; iv) helping clients form and pursue realistic goals; and v)  
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19 supporting multiple positive factors such as self-esteem, self-efficacy, spirituality and well-being,  
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21 identifying this last element as one most neglected in clinical practice [14].  
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### 28 ***Homelessness and Hope***

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31 Homelessness interferes with these and other elements key to recovery: for example, it  
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33 complicates illness management and medication maintenance, erodes self-control and self-esteem, and  
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35 engenders mistrust and self-isolation[15, 16]. Indeed, some have declared homelessness “the antithesis  
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37 of recovery” [17] (p.69). Qualitative studies which have studied hope with persons experiencing  
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39 homelessness, including children, street youth, women and families, veterans, and shelter residents, all  
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41 share the common theme that powerlessness associated with the experience of homelessness has a  
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43 destructive impact on self-esteem and hope [8, 15, 16, 18-20]. An interesting exception to this was one  
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45 of the few quantitative studies measuring hope with homeless persons, in this case participants in a  
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47 consumer-run mental health services program, which found a positive association between  
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49 homelessness and hope [21]. While all of these researchers agree development of hope-inspiring  
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51 interventions that address the complexity of homelessness is important and possible, and some  
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3 progress has been made with homeless women and families, the “how” of inspiring hope remains  
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5 elusive – especially for single, chronically homeless adults [22-24].  
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### 10 ***The Role of Housing***

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12 The role of housing in inspiring hope and facilitating recovery has been explored with homeless  
13 populations, though it is not well-understood. ‘Housing First’ is an intervention for individuals  
14 experiencing homelessness and mental illness which places individuals into permanent independent  
15 housing first - without prerequisites for sobriety and treatment - and offers flexible access to supportive  
16 health services [25]. Research on this intervention has consistently found that placing individuals in  
17 housing first does not affect ability to maintain housing, has no deleterious effects on recovery and has  
18 led to improved mental health outcomes [26, 27]. While housing creates critical stability to facilitate the  
19 recovery process, its role and importance is otherwise unclear; one qualitative study found newly  
20 housed Housing First participants only “partially attained” core elements of recovery, including hope  
21 and social connections, once housed [28].  
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35 This study contributes to this body of literature by exploring the importance of housing to hopes  
36 for recovery from the perspective of chronically homeless adults with mental illness. The study draws  
37 on data from in-depth qualitative interviews with participants from the Toronto, Ontario site of the  
38 multi-site ‘At Home/Chez Soi’ Project in Canada.  
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### 47 **METHODS**

48  
49 The ‘At Home/Chez Soi’ study is a randomized controlled trial that evaluates the effectiveness of  
50 a ‘Housing First’ approach to improving the lives of individuals who experience both homelessness and  
51 mental illness. The project was implemented across five cities in Canada – Moncton, Montreal, Toronto,  
52 Winnipeg and Vancouver – and received federal funding for three years.  
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3 'At Home/Chez Soi' project participants in Toronto were randomized to one of two Housing First  
4 interventions based on level of mental health service need, or to a 'Treatment as Usual' arm. High needs  
5 participants (N=197) were randomized to an Assertive Community Treatment (ACT) arm or Treatment as  
6 Usual, while moderate needs participants (N=378) were randomized to an Intensive Case Management  
7 (ICM) arm or Treatment as Usual. Moderate needs participants who identified as ethnoracial and were  
8 randomized to the intervention were further provided with the option to participate in an ethnoracial-  
9 intensive case management intervention (ER-ICM; specific to the Toronto site of the project).  
10  
11 Participants in the Housing First interventions received a rent supplement and housing of their choice,  
12 and mental health service supports according to their level of need. Participants in the 'Treatment as  
13 Usual' arm received information materials about services available in the community but no direct  
14 services. Study participants were classified as high or moderate need using an algorithm described in  
15 Goering et al. that draws from Section 3 of the Ontario Standards for ACT teams [3].  
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31 Participants completed a series of surveys at specific time intervals to assess the effects of the  
32 housing first intervention on such outcomes as mental health, substance use, social functioning,  
33 community integration, and criminal justice system involvement. A subsample of 60 participants took  
34 part in in-depth qualitative interviews at the beginning of the study (baseline).  
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#### 40 **Data Collection**

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42 Participants in the baseline qualitative interviews were selected by sampling every 10<sup>th</sup>  
43 participant randomized to each study arm. These interviews were conducted with 36 participants from  
44 the Intervention group (12 from the ACT intervention, 12 from the ICM and 12 from the ER-ICM  
45 intervention), and 24 from the Treatment as Usual group (12 with high needs and 12 with moderate  
46 needs). Interviews were conducted by a group of three research staff between March 2010 and June  
47 2011. All participants provided written, informed consent to participate, and agreed to have the  
48 interviews audio-recorded. Interviews ranged from approximately 45 minutes to 1.5 hours in length.  
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3 Interview participants were also asked to complete a brief demographic form. Interview participants  
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5 each received an honorarium of \$25, two transit tokens, and a resources sheet outlining health and  
6  
7 social services in the Toronto area. The study was approved by the St. Michael's Hospital Ethics Review  
8  
9 Board.  
10

### 11 **Data Analysis**

12  
13 Qualitative interview data were analyzed with a coding process involving the constant  
14  
15 comparative technique derived from grounded theory methods [29]. Data were coded into common  
16  
17 categories based on similar content, and then emerging categories were compared with previous  
18  
19 categories. The analysts then transformed codes into higher-level categories by analyzing and grouping  
20  
21 similar codes into conceptual categories, using the constant comparative method of analysis [30].  
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23 Eventually, broader categories were reduced to a set of higher-level themes. To ensure reliability during  
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25 this process, the analysts double-coded six interview transcripts, and met regularly to compare the  
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27 accuracy of their codes and worked by consensus to refine discrepancies. There was a high degree of  
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29 consensus in the coding, with slight differences in the wording of codes. Discrepancies in coding were  
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31 discussed and resolved in consultation with the original interviewer and a qualitative research  
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33 supervisor. Descriptive statistics were calculated on the demographic data using SAS software.  
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## 42 **RESULTS**

### 43 **Sample Characteristics**

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45 Demographic information for the study sample is presented in Table 1. Sixty-seven percent of  
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47 participants were male, 30% were female, and 2% identified as transgendered. Fifty-five percent of  
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49 participants identified as members of an ethnoracial group, and seven percent of these participants  
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51 identified as Aboriginal. Mean participant age was 41 years. Thirteen percent of participants completed  
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53 grade 8 or less, and 37% had not completed high school. Twelve percent of participants reported having  
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3 been homeless for six months or less, and 32% reported having been homeless for six or more years.  
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5 Forty percent of participants were identified as having a high need level, and 60% were identified as  
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7 having moderate needs.  
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10 A number of study participants in the intervention arms were already housed through the 'At  
11 Home/Chez Soi' project at the time of the baseline in-depth interview, while other intervention  
12 participants were still waiting to be housed through the project. At the time of the interview, some  
13 study participants who had been randomized into the Treatment As Usual arm had obtained housing  
14 independently of the project through the private market or through various social housing organizations  
15 in the city. Thus, it is important to note that in the interviews, participants in the sample who were  
16 waiting for housing discussed anticipated benefits of housing for both their mental and physical well-  
17 being, while others in housing were noting benefits that may have already been experienced.  
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28 ---Insert Table 1 here---

### 30 31 **Hopes for Recovery**

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33 Regardless of whether the participants were randomized to the intervention groups or  
34 Treatment as Usual group, many had a clear vision for recovery and hoped to make many life changes as  
35 part of this process. For a number of participants, recovery was associated with the idea of starting over.  
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37 For one participant in particular, being randomized to the intervention group in the 'At Home/Chez Soi'  
38 project was an opportunity to begin a new life:  
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44 *I've lived a very rough life but I've made it, I am here today to say that this program has*  
45 *helped me in so many ways of my life...a turning point where I don't have to think about*  
46 *drugs and I don't have to think about being homeless, I don't have to think about*  
47 *anything but positive things from now on. Like I had doubts when I first came even when*  
48 *I got accepted but when I see everything happening according to the way they said it*  
49 *would, I was like this is the start of a new life for me.*  
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52  
53 A number of participants expressed wanting to experience personal growth. One participant discussed  
54 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*  
55 *not all that proud of me right now."*  
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3 For many, dealing with substance use problems facilitated the recovery process. Without  
4  
5 “getting clean”, some participants felt that recovery and finding stability in life would not be possible:  
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8 *There’s a lot of people out there who would like to...get the help that I have gotten, right? But*  
9 *then due to this... addiction, a lot of them [are]... going to ruin it.*

10  
11  
12 Some also hoped to achieve self-acceptance as part of the recovery process. This participant  
13 explained that recovery involved accepting past experiences and finding self-worth:  
14

15 *...I guess part of that [recovery] would be to...learn to at least like myself or not hate myself*  
16 *um,...try and get well you know, trying to understand the different emotions about what*  
17 *happened in the past like you know, guilt or...and, and whatever all that, all those different*  
18 *emotions that come up from that...and being able to see some you know, like some worth in life.*  
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23 For a number of these participants, spirituality was central to the journey of recovery, and some felt that  
24 it gave them hope in the process.  
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27 *I said, “I[w]as...blinded for 35 years. If they had only invited me to the Bible, I wouldn’t be...so*  
28 *dead. I would have at least had a fighting chance.” But the Bible helped me a lot. Because the*  
29 *Bible gives you hopes. I don’t know why other people read it, but...at least for me, that’s what*  
30 *happened to me.*  
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34 Some participants recalled that religion and spirituality were always part of their lives, while others  
35 connected or reconnected to their faith as part of the healing process: “How I got out is just praying, you  
36 know, just believing. You’ve got to believe in yourself and you’ve got to believe that there is a better way  
37 than what you’re doing [... ]”.  
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43 However, some participants discussed the barriers that they would need to overcome in order  
44 to establish the kind of life they would like for themselves:  
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46 *I hope that maybe one day I will get healed, I won’t have to take medications anymore*  
47 *[...] I wouldn’t have to be drowsy and I can do what I want, get a job, you know? And*  
48 *fulfill my dreams.*  
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### 53 **Hope and Personal Goal-Setting**

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3 A number of participants expressed hope for future recovery through personal goal-setting. Goals  
4 included seeking education, employment and re-building relationships in the future. Many discussed  
5 wanting to get a job or to establish a career, as a way to support their future and to rebuild their self-  
6 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  
7 regular job with great benefits and old age security. I want all of that."*

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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.*

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*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.*

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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:

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*[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...*

#### 20 21 22 *Anticipated Benefits of Housing on Health and Well-Being*

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

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*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...*

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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.

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One participant who was housed at the time of the interview noted an immediate effect on his physical health:

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*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.*

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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

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3 to get better, more consistent rest and engage in self-care. Another participant in the intervention  
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5 group discussed the impact of being housed on his overall well-being:  
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8 *I feel different, you know? I feel more, more together, yeah. I sleep until sometimes*  
9 *9:30, 10 o'clock. And I'm like, 'Oh my God, this is great. I can actually sleep!'*  
10

11  
12 Another newly housed participant described that housing contributed to improved emotional well-being  
13  
14 and facilitated planning for the future:  
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17 *But in terms of emotional, you know, it's been a month...right now, I feel a lot better. I'm feeling*  
18 *better, you know? It is really that, thanks to this program, I think, uh...I start to...I'm starting to*  
19 *calculate and saying, "You know what? I think this is where I'd like to see myself some time",*  
20 *you know? I want to be here. I don't want to go back out there.*  
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24 For some study participants, access to a proper kitchen, the ability to cook their own food and eat when  
25  
26 they were hungry represented important health and nutritional benefits, in addition to providing  
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28 welcome freedoms.  
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### 33 *Anticipated Independence and Control Associated with Housing*

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35 In addition to the health benefits of being housed, many participants anticipated a sense of  
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37 independence and control associated with living on their own – especially after living on the streets or in  
38  
39 a shelter:  
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42 *Home to me is the best, it's your home, you own everything that's in there, you have*  
43 *your own key, you have your freedom to go in and out, you know? You have your own*  
44 *shower, you can cook, you can do whatever in there.*  
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48 The door key, as a symbol of this independence, was described by a number of participants: *"I pray*  
49 *every day that I would get somewhere to go on my own again, you know? That I can put my own key*  
50 *and turn it myself."* For many participants, having their own key represented a renewed sense of  
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52 freedom and self-reliance – something they had not felt while they were homeless. As one participant  
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54 explained:  
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3 *Home is like your own place, your own rules, you know? You wake up and [...] you can*  
4 *do whatever you want, no one can tell you anything because it's your own place.*  
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8 A number of participants who were newly housed discussed feeling more independent and self-  
9  
10 sufficient, and generally having more control over their lives: *"Now at least I can clean my house the way*  
11 *I want it [...] That's important to me, I can run my house the way I want it."*  
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15 Several participants discussed that an important part of maintaining stable housing was the ability  
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17 to pay their rent regularly and on time. One participant described the ability to pay his own rent as a  
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19 symbol of self-worth and self-sufficiency:  
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22 *I want to be able to pay my own rent that's what I want to change, I want to get a job*  
23 *and pay my own rent, man. Feel like a somebody, you know? Right now I don't feel like*  
24 *a somebody, you know? I don't.*  
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#### 28 *Housing as a Precursor for Relationship Re-Building*

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31 A number of participants discussed wanting to re-establish relationships once they were in  
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33 stable housing. One participant talked about how difficult it was to maintain relationships with his  
34  
35 family while he was living on the streets:  
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37  
38 *When you're out there, you don't have a family. You can't [...] Where are you going to*  
39 *receive them? Who wants a person who hasn't taken a shower for three or four days?*  
40

41 Newly housed, this participant was proud to invite his brother over and could now take the first step  
42  
43 toward rebuilding this relationship: *"I have a place where I can receive him. That's an important thing.*  
44 *So I can have a family again."*  
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49 Stable housing also allowed a number of participants to regain or maintain relationships with  
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51 their children. One participant spoke about her sons not being able to visit her when she was living in a  
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53 shelter. Now housed, one of her sons is living with her and another son is able to visit whenever he likes.  
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55 Others indicated the importance of being able to open up their homes to friends and potential romantic  
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3 partners, something that they were previously unable to do while homeless, either due to shelter rules  
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5 or out of embarrassment. A number of participants also discussed valuing the companionship of pets,  
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7 and expressed the desire to get a companion animal once housed. However, some expressed concern  
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9 about their ability to have a pet while housed due to regulations preventing pet ownership in apartment  
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11 buildings:  
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16 *They [dogs] go into shelters and then they're euthanized or whatever, like you've got to find*  
17 *room for people with dogs because they're a companion and Louis was with... my dog's named*  
18 *Louis, he was with me when I went through... I didn't tell you all my illnesses...*  
19

### 20 21 22 **Concerns about Housing: Issues that May Temper the Benefits** 23

24 While most participants in the intervention arms of the project discussed the benefits of being  
25  
26 housed, there was some concern around being isolated in their apartments and the potential effect this  
27  
28 could have on their recovery:  
29

30  
31 *So... I am excited but I am nervous, you know? Because I am institutionalized now, I have been in*  
32 *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*  
33 *little worried about the isolation so I am going to have [to] like take steps towards not being*  
34 *isolated, you know?*  
35

36  
37 One participant who had recently been housed noted a negative effect of being housed on his mental  
38  
39 health: *"I don't do very much anymore. I have been staying right in my apartment. I haven't been feeling*  
40 *good, like, mentally I guess you can say."* Another participant in one of the intervention arms who had  
41  
42 recently been housed discussed not yet feeling comfortable in his new home due to the drastic shift  
43  
44 from being surrounded by other people in a shelter or in jail, to living alone: *"Even if I am in jail, I am not*  
45  
46 *alone ... there is nothing wrong with the house, you know, it's me, I have to change that thinking."* At  
47  
48 times, living alone was so overwhelming for this participant that he considered giving up the apartment  
49  
50 and leaving town.  
51  
52

53  
54  
55 Based on previous experiences with destructive relationships, several participants discussed  
56  
57 being very selective about who they would invite over – if anyone at all – in order to maintain their  
58  
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1  
2  
3 current housing and limit the potential for any disturbances. As one participant said: *“A few guys pop*  
4 *over but there is only a select few that know where I live. I like to keep it that way.”* Overall, it was  
5  
6  
7  
8 invaluable for many participants to be able to choose when and how much time they would spend with  
9  
10 others, but this was another contributing factor to feelings of social isolation for some participants.  
11  
12

## 13 14 15 **DISCUSSION and CONCLUSION**

16  
17 Study findings reflect that participants show considerable hope and optimism for recovery in the  
18  
19 future. This hope was manifested in key self-management strategies of goal-setting, rebuilding self-  
20  
21 esteem, and finding meaning through relationships and symbolism (e.g., the door key) [14]. Specifically,  
22  
23 participants’ perceptions of recovery are focused on hopes to regain control over their lives and a sense  
24  
25 of independence after a period of powerlessness, achieve self-acceptance, rebuild and develop new  
26  
27 relationships, as well as reclaim their lives in the community.  
28  
29

30  
31 Participants’ narratives show clear visualization of the role of housing in implementing these  
32  
33 strategies, and emphasize that housing is an integral factor that can facilitate hope and support  
34  
35 dimensions of recovery. Many felt that achieving the above-mentioned dimensions of recovery was  
36  
37 dependent on housing, as a stable roof over their heads would alleviate the need to focus on survival  
38  
39 concerns and provide them with the opportunity to instead concentrate on their recovery-oriented  
40  
41 goals. These findings thus support theories of recovery and Housing First, in that actual and anticipated  
42  
43 housing, without preconditions for “housing readiness”, can stimulate hope, a key component in the  
44  
45 recovery process [13, 14, 28].  
46  
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48  
49 This study clearly shows that housing is a necessary foundation from which to build hope, providing  
50  
51 participants with control, independence, an opportunity to sleep, reflect, and care for their physical and  
52  
53 mental health. It also reveals some critical areas in which housing is not, alone, sufficient for recovery,  
54  
55 but could be strongly bolstered by interventions expressly aimed at building hope. The Housing First  
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3 model's emphasis on positive relationships with service providers, and client-driven goal-setting, are  
4 elements already known to be important bases for successful hope-building interventions [14] and this  
5 study identifies areas of focus with the greatest potential. For example, many of these participants  
6 considered housing an opportunity to repair lost or damaged relationships, and to build new healthy  
7 relationships, but were not always clear on how to actualize those hopes. While many participants  
8 desired to reduce or cease harmful substance use behaviors, and saw control over their housing as key,  
9 they needed help to overcome the social isolation that resulted from their turning away friends  
10 previously associated with substance use.  
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21 Study limitations include that these are findings on the experiences of individuals experiencing  
22 homelessness and mental health issues and thus do not necessarily generalize across all homeless  
23 populations.  
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28 Overall, these findings contribute to existing research in this area showing that housing, and  
29 specifically Housing First programs that provide housing and supports to homeless individuals with  
30 mental illness, can foster hope in achieving recovery [28]. However, housing alone is not sufficient to  
31 foster hope and support this population in moving forward in the recovery journey. In order to support  
32 the hope that is inspired by such interventions, these programs need to focus on assisting clients during  
33 the adjustment period while becoming newly housed to prevent and address social isolation.  
34 Furthermore, these programs should explicitly integrate hope-inspiring, recovery-oriented approaches  
35 [14], such as goal-setting, finding meaning, and implementing strategies to manage illness, build self-  
36 esteem, and (re)develop relationships.  
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Table 1. Sample Demographics (N=60)

	%
<b>Gender</b>	
Male	67%
Female	30%
Transgender	2%
Not Indicated	2%
<b>Ethnoracial</b>	
Yes	55%
No	45%
<b>Age (mean)</b>	41
<b>Education Level</b>	
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%
<b>Months Homeless in Lifetime</b>	
≤ 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:	<i>BMJ Open</i>
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
<b>Primary Subject Heading</b>:	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

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Manuscripts

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3 ***The promise of recovery: Narratives of hope among homeless individuals with mental illness***  
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5 ***participating in a Housing First randomized controlled trial in Toronto, Canada***  
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10 Maritt Kirst<sup>\*1,2</sup>, Suzanne Zerger<sup>1</sup>, Deborah Wise Harris<sup>1</sup>, Erin Plenert<sup>1</sup> & Vicky Stergiopoulos<sup>1,3</sup>  
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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*

- 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
- 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-

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2  
3 inspiring interventions for people with mental disorders identified numerous recovery-oriented  
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5 interventions with hope as a secondary outcome, but indicated that no successful interventions  
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7 specifically focused on increasing hope [14]. These authors concluded that interventions with the  
8  
9 greatest impact on increasing hope relied on multi-dimensional hope concepts, and those narrowly  
10  
11 focused – such as only on goal setting and achievement – were ineffective. They also identified five  
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13 promising elements for inclusion in interventions: i) collaborative strategies for illness management, ii)  
14  
15 focus on fostering relationships with service providers and others outside the mental health system; iii)  
16  
17 facilitating peer connections and support; iv) helping clients form and pursue realistic goals; and v)  
18  
19 supporting multiple positive factors such as self-esteem, self-efficacy, spirituality and well-being,  
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21 identifying this last element as one most neglected in clinical practice [14].  
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### 28 ***Homelessness and Hope***

30  
31 Homelessness interferes with these and other elements key to recovery: for example, it  
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33 complicates illness management and medication maintenance, erodes self-control and self-esteem, and  
34  
35 engenders mistrust and self-isolation[15, 16]. Indeed, some have declared homelessness “the antithesis  
36  
37 of recovery” [17] (p.69). Qualitative studies which have studied hope with persons experiencing  
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39 homelessness, including children, street youth, women and families, veterans, and shelter residents, all  
40  
41 share the common theme that powerlessness associated with the experience of homelessness has a  
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43 destructive impact on self-esteem and hope [8, 15, 16, 18-20]. An interesting exception to this was one  
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45 of the few quantitative studies measuring hope with homeless persons, in this case participants in a  
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47 consumer-run mental health services program, which found a positive association between  
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49 homelessness and hope [21]. While all of these researchers agree development of hope-inspiring  
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51 interventions that address the complexity of homelessness is important and possible, and some  
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3 progress has been made with homeless women and families, the “how” of inspiring hope remains  
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5 elusive – especially for single, chronically homeless adults [22-24].  
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### 10 ***The Role of Housing***

11  
12 The role of housing in inspiring hope and facilitating recovery has been explored with homeless  
13 populations, though it is not well-understood. ‘Housing First’ is an intervention for individuals  
14 experiencing homelessness and mental illness which places individuals into permanent independent  
15 housing first - without prerequisites for sobriety and treatment - and offers flexible access to supportive  
16 health services [25]. Research on this intervention has consistently found that placing individuals in  
17 housing first does not negatively affect ability to maintain housing, has no deleterious effects on  
18 recovery and has led to improved mental health outcomes [26, 27]. While housing creates critical  
19 stability to facilitate the recovery process, its role and importance is otherwise unclear; one qualitative  
20 study found newly housed Housing First participants only “partially attained” core elements of recovery,  
21 including hope and social connections, once housed [28].  
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35 This study contributes to this body of literature by exploring the importance of housing to hopes  
36 for recovery from the perspective of chronically homeless adults with mental illness. The study draws  
37 on data from in-depth qualitative interviews with participants from the Toronto, Ontario site of the  
38 multi-site ‘At Home/Chez Soi’ Project in Canada.  
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### 47 **METHODS**

48  
49 The ‘At Home/Chez Soi’ study is a randomized controlled trial (RCT) that evaluates the  
50 effectiveness of a ‘Housing First’ approach to improving the lives of individuals who experience both  
51 homelessness and mental illness. The project was implemented across five cities in Canada – Moncton,  
52 Montreal, Toronto, Winnipeg and Vancouver – and received federal funding for three years.  
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3 'At Home/Chez Soi' project participants in Toronto were randomized to one of two Housing First  
4 interventions based on level of mental health service need, or to a 'Treatment as Usual' arm. High needs  
5 participants (N=197) were randomized to an Assertive Community Treatment (ACT) arm or Treatment as  
6 Usual, while moderate needs participants (N=378) were randomized to an Intensive Case Management  
7 (ICM) arm or Treatment as Usual. Moderate needs participants who identified as ethnoracial and were  
8 randomized to the intervention were further provided with the option to participate in an ethnoracial-  
9 intensive case management intervention (ER-ICM; specific to the Toronto site of the project).  
10  
11 Participants in the Housing First interventions received a rent supplement and housing of their choice,  
12 and mental health service supports according to their level of need. Participants in the 'Treatment as  
13 Usual' arm received information materials about services available in the community but no direct  
14 services. Study participants were classified as high or moderate need using an algorithm described in  
15 Goering et al. that draws from Section 3 of the Ontario Standards for ACT teams [3].  
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31 Participants completed a series of surveys at specific time intervals to assess the effects of the  
32 housing first intervention on such outcomes as mental health, substance use, social functioning,  
33 community integration, and criminal justice system involvement. A subsample of 60 participants took  
34 part in in-depth qualitative interviews at the beginning of the study (baseline).  
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#### 40 **Data Collection**

41  
42 Participants in the baseline qualitative interviews were selected from the larger RCT sample by sampling  
43 every 10<sup>th</sup> participant randomized to each study arm. This approach was taken to facilitate sampling  
44 across the larger RCT sample. Purposive sampling was also employed in order achieve representation  
45 across gender and ethnicity. Eighty three participants were invited to participate in the interview by the  
46 study recruitment staff, and 23 participants either declined to participate, or it was not possible to  
47 schedule an interview with them. Sixty participants agreed to participate, and interviews were  
48 conducted with 36 participants from the Intervention group (12 from the ACT intervention, 12 from the  
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3 ICM and 12 from the ER-ICM intervention), and 24 from the Treatment as Usual group (12 with high  
4 needs and 12 with moderate needs). Interviews were conducted by three research staff, including one  
5 peer researcher, with training in conducting in-depth interviews, between March 2010 and June 2011.  
6  
7 All participants provided written, informed consent to participate, and agreed to have the interviews  
8 audio-recorded. Interviews were semi-structured, and asked questions on history of homelessness and  
9 mental health issues, daily activities, experiences with mental health and social services, and hopes for  
10 the future. Interviews were took place in a location that was convenient for the participant, typically the  
11 project office or conducted ranged from approximately 45 minutes to 1.5 hours in length. Interview  
12 participants were also asked to complete a brief demographic form. Interview participants each received  
13 an honorarium of \$25, two transit tokens, and a resources sheet outlining health and social services in  
14 the Toronto area. The study was approved by the St. Michael's Hospital Ethics Review Board.  
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### 28 **Data Analysis**

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31 Qualitative interview data were analyzed with a coding process involving the constant  
32 comparative technique derived from grounded theory methods [29]. Sensitizing questions regarding  
33 hope for the future and the related role of housing in hopes for the future guided the coding process  
34 [30]. Data were coded into common categories based on similar content, and then emerging categories  
35 were compared with previous categories. The analysts then transformed codes into higher-level  
36 categories by analyzing and grouping similar codes into conceptual categories, using the constant  
37 comparative method of analysis [30]. Eventually, broader categories were reduced to a set of higher-  
38 level themes. To ensure reliability during this process, the analysts double-coded six interview  
39 transcripts, and met regularly to compare the accuracy of their codes and worked by consensus to refine  
40 discrepancies. There was a high degree of consensus in the coding, with slight differences in the wording  
41 of codes. Discrepancies in coding were discussed and resolved in consultation with the original  
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3 interviewer and a qualitative research supervisor. Descriptive statistics were calculated on the  
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5 demographic data using SAS software.  
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## 10 RESULTS

### 11 *Sample Characteristics*

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13 Demographic information for the study sample is presented in Table 1. Sixty-seven percent of  
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15 participants were male, 30% were female, and 2% identified as transgendered. Fifty-five percent of  
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17 participants identified as members of an ethnoracial group, and seven percent of these participants  
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19 identified as Aboriginal. Mean participant age was 41 years. Thirteen percent of participants completed  
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21 grade 8 or less, and 37% had not completed high school. Twelve percent of participants reported having  
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23 been homeless for six months or less, and 32% reported having been homeless for six or more years.  
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25 Forty percent of participants were identified as having a high need level, and 60% were identified as  
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27 having moderate needs.  
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29 Thirtystudy participants in the intervention arms were newly housed through the 'At Home/Chez Soi'  
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31 project at the time of the baseline in-depth interview, while five intervention participants were still  
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33 waiting to be housed through the project. At the time of the interview, 11 study participants who had  
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35 been randomized into the Treatment As Usual arm had obtained housing independently of the project  
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37 through the private market or through various social housing organizations in the cityThus, participants  
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39 were either newlyhoused (within a month or two) through the project or independently, were about to  
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41 receive housing through the project, or were aspiring to be housed (unhoused TAU participants), and  
42  
43 were reflecting on hopes for the future as well as anticipated benefits and challenges associated with  
44  
45 being housed. As a result, we do not treat TAU participants as an explicit comparison group in the  
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47 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:



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2  
3 *I hope that maybe one day I will get healed, I won't have to take medications anymore*  
4 *[...] I wouldn't have to be drowsy and I can do what I want, get a job, you know? And*  
5 *fulfill my dreams. (Female participant, ACT, housed)*  
6  
7

### 8 9 **Hope and Personal Goal-Setting**

10  
11 A number of participants expressed hope for future recovery through personal goal-setting. Goals  
12 included seeking education, employment and re-building relationships in the future. Many discussed  
13 wanting to get a job or to establish a career, as a way to support their future and to rebuild their self-  
14 esteem.  
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21 Returning to school or pursuing further education and training was also an important aspect of  
22 participants' vision for their future: *"I have to prove to myself that I could have been who I wanted to be.*  
23 *I am going to get my Grade 12 and I am going to take my nursing course..." (Female participant, ACT,*  
24 *housed).*  
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31 Many participants discussed the desire to develop or re-establish positive, healthy relationships.  
32 Some hoped that they might meet a romantic partner, and discussed wanting to get married and have a  
33 family: *"I still want to get married. I still want to have another child. I still want to live."*(Female  
34 *participant, ICM, housed).* Other participants were more focused on rebuilding relationships that were  
35 lost or damaged during their time while homeless.  
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### 44 **Housing as a Condition for Realization of Hope for Future Recovery – Anticipated and Experienced** 45 **Benefits**

#### 46 *Housing as the First Step*

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48 Despite having well-defined hopes for future recovery, for most participants, becoming housed  
49 was key to the realization of these hopes. Many participants saw becoming housed as the first step in a  
50 move towards rebuilding their lives, and addressing broader notions of recovery:  
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55 *A place to live and then from there I can start doing my things, like getting better and going out.*  
56 *Getting into a routine. Finding a job, getting the training for something else. (Male participant,*  
57 *TAU, unhoused)*  
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*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*

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3 *I want it [...] That's important to me, I can run my house the way I want it." (Female participant, ER-ICM,*  
4  
5 *housed)*

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8 Several participants discussed that an important part of maintaining stable housing was the ability  
9  
10 to pay their rent regularly and on time. One participant described the ability to pay his own rent as a  
11  
12 symbol of self-worth and self-sufficiency:

13  
14  
15 *I want to be able to pay my own rent that's what I want to change, I want to get a job*  
16 *and pay my own rent, man. Feel like a somebody, you know? Right now I don't feel like*  
17 *a somebody, you know? I don't. (Male participant, ER-ICM, housed)*  
18  
19

### 20 21 22 23 *Anticipated Benefits of Housing on Health and Well-Being*

24  
25 A sense of control and security anticipated to accompany housing was also central to the achievement  
26  
27 of other hopes, for example improvements to health and well-being. Many participants felt that their  
28  
29 physical and mental health would improve with the security and stability that comes with housing:  
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31

32  
33 *Well, it [recovery] means having as few mania attacks as possible I don't think they'll stop*  
34 *entirely ever, having a few depression attacks as possible. Certainly getting my physical health*  
35 *back which is happening now because... I think mostly recovery has to do strangely enough with*  
36 *having permanent subsidized housing... (Female participant, ER-ICM, housed)*  
37  
38

39 For a number of participants in the intervention arms, the most significant shift related to moving from  
40  
41 homelessness to housing was perceived to be the ability to stay in during the day and care for their  
42  
43 health, as opposed to having to be out on the streets during the day in accordance with shelter policies.  
44  
45 One participant who was housed at the time of the interview noted an immediate effect on his physical  
46  
47 health:  
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51 *I feel a lot better because I don't have to go running [...] When I got kicked out (of the*  
52 *shelter) I had to walk around and it was really hard on my knees and feet. So it's a lot*  
53 *better now. (Male participant, ACT, housed)*  
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3 Lack of sleep while homeless was another important factor that many participants discussed as  
4  
5 negatively affecting their physical health. With stable housing, participants felt that they would be able  
6  
7  
8 to get better, more consistent rest and engage in self-care. Another participant in the intervention  
9  
10 group discussed the impact of being housed on his overall well-being:

11  
12 *I feel different, you know? I feel more, more together, yeah. I sleep until sometimes*  
13 *9:30, 10 o'clock. And I'm like, 'Oh my God, this is great. I can actually sleep!' (Male*  
14 *participant, ER-ICM, housed)*  
15  
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17  
18 This participant described that housing contributed to improved emotional well-being and facilitated  
19  
20 hopes for the future:

21  
22 *But in terms of emotional, you know, it's been a month...right now, I feel a lot better. I'm feeling*  
23 *better, you know? It is really that, thanks to this program, I think, uh...I start to...I'm starting to*  
24 *calculate and saying, "You know what? I think this is where I'd like to see myself some time",*  
25 *you know? I want to be here. I don't want to go back out there.*  
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29  
30 For some study participants, access to a proper kitchen, the ability to cook their own food and eat when  
31  
32 they were hungry represented important health and nutritional benefits, in addition to providing  
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34 welcome control and freedom.  
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#### 42 *Housing as a Precursor for Relationship Re-Building*

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44 A number of participants hoped to re-establish relationships once they were in stable housing.

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46 One participant talked about how difficult it was to maintain relationships with his family while he was  
47  
48 living on the streets:

49  
50 *When you're out there, you don't have a family. You can't [...] Where are you going to*  
51 *receive them? Who wants a person who hasn't taken a shower for three or four days?*  
52 *(Male participant, ER-ICM, housed)*  
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56 Newly housed, this participant was proud to invite his brother over and could now take the first step  
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3 toward rebuilding this relationship: *"I have a place where I can receive him. That's an important thing.*  
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5 *So I can have a family again."*  
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9 Stable housing also allowed a number of participants to regain or maintain relationships with  
10 their children. One participant spoke about her sons not being able to visit her when she was living in a  
11 shelter. Now housed, one of her sons is living with her and another son is able to visit whenever he likes.  
12  
13 Others indicated the importance of being able to open up their homes to friends and potential romantic  
14 partners, something that they were previously unable to do while homeless, either due to shelter rules  
15 or out of embarrassment. A number of participants also discussed valuing the companionship of pets,  
16 and four expressed the desire to get a companion animal once housed. However, some expressed  
17 concern about their ability to have a pet while housed due to regulations preventing pet ownership in  
18 apartment buildings:  
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31 *They [dogs] go into shelters and then they're euthanized or whatever, like you've got to find*  
32 *room for people with dogs because they're a companion and Louis was with... my dog's named*  
33 *Louis, he was with me when I went through... I didn't tell you all my illnesses... (Female*  
34 *participant, TAU, housed)*  
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### 38 **Concerns about Housing: Issues that May Temper the Benefits**

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40 While most participants in the intervention arms of the project discussed the benefits of being  
41 housed, there was some concern around being isolated in their apartments and the potential effect this  
42 could have on their recovery:  
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47 *So... I am excited but I am nervous, you know? Because I am institutionalized now, I have been in*  
48 *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*  
49 *little worried about the isolation so I am going to have [to] like take steps towards not being*  
50 *isolated, you know? (Female participant, ICM, housed)*  
51  
52

53 One participant who had recently been housed noted a negative effect of being housed on his mental  
54 health: *"I don't do very much anymore. I have been staying right in my apartment. I haven't been feeling*  
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3 *good, like, mentally I guess you can say”* (Male participant, ICM, housed). Another participant in one of  
4  
5 the intervention arms who had recently been housed discussed not yet feeling comfortable in his new  
6  
7 home due to the drastic shift from being surrounded by other people in a shelter or in jail, to living  
8  
9 alone: *“Even if I am in jail, I am not alone ... there is nothing wrong with the house, you know, it’s me, I*  
10  
11 *have to change that thinking.”* (Male participant, ACT, housed). At times, living alone was so  
12  
13 overwhelming for this participant that he considered giving up the apartment and leaving town.  
14  
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17 Based on previous experiences with destructive relationships, several participants discussed  
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19 being very selective about who they would invite over – if anyone at all – in order to maintain their  
20  
21 current housing and limit the potential for any disturbances. As one participant said: *“A few guys pop*  
22  
23 *over but there is only a select few that know where I live. I like to keep it that way.”* (Male participant,  
24  
25 ICM, housed). Overall, it was invaluable for many participants to be able to choose when and how much  
26  
27 time they would spend with others, but this was another contributing factor to feelings of social  
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29 isolation for some participants.  
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## 35 **DISCUSSION and CONCLUSION**

36  
37 Study findings reflect that participants show considerable hope and optimism for recovery in the  
38  
39 future. This hope was manifested in key self-management strategies of goal-setting, rebuilding self-  
40  
41 esteem, and finding meaning through relationships and symbolism (e.g., the door key) [14]. Specifically,  
42  
43 participants’ perceptions of recovery are focused on hopes to regain control over their lives and a sense  
44  
45 of independence after a period of powerlessness, which would facilitate achieving self-acceptance,  
46  
47 rebuilding and developing new relationships, as well as help them to reclaim their lives in the  
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49 community. These findings regarding hope for future recovery echo results from other research in this  
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51 area [31-33].  
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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

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3 housing as key, they needed help to overcome the social isolation that resulted from their turning away  
4  
5 friends previously associated with substance use.  
6

7  
8 Study limitations include that these findings reflect point in time observations and do not explore  
9  
10 long-term impacts of housing on hopefulness and recovery trajectories among study participants.  
11  
12 However, longitudinal analysis of the data in this area is currently ongoing.  
13

14  
15 Overall, these findings contribute to existing research in this area by showing how hope, housing  
16  
17 and recovery are connected in a large sample of homeless individuals experiencing mental illness  
18  
19 participating in a Housing First RCT. Specifically, findings support that anticipated and actual housing,  
20  
21 facilitated through the mechanism of Housing First programs that provide housing and supports to this  
22  
23 population can foster hope for increased ontological security and achievement of other recovery-  
24  
25 oriented goals [28]. However, housing alone is not sufficient to foster hope and support this population  
26  
27 in moving forward in the recovery journey. In order to support the hope that is inspired by such  
28  
29 interventions, these programs need to focus on assisting clients during the adjustment period while  
30  
31 becoming newly housed to prevent and address social isolation. Furthermore, these programs should  
32  
33 explicitly integrate hope-inspiring, recovery-oriented approaches [14], such as goal-setting, finding  
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35 meaning, and implementing strategies to manage illness, build self-esteem, and (re)develop  
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37 relationships.  
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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%

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3 **Funding Statement:** This research was made possible through a financial contribution by Health Canada  
4 and funded by the Mental Health Commission of Canada. The views expressed herein solely represent  
5  
6 the authors.  
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9  
10 **Contributors:** MK and SZ drafted the manuscript. MK oversaw data collection and contributed to  
11  
12 analysis; DWH and EP conducted interviews, data analysis and drafted thematic sections. VS supervised  
13  
14 the research and critically reviewed the manuscript.  
15  
16

17 **Competing Interests:** None to declare.  
18

19 **Data Sharing Statement:** No additional data available.  
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9 ***The promise of recovery: Narratives of hope among homeless individuals with mental illness***  
10 ***participating in a Housing First randomized controlled trial ~~from participants in a Housing First~~***  
11 ***intervention in Toronto, Canada***  
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16 Maritt Kirst\*<sup>1,2</sup>, Suzanne Zerger<sup>1</sup>, Deborah Wise Harris<sup>1</sup>, Erin Plenert<sup>1</sup> & Vicky Stergiopoulos<sup>1,3</sup>

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

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## 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,

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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 ~~at one point in time and thus do not necessarily generalize across all homeless populations~~
- 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
- 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

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## 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-



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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

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9 progress has been made with homeless women and families, the “how” of inspiring hope remains  
10 elusive – especially for single, chronically homeless adults [22-24].  
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### 13 14 **The Role of Housing**

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16 The role of housing in inspiring hope and facilitating recovery has been explored with homeless  
17 populations, though it is not well-understood. ‘Housing First’ is an intervention for individuals  
18 experiencing homelessness and mental illness which places individuals into permanent independent  
19 housing first - without prerequisites for sobriety and treatment - and offers flexible access to supportive  
20 health services [25]. Research on this intervention has consistently found that placing individuals in  
21 housing first does not negatively affect ability to maintain housing, has no deleterious effects on  
22 recovery and has led to improved mental health outcomes [26, 27]. While housing creates critical  
23 stability to facilitate the recovery process, its role and importance is otherwise unclear; one qualitative  
24 study found newly housed Housing First participants only “partially attained” core elements of recovery,  
25 including hope and social connections, once housed [28].  
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34 This study contributes to this body of literature by exploring the importance of housing to hopes  
35 for recovery from the perspective of chronically homeless adults with mental illness. The study draws  
36 on data from in-depth qualitative interviews with participants from the Toronto, Ontario site of the  
37 multi-site ‘At Home/Chez Soi’ Project in Canada.  
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### 43 **METHODS**

44  
45 The ‘At Home/Chez Soi’ study is a randomized controlled trial (RCT) that evaluates the  
46 effectiveness of a ‘Housing First’ approach to improving the lives of individuals who experience both  
47 homelessness and mental illness. The project was implemented across five cities in Canada – Moncton,  
48 Montreal, Toronto, Winnipeg and Vancouver – and received federal funding for three years.  
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9 'At Home/Chez Soi' project participants in Toronto were randomized to one of two Housing First  
10 interventions based on level of mental health service need, or to a 'Treatment as Usual' arm. High needs  
11 participants (N=197) were randomized to an Assertive Community Treatment (ACT) arm or Treatment as  
12 Usual, while moderate needs participants (N=378) were randomized to an Intensive Case Management  
13 (ICM) arm or Treatment as Usual. Moderate needs participants who identified as ethnoracial and were  
14 randomized to the intervention were further provided with the option to participate in an ethnoracial-  
15 intensive case management intervention (ER-ICM; specific to the Toronto site of the project).  
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17 Participants in the Housing First interventions received a rent supplement and housing of their choice,  
18 and mental health service supports according to their level of need. Participants in the 'Treatment as  
19 Usual' arm received information materials about services available in the community but no direct  
20 services. Study participants were classified as high or moderate need using an algorithm described in  
21 Goering et al. that draws from Section 3 of the Ontario Standards for ACT teams [3].  
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31 Participants completed a series of surveys at specific time intervals to assess the effects of the  
32 housing first intervention on such outcomes as mental health, substance use, social functioning,  
33 community integration, and criminal justice system involvement. A subsample of 60 participants took  
34 part in in-depth qualitative interviews at the beginning of the study (baseline).  
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### 38 **Data Collection**

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40 Participants in the baseline qualitative interviews were selected from the larger RCT sample by sampling  
41 every 10<sup>th</sup> participant randomized to each study arm. This approach was taken to facilitate sampling  
42 across the larger RCT sample. Purposive sampling was also employed in order achieve representation  
43 across gender and ethnicity. Eighty three participants were invited to participate in the interview by the  
44 study recruitment staff, and 23 participants either declined to participate, or it was not possible to  
45 schedule an interview with them. Sixty participants agreed to participate, and  
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9 ~~ntation across the larger RCT sample. These~~ interviews were conducted with 36  
10 participants from the Intervention group (12 from the ACT intervention, 12 from the ICM and 12 from  
11 the ER-ICM intervention), and 24 from the Treatment as Usual group (12 with high needs and 12 with  
12 moderate needs). Interviews were conducted by ~~a group of~~ three research staff, including one peer  
13 researcher, with training in conducting in-depth interviews, between March 2010 and June 2011. All  
14 participants provided written, informed consent to participate, and agreed to have the interviews audio-  
15 recorded. Interviews were semi-structured, and asked questions on history of homelessness and mental  
16 health issues, daily activities, experiences with mental health and social services, and hopes for the  
17 future. Interviews were took place in a location that was convenient for the participant, typically the  
18 project office or conducted, ranged from approximately 45 minutes to 1.5 hours in length. Interview  
19 participants were also asked to complete a brief demographic form. Interview participants each received  
20 an honorarium of \$25, two transit tokens, and a resources sheet outlining health and social services in  
21 the Toronto area. The study was approved by the St. Michael's Hospital Ethics Review Board.

### 22 **Data Analysis**

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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~~ready 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, 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)*



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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

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

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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<sup>15</sup> participant described that housing contributed to improved emotional well-being and facilitated <sup>16</sup>hopes<sup>17</sup>planning<sup>18</sup> 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 <sup>29</sup>control and <sup>30</sup>freedom<sup>s</sup>.

#### *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*

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9 freedom and self-reliance—something they had not felt while they were homeless. As one participant  
10 explained:

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

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16 A number of participants who were newly housed discussed feeling more independent and self-  
17 sufficient, and generally having more control over their lives: “Now at least I can clean my house the way  
18 I want it [...] That’s important to me, I can run my house the way I want it.”

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

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

### 31 32 33 *Housing as a Precursor for Relationship Re-Building*

34 A number of participants ~~discussed~~ hoped wanting to re-establish relationships once they were  
35 in stable housing. One participant talked about how difficult it was to maintain relationships with his  
36 family while he was living on the streets:

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39 *When you’re out there, you don’t have a family. You can’t [...] Where are you going to*  
40 *receive them? Who wants a person who hasn’t taken a shower for three or four days?*  
41 *(Male participant, ER-ICM, housed)*

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

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50 Stable housing also allowed a number of participants to regain or maintain relationships with  
51 their children. One participant spoke about her sons not being able to visit her when she was living in a  
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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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9 | *have to change that thinking.” (Male participant, ACT, housed).* At times, living alone was so  
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11 | overwhelming for this participant that he considered giving up the apartment and leaving town.

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13 | Based on previous experiences with destructive relationships, several participants discussed  
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15 | being very selective about who they would invite over – if anyone at all – in order to maintain their  
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17 | current housing and limit the potential for any disturbances. As one participant said: “*A few guys pop*  
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19 | *over but there is only a select few that know where I live. I like to keep it that way.” (Male participant,*  
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21 | *ICM, housed).* Overall, it was invaluable for many participants to be able to choose when and how much  
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23 | time they would spend with others, but this was another contributing factor to feelings of social  
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25 | isolation for some participants.

## 26 27 | **DISCUSSION and CONCLUSION**

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29 | Study findings reflect that participants show considerable hope and optimism for recovery in the  
30  
31 | future. This hope was manifested in key self-management strategies of goal-setting, rebuilding self-  
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33 | esteem, and finding meaning through relationships and symbolism (e.g., the door key) [14]. Specifically,  
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35 | participants’ perceptions of recovery are focused on hopes to regain control over their lives and a sense  
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37 | of independence after a period of powerlessness, *which would facilitate achieving/achieve* self-  
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39 | acceptance, rebuild*ing* and develop*ing* new relationships, as well as *help them to* reclaim their lives in  
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41 | the community. *[31, 32] These findings regarding hope for future recovery echo results from other*  
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43 | *research in this area* [31-33].

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

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~~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 sense of ontological security which can further build and also support action on hope, a key component in the recovery process ~~others~~ [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

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

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

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