

COMMUNITY INTEGRATION FOR FORMERLY HOMELESS WOMEN

Experiences of Community Integration for Vulnerably Housed Formerly Homeless Women

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This thesis is dedicated to the women who have generously shared their experiences and spent numerous hours showing me their neighbourhoods through their eyes.

I would also like to dedicate this thesis to the strong and intelligent woman in my life, my mother, Surinder Bassi.

Abstract

Community integration is based on the premise that people with disabilities should have opportunities equal to their non-disabled counterparts (Wong & Solomon, 2002). The purpose of this research was to investigate predictors of community integration and the experiences of community integration for vulnerably housed (i.e., housing that falls below standard levels of adequacy, affordability, and suitability (Canadian Mortgage and Housing Corporation, 2008)) women with a history of homelessness. A quantitative study design used data from women participants in the *Health and Housing in Transition* (HHiT) study in Ottawa, Toronto, and Vancouver at two-time points (i.e., follow-up 2 (N = 217) and follow-up 3 (N = 208)). Furthermore, a longitudinal qualitative study (i.e., baseline (N = 16) and 6-month follow-up (N = 13)) was also conducted with female participants from the *Supportive Housing for People with Problematic Substance Use* (SHARPE) evaluation study in Ottawa. Participants were interviewed using mapping techniques, neighbourhood walk-along, and semi-structured photo-elicitation methods. Overall, the findings of the studies show that both individual and environmental factors play an important role in community integration. Together, these studies suggest that for formerly homeless women, factors that have the greatest association with community integration are feeling healthy, having social support, partaking in organized activities, receiving greater income support, feeling protected from victimization, and living in high quality apartments and neighbourhoods close to amenities. Implications of these findings for future research and for improving neighbourhood integration of tenants were also discussed.

Keywords: community integration, women, vulnerably housed, homeless, citizenship, housing first

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GENERAL INTRODUCTION

Structure and Scope of Thesis

Statement of the Problem

An estimated 235,000 Canadians experience homelessness and use emergency shelters every year (Gaetz, DeJ, Richter, & Redman, 2016). In 2014 alone, 72.4% of men compared to 27.3% of women used homeless shelters across Canada (Employment and Social Development Canada, 2016). The study however does not include Violence Against Women shelters, which would be important to include to have a complete percentage of women who are homeless. Following deinstitutionalization, the issue of homelessness has been dealt with different models of housing (Parkinson, Nelson, & Horgan, 1999). Housing models have included a custodial to a supportive housing model in the 1970s to 1990s, to supported housing in the late 1980s and early 1990s. Each shift has represented more autonomy, choice and control for residents. More recently, in the late 1990s and early 2000s, Housing First (HF) emerged, which was built on the values of supported housing (Aubry, Nelson, & Tsemberis, 2015).

Despite the emergence of these various models of housing, participation in the community among formerly homeless people has been an ongoing challenge (Aubry & Myner, 1996; Carling, 1995; Fellin, 1993; Townley, Kloos, & Wright, 2009). An understanding of why people continue to face the challenges requires first an understanding of what we mean by the term community integration. There are three dimensions of community integration, including physically participating in the community (i.e., physical integration), being involved in social interactions and receiving positive support and reciprocity from the social network (i.e., social integration), and having a sense of belonging and feeling accepted in the community (i.e., psychological integration) (Aubry & Myner, 1996; Wong & Solomon, 2002). Overall,

community integration has been examined both subjectively and objectively by researchers. To measure the subjective elements of community integration, researchers have looked at factors such as individuals' well-being (Prince & Gerber, 2005), experiences of loneliness (Granerud & Severinsson, 2006), and sense of belonging (Townley & Kloos, 2011). To measure community integration objectively, researchers have examined participants' use of their activity space (Chan, Helfrich, Hursh, Rogers, & Gopal, 2014; Townley et al., 2009), length of residency in a neighbourhood (Keene, Bader, & Ailshire, 2013), amount of social support available to participants (Wieland, Rosenstock, Kelsey, Ganguli, & Wisniewski, 2007), and the availability of community resources for participants (Metraux, Brusilovskiy, Prvu-Bettger, Wong, & Salzer, 2012). For persons with serious mental illnesses, community integration has been associated with positive mental health outcomes, such as subjective quality of life, the level of symptoms experienced, and self-esteem (Aubry & Myner, 1996; Bond et al., 2001; Prince & Gerber, 2005).

Numerous studies have looked at community integration among formerly homeless people. A closer examination of the unique experiences of community integration for women has been missing from the literature. Researchers have found that women's pathways into homelessness and their experiences during homelessness are shaped by their position in society and how society perceives gender (Baptista, 1990; Klodawsky, 2006). These experiences consequently affect how these women view society and the communities they are expected to integrate into once they become housed. Thus, to understand the recovery process for this population, which includes both a process (i.e., self-perception and psychological state) and outcome (i.e., more concrete measurable factors such as social ties), a thorough understanding of the factors that inhibit and facilitate community integration for women with a history of mental

health issues, substance abuse, and homelessness was necessary (Abdallah, Cohen, Sanchez-Almira, Reyes, Ramirez, 2009).

Overview of the Current Research

The purpose of this dissertation was to understand community integration for women who have histories of mental health issues, substance abuse, and histories of homelessness, using both quantitative and qualitative methods. The thesis is grounded in the multidimensional model of community integration which includes physical, social, and psychological integration (Aubry & Myner, 1996; Wong & Solomon, 2002).

The dissertation includes three studies. The first is a quantitative study based on self-reported data that examined individual (i.e., age, school enrollment and training program, income, physical health, mental health, substance abuse, alcohol use, and social support) and environmental (i.e., city, housing stability, and neighbourhood impact) predictors of physical, social, and psychological integration among vulnerably housed women participating in the Health and Housing in Transition (HHiT) study. The HHiT study tracked the health and housing status for homeless and vulnerably housed individuals in three Canadian cities (i.e., Ottawa, Toronto, and Vancouver). This study provides an overall understanding of what the key individual and environmental predictors of community integration are among these women.

The second study is a qualitative study that focused on women participating in a Housing First (HF) program in Ottawa, who have histories of mental and addiction problems, and homelessness. In this study, a deeper contextual understanding of participants' experiences of community integration in their day-to-day lives was sought using mapping techniques, neighbourhood walk-along, and semi-structured photo-elicitation methods. This study explored

the types of locations, activities, and amenities identified by the participants as being important in their neighbourhood. The third and final study was a follow-up study conducted six months after the first qualitative study. It explored changes in participants' perceptions of community integration. Interviews were conducted using documents produced in the baseline interviews such as neighbourhood maps and the list of amenities that participants used in the neighbourhood, as well as photos taken during the neighbourhood walk-along.

Chapter 1

Homeless Women

Individual and Structural Risk Factors

There are three common individual pathways to homelessness among women: painful childhood experiences, mental health and addiction problems, and the breakdown of interpersonal relationships. The childhood of some homeless women is characterized by physical and sexual abuse, and mental health issues, substance abusing parents, neglect, and poverty (Browne, 1993; Sundin & Baguley, 2015; Tomas & Dittmar, 1995; Torchalla, Linden, Strehlau, Neilson, & Krausz, 2014; Weinrich et al., 2016). Researchers have found that childhood abuse and parental substance abuse contribute to later chronic homelessness, sexual victimization, depression, and substance abuse problems in homeless women (Herman, Susser, Struening, & Link, 1997; Nyamathi, Longshore, Keenan, Lesser, & Leake, 2001; Stein, Leslie, & Nyamathi, 2002; Tyler, Hoyt, & Whitbeck, 2000). Exposure to traumatic childhood experiences and negative life events in the context of homelessness can cause or exacerbate mental health outcomes for homeless women (Chambers et al., 2014; Rayburn et al., 2005; Robertson & Winkleby, 1996; Strehlau, Torchalla, Li, Schuetz, & Krausz, 2012; Wong & Piliavin, 2001).

Research shows that homeless women have high rates of depression, anxiety disorders, posttraumatic stress disorder, and concurrent substance dependence (Levine & Fritz, 2016; Rayburn et al., 2005; Strehlau et al., 2012). Exiting homelessness and becoming stably housed is particularly challenging for people with substance abuse problems (Aubry, Klodawsky, & Coulombe, 2012). The breakdown of interpersonal relationships has also been commonly identified as a pathway to homelessness for women (Tessler, Rosenheck, & Gamache, 2001). Abuse or threat of violence by intimate partners have been shown to be a significant predictor of

housing instability in women (Baker, Billhardt, Warren, Rollins, & Glass, 2010; Baker, Cook, & Norris, 2003; Pavao, Alvarez, Baumrind, Induni, & Kimerling, 2007). To avoid living in the streets or staying in shelters, many women remain in abusive relationships or turn to couch surfing for extended periods of time, placing them in the 'hidden homeless' category (Gaetz et al., 2014; Tomas & Dittmar, 1995). When on the streets, some women employ survival strategies that involve criminal activities, seeking a male companion for protection, survival sex, drug use and other risky behavior that pushes them deeper into street life (Nyamathi, Leake, & Gelberg, 2000). Increased drug use and remaining in abusive relationships were strategies commonly found among homeless women with intimate partners (May, Cloke, & Johnsen, 2007; Padgett, Hawkins, Abrams, & Davis, 2006).

Along with individual risk factors, researchers have also examined structural factors, such as poverty, lack of affordable housing, and lack of employment, and their contribution among both men and women (Gaetz et al., 2014). Indigenous persons, visible minorities, and single women including those with children after divorce or relationship dissolution, are more likely to live below the poverty line in Canada (Statistics Canada, 2011). Canadian policies continue to contribute to the high poverty rate among women (Townson, 2009). In particular, factors such as income inequality contribute to women's poverty levels, where women continue to earn less than men and have low paying part-time jobs that do not include benefits (Townson, 2009). Furthermore, women are also likely the sole caretakers of children especially because child care is unavailable or unaffordable. These factors represent additional barriers to getting back in the workforce (Townson, 2009). It is commonly found that women fall into a cycle of unstable housing and stressful environments, which lead to health problems, poor quality of life and limited access to services within the community (Kidd et al. 2013b).

Both individual and structural risk factors contribute to homelessness. However, researchers do not view these factors as contributing to homelessness separately (Kloos & Shah, 2009; Nooe & Patterson, 2010). Examining homelessness through the social-ecological lens has been useful in understanding the pathway to homelessness and the complex interactions between different system levels: personal, social, and economic (Kloos & Shah, 2009; Nooe & Patterson, 2010).

Survival Strategies Used by Homeless Women

Homeless people are at a greater risk of victimization compared to the general population (Lee & Schreck, 2005; Roy et al., 2014). Research also shows that the longer a person spends on the streets, the greater the increased risk of becoming victimized (Ferguson, Bender, & Thompson, 2014; Lee & Schreck, 2005; Roy, Crocker, Nicholls, Latimer, & Ayllon, 2014). Factors such as weak connection to people, places, and institutions, health problems, traumatic events, and lifestyle-exposure (e.g., sleeping outdoors, prostitution, drug dealing) make homeless people more vulnerable to victimization (Browne, 1993; Lee & Schreck, 2005; Roy et al., 2014; Wenzel, Koegel, & Gelberg, 2000). The role of gender and the impact it has on victimization has been examined by researchers (Evans & Forsyth, 2004; Roy et al., 2014; Wenzel et al., 2000). Research shows that among homeless women, there are high rates of harassment and physical and sexual victimization (D'Ercole & Struening, 1990; Evans & Forsyth, 2004; Kushel, Evan, Perry, Roberston, & Moss, 2003; Wenzel et al., 2000). Rates of victimization, particularly robbery and physical abuse, are higher among women living on the streets than among those in shelters (Nyamathi et al., 2000). However, Nyamathi and colleagues (2000) did not find a difference for sexual assault between sheltered and unsheltered women.

Homeless women use a number of different strategies to avoid victimization (Evans & Forsyth, 2004; Huey & Berndt, 2008; Maher, Dunlap, Johnson, & Hamid, 1996; Watson, 2016). Huey and Berndt (2008) described four strategies or gender performances that homeless women use to prevent victimization in a “masculine space”. The first is the femininity simulacrum, where the individual acts out in more stereotypically feminine ways. This includes passivity, emotionalism, tenderness, and flirtatiousness. Such behavior induces sympathy and courtesy for females and for some women it is a way to attract males who would protect them. The second is the masculinity simulacrum, which includes aggressiveness, mental and physical toughness, emotionlessness and fearlessness. Women apply this behavior in their speech, behavior and their appearance. The third strategy is genderlessness where the female avoids attention from others by wearing loose fitting clothes and by isolating themselves from others. The fourth strategy is the passing whereby heterosexual females describe themselves as lesbians when approached by men. The researchers found that this strategy often occurred in combination with the masculine simulacrum or genderlessness. The researchers also noted that the passing strategy can endanger women due to the streets generally being a masculine space with hetero-normative rules (Huey and Berndt, 2008).

Another strategy used by homeless women includes forming intimate relationships (Evans & Forsyth, 2004; Levine & Fritz, 2016; Maher et al., 1996; Watson, 2016). Watson (2016) refers to these relationships with men as a bodily alliance so that women have access to physical protection in an environment that is hostile to the female body. The researcher attributed women’s decision to exchange sex for physical protection as stemming from society’s neoliberal views and the structural disadvantages of homelessness that force women to take responsibility for protecting themselves on their own. Watson (2016) found that the physical and emotional

abuse against women were often present even within these intimate relationships, however, with the potential physical and sexual dangers of homelessness and absence of structural support, women viewed these intimate relationships as a solution for protection.

Maher and colleagues (1996) also found that homeless women with substance abuse problems exchanged drugs, sex, cash, or services as a “solution” to finding stable housing. In their study, a majority of the women preferred to stay in households with an older male who had a stable income, rather than live in shelters. Women in the study described their experiences in these households as being sexually degrading; however, they saw this housing arrangement as putting them in a less vulnerable state with regard to being robbed and/or violently victimized (Maher et al., 1996).

In addition to forming intimate relationships to avoid victimization, homeless women also have to strategically navigate the homeless space, keeping in mind their visibility, particularly in areas where homeless services are provided (May et al., 2007). Drawing on May et al.’s (2007) study, homeless women’s experiences with their space can be placed into one of four categories: 1) women who separated themselves from the homeless identity and space where the homeless congregated, 2) women who existed in the space for the homeless, but were not visibly present because they spent little time in these services or stayed hidden from services that were predominately used by men or they sought out male companions for protection, 3) women who identified with being homeless and were visibly homeless by playing different roles as a female and as a homeless person at different times of the day and night, and 4) homeless women who were prostitutes. These women experience the stigma that is associated with prostitution from both the public and other homeless people. The threat of male violence is common among

homeless women, and it directs homeless women's level of visibility and how homeless women use their space.

This review highlighted different strategies homeless women use to avoid being victimized. The strategies women use is a demonstration of what Watson (2016) describes as the value attached to a homeless women's body and unequal power relations between men and women in a homeless space. The researcher argues that for homeless women, there is a diminished value associated with their bodies as there is a potential for it being victimized. The male body, on the other hand, is seen as valuable with its masculinity, physical strength and social power in that same space (Watson, 2016).

Chapter 2

Housing Models and Community Integration

Definition of Housing Models

Between 1960 and 1999 deinstitutionalization led to a change in the way people received psychiatric services (Sealy & Whitehead, 2004). Through deinstitutionalization, there was a shift from depending on psychiatric hospitals to provide treatment, to the provision of care and support in community facilities. This shift was accompanied by an increase in the number of beds in general hospitals for mental health patients, also referred to as “transinstitutionalization”, and an increase in community-based services for people with mental illness (Sealy & Whitehead, 2004).

As deinstitutionalization progressed, there was also a shift in the approach taken to house people with serious mental illness. Service providers adopted different housing approaches and were guided by changing values and assumptions. In this section, I will discuss the evolution of the three housing approaches (i.e., custodial, supportive, and supported) and how the Housing First (HF) approach has emerged as a favoured housing approach by some service providers and mental health consumers.

During the early deinstitutionalization period, custodial housing was the dominant approach to housing. Custodial housing included boarding houses, nursing homes or special care homes (Trainor, Morrell-Bellai, Ballantyne, & Boydell, 1993). Rather than focusing on rehabilitation, custodial housing had an approach similar to that found in psychiatric institutions (Nelson, 2010; Trainor et al., 1993). Service providers focused on care services (i.e., medication and meals) and residents were not expected to have an active role in their housing (Nelson, 2010; Trainor et al., 1993).

A shift to supportive housing brought a focus on rehabilitation. In the late 1970s and 1980s, it became evident to service providers that housing for mental health consumers needed to provide community rehabilitation programs that focused on life-skill development (Sylvestre, Nelson, Sabloff, & Peddle, 2007). In response, mental health professionals developed supportive housing, which combined housing and support within a single setting (e.g., group homes or supervised apartments) (Nelson, Aubry, & Hutchison, 2009). Initially, the supportive housing approach was based on a linear continuum where clients “graduated” to different types of housing (i.e., from restrictive custodial housing to less restrictive supported housing) as their level of functioning improved (Ridgway & Zipple, 1990). The continuum model, however, was not created in all communities and residents found it difficult to move away from supportive relationships and housing that had become their home (Ridgway & Zipple, 1990). For individuals moving to the end of the continuum, which was independent housing, financial and rehabilitation support was not available (Nelson, 2010). Today, the supportive housing approach remains, but there has been a shift to the supported housing model, which has led to a change in the mental health system (Nelson, 2010).

The supported housing approach reflects a shift in power between the service provider and recipient (Nelson, 2010). There has also been a change in values in providing housing for consumers of mental health services (Nelson, 2010). These changes have occurred at the individual, relational, organizational, community, and societal levels (Carling, 1995). Within the supported housing approach, at the individual level consumers of mental health services are not seen as patients, but instead viewed as tenants with rights (Carling, 1995). At the relational level, residents are not living in specialized housing and are expected to create a network of support outside of their house. Furthermore, according to the supported housing model, the support

provided is tailored to each individual's needs (Dorvil, Morin, Beaulieu, & Robert, 2005). Unlike earlier models where housing and treatment were linked, a transformation at the organizational level has occurred in the supported housing model with the housing management services and mental health services operating independently of one another (Wong & Solomon, 2002). At the community level, people are housed in normal housing settings in the community. Additionally, with the supported housing model, there is focus on integration into the community as citizens. With the supported model approach, change has also occurred at a societal level. Rent supplements are provided to consumers so that people have equal access to housing within a community (Nelson, 2010). The supported housing approach has reflected a shift in fundamental assumptions away from the expectation that consumers progress linearly towards improvement. With this shift in values and power, a transformation has occurred at the individual, relational, organizational, community, and societal level.

The Housing First (HF) approach incorporates the values and practices of the supported housing model, but is focused on housing people who have been chronically homeless. The program, Pathways to Housing in New York City, was the first to use the HF model in practice (Tsemberis & Eisenberg, 2000). The shift in power from the perspective of the resident is evident within this approach (Tsemberis & Eisenberg, 2000). Unlike other housing models, treatment and sobriety are not mandatory before receiving housing, and tenants are provided with housing in the regular private rental market (Aubry et al., 2015a). Additionally, tenants are provided with rental subsidies, furniture, and support services either through Assertive Community Treatment (ACT) or Intensive Case Management (ICM) (Aubry et al., 2015a). Overall, the HF model includes four central elements: 1) consumer choice, where after choosing the location of their apartment, consumers decide on which goals they would like to set for themselves, 2) separation

of housing and treatment, whereby, participants' status of getting and keeping their housing remains irrespective of their treatment status, 3) recovery orientation, which is based on the principle that consumers make their own decision on treatment goals, and 4) community integration, which is promoted by renting normal apartments and through program staff supporting social connections (Tsemberis, 2010).

Overall, research has shown that HF recipients have greater improvements in housing outcomes, such as exiting homelessness and remaining stably housed compared to people receiving standard care (Aubry, et al., 2015a; Aubry, Ecker, Jetté, 2014; Gulcur, Stefancic, Shinn, Tsemberis, & Fisher, 2003; Padgett, Gulcur, & Tsemberis, 2006; Tsemberis, Gulcur, & Nakae, 2004). Aubry and colleagues' (2015a) study showed that participants living in HF had lower levels of negative life experiences, which included negative social contacts, social isolation, and continued substance use. Although previous research on HF has shown superior outcomes, a notable limitation, particularly found in qualitative studies, is that HF consumers often experience feelings of social isolation and loneliness (Macnaughton et al., 2016; Polvere, Macnaughton, & Piat, 2013). Along with losing touch with their old social networks after receiving housing (Aubry et al., 2015a), it is also argued that HF can have a "warehousing" effect for the sake of producing a "façade of normalcy", which intensifies isolation and exclusion (Klodawsky, 2009).

Since deinstitutionalization, the state of housing for individuals with mental health problems and addictions has been one of trial and error. Currently, the HF model has gained the most attention among service providers. The model has not only shifted away from the traditional linear treatment programs, but it has also been the only model that has included community integration as a fundamental element. A closer examination of the role of the HF model and

community integration among women residents was examined in the qualitative studies two and three.

Defining Community and Neighbourhood

The terms community and neighbourhood are often used interchangeably (Jenks & Dempsey, 2007). A key difference, however, is that a community is not geographically bounded, whereas neighbourhood refers to a more geographically bounded area. Neighbourhood boundaries are defined subjectively by factors such as social connections, public facilities (e.g., schools, community centres), and physical barriers (e.g., highways, rivers) (Chaskin, 1997). Additionally, individual characteristics such as gender, age, ethnicity, family circumstances, and socioeconomic status also play an important role in neighbouring behaviour. Communities, on the other hand, can be organized into four sets of connections where people have shared beliefs: 1) social connections such as those within social networks, 2) functional connections, where there is a production, consumption, and transfer of goods and services, 3) cultural connections such as ethnic identity, and 4) circumstantial connections, such as economic status or lifestyle (Chaskin, 1997).

For this thesis, we will not use predefined neighbourhood boundaries; instead participants' neighbourhood will be defined as the surrounding walkable distance from the participants' residence, where they engage in daily activities.

Defining Community Integration

Using the principle of normalization and then later the social role valorization theory, Wolfensberger's (1972) theoretical work on community integration for people with developmental disabilities was one of the first and most influential. The principle of

normalization states that through culturally normative means one establishes and maintains culturally normative behaviours and characteristics (Wolfensberger, 1972). Social role valorization has evolved from the principle of normalization, and the primary goal of social role valorization is to create valued social roles for individuals who have been marginalized (e.g., mental health consumers and those with developmental disabilities) (Aubry, Flynn, Virley, & Neri, 2013; Nelson & Macleod, 2017). Using these guiding principles, Wolfensberger (1972) defined two elements of integration: physical and social integration.

According to Wolfensberger (1998), physical integration refers to being physically present in normal settings, activities and contexts (Segal, Baumohl, & Moyles, 1980). Physical integration does not mean interacting with others in these settings, it is physically being present in a “normal” setting. Although physical integration has been seen as a prerequisite for community integration, it is social integration that is seen as fundamentally more important (Flynn & Aubry, 1999).

According to Wolfensberger (1998), integration occurs when an individual, devalued in society, has valued social participation “in a culturally normative quantity of contacts, interactions, relationships, and roles with ordinary and valued citizens, in valued (or at least normative) activities, and in valued (or at least ordinary) physical and social settings” (p. 58). In other words, community integration does not include programs that are offered by mental health professionals, which may divert people away from “regular” community life (Bond, Salyers, Rollins, Rapp, Zipple, 2004). It is social integration, not just being physically present in a community, that determines if a meaningful level of community integration has been successfully achieved for an individual (Flynn & Aubry, 1999).

The concept of community integration was initially applied to people with developmental disabilities, although over time within the field of community psychology the concept was also applied to people who are homeless (Nemiroff, Aubry & Klodawsky, 2010). Aubry and Myner (1996) were the first to use a multidimensional concept of community integration by broadening the definition of community integration to include a third type of integration: psychological integration (Aubry & Myner, 1996). Both social and physical integration primarily focus on an individual's physical presence within a community and on activities that are initiated by the individual alone such as going to the movies or going shopping (Aubry & Myner, 1996). What was missing was how people think, experience, or feel about their involvement in the community. Therefore, Aubry and Myner (1996) used the definition of sense of community, which includes four domains: 1) membership, 2) influence, 3) integration and fulfilment of needs, and 4) shared emotional connection (McMillan & Chavis, 1986).

Using the work of previous researchers, Wong and Solomon (2002) updated the definition of community integration for supported housing. Physical integration refers to the amount of time spent, the activities one participates in, and the use of goods and services of the individual's choosing in the community outside of the home or facility (Segal & Everett-Dille, 1980). Social integration includes both an interactional and social network dimension. The interactional dimension refers to engaging in social interactions with community members that are not only culturally normative, but that also occur in normative contexts (Wolfensberger & Thomas, 1983). For the social network dimension, the social network's size and the type of support and reciprocity of the support were included in the definition (Fellin, 1993; Storey, 1993). Finally, psychological integration has been defined by three elements: 1) a person's sense of community, that is defined by whether they see themselves as having membership in their community, 2)

person's emotional connection to the people living in the neighbourhood, and 3) whether the person has their needs met through their community, while being involved in their community (Aubry & Myner, 1996; McMillan & Chavis, 1986).

Based on Moos and colleagues' (Moos, 1997; Moos & Lemke, 1996) conceptual framework that recognized the impact of personal and environmental factors on residential treatment programs, Wong and Solomon (2002) proposed four factors that influence community integration within supported housing. These factors included: 1) the housing environment, which refers to the physical and social characteristics of the housing and immediate neighbourhood, 2) the behavioural environment that includes the policy and operational characteristics of the residential program, 3) the support environment, which refers to the staff-resident relationship, and 4) personal factors, which includes the sociodemographic attributes, clinical characteristics, physical health status, level of functioning, chronicity and severity of psychiatric symptoms, housing preference, length of stay and living arrangement.

Ware, Hopper, Tugenberg, Dickey, and Fisher (2007) developed a theory of social integration using the capabilities approach as a conceptual framework. This framework is based on the premise that a person's functioning is not just dependent on the individual, but also the social environment and opportunities that surround the person (Sen, 1999). The researchers found social integration to be a process, where people experience both connectedness and citizenship over time. Connectedness, which is similar to Wong and Solomon's (2002) definition, includes reciprocal relationships, where social (i.e., effective communication skills), moral (i.e., trust), and emotional competencies (i.e., empathy and capacity for commitment) are necessary. Feeling part of and having things in common with the larger group is also part of connectedness (Ware et al.,

2007). Citizenship refers to individuals with psychiatric disabilities having the same rights and opportunities that are available to the rest of society (Ware et al., 2007).

Over time, researchers have redefined and expanded the concept of community integration. However, a component that has remained the same in the definition is the importance of inclusion of individuals with psychiatric disabilities. This thesis will be grounded in the multidimensional model of community integration (i.e., physical, social, and psychological integration), proposed by Aubry and Myner (1996) and Wong and Solomon (2002).

Review of Literature on Community Integration

In the following section, a discussion of the research with the greatest impact on the topic of community integration will be examined. Research shows that housing type can facilitate or limit community integration (Yanos, Felton, Tsemberis, & Frye, 2007; Yanos, Barrow, & Tsemberis, 2004); therefore, the studies in this section will be organized according to the study sample's place of residence and if a control group was included in the design. The search strategy involved the use of electronic social sciences and health databases. Both Canadian and American literature were the primary target of the search.

Residential care settings. Trute and Segal (1976) used California and Saskatchewan census tract data to examine the influence of social-environmental factors on levels of social integration. A total of 4,648 people in California and 916 people in Saskatchewan were examined in sheltered care facilities (i.e., family-care homes, half-way houses, and board-and-care homes). After controlling for pathology and education level, participants in Saskatchewan scored higher on social integration levels than California participants. Compared to California participants, participants in Saskatchewan had greater access to goods and services, had more consumption of

goods and services, and spent more time with family and friends, which exposed them to more social activities in their communities. The researchers also reasoned that participants in Saskatchewan were possibly living in “supportive communities” that were more accepting of people with mental health issues.

Segal and Aviram (1978) examined the Californian participants further in a groundbreaking study looking at the influences of individual characteristics and the social environment on social integration for hospitalized patients in sheltered-care facilities. The researchers interviewed 499 sheltered-care residents with a history of psychiatric hospitalization and 234 operators within these facilities. In their study, the researchers examined external integration, which was defined by the amount of time participants spent taking part in community activities and also consuming goods and services in their community independently from participants’ facility (i.e., physical integration) (Segal & Aviram, 1978). Segal and Aviram (1978) identified individual, community, and residential characteristics, as factors that facilitated or hindered social integration.

The researchers found that participants’ level of external integration was reduced if they were psychologically distressed, did not have sufficient spending money and financial control, were socially isolated, and if residents had not chosen their housing. The researchers also found that participants had greater external integration when they received positive response such as being invited to other residents’ homes in the shelter-care facility; however external integration was reduced when complaints were made to authorities about the facility (Segal & Aviram, 1978). Furthermore, participants residing in rural neighbourhoods had less external integration than urban dwellers because they were dependent on transportation when accessing communities. The researchers also found that the closer participants lived near resources and services (e.g.,

community resources and medical and social services) the higher their level of social integration (Segal & Aviram, 1978).

To understand external integration even further, Segal and Everett-Dille (1980) went on to examine the predictors most significant for social integration among the 499 men and women participants who were living in sheltered-care residents in California. The researchers found that female residents in shelters were less likely than male residents to be externally integrated. Women's integration was also more dependent on community characteristics. Specifically, the strongest predictor of external integration for women was having neighbours that initiated contact with participants and the presence of other shelters within the community.

Using the same 499 California sheltered-care residents, Segal, Baumohl, and Moyles (1980) examined neighbourhood characteristics and the communities' reaction to the sheltered-care facilities. The researchers found that liberal non-traditional neighbourhoods, which were characterized as being racially diverse, with low income, greater proportion of renters, and high crime rates, were the most accepting and promoted the highest level of external integration for people with mental health problems. The conservative middle-class neighbourhood, on the other hand, was not conducive to greater external integration levels. This neighbourhood was described as being predominately white, high income, and with a greater proportion of family households (Segal et al., 1980).

Kruzich's (1985) study also examined environmental factors that influenced social integration for clients living in residential facilities (i.e., nursing and intermediate care facilities, freestanding immediate care facilities, and congregate care facilities) in Washington State. The researchers found that city size such as cities with populations from 10,000 to 100,000 was the strongest predictor of social integration. Furthermore, living in residential care facilities where

residents received social skills training and staff recognized the individuality of residents, was also positively related to social integration.

The challenges and facilitators of transitioning into the community from psychiatric hospital care were examined in Manuel, Hinterland, Conover, and Herman's (2012) study. The researchers conducted three focus groups with 25 female participants with serious mental illnesses. The participants had transitioned from psychiatric hospital care to the community in New York City and they described barriers to transitioning into the community and community integration, including concerns about 1) psychiatric stability and sobriety in a community setting without having access to staff and a structured environment, 2) loneliness and isolation and not being able to make friends, 3) safety and the worry of being physically assaulted in their new neighbourhoods, 4) being stigmatized about their mental illness in their new neighbourhoods, and 5) financial stability to pay for basic needs such as food and housing.

Participants also described three facilitators of transition and community integration, which included: 1) visiting and becoming oriented about resources in their neighbourhood prior to transitioning to lessen concerns about safety, 2) having access to support for their treatment and with meeting their needs in their neighbourhoods, while maintaining their independence, and 3) reconnecting with family and friends to facilitate community integration (Manuel et al., 2012). The researchers pointed out that although the perspectives of men who were also transitioning from psychiatric hospital to the community were not presented in the study, previous research by Scheyett and McCarthy (2006) point to similarities between men and women for similar basic needs and mental health services.

Comparisons of different housing types. As the shift in the approach taken to house people with serious mental illness progressed, researchers also examined community integration

outcomes for different housing models. Nelson, Hall, Squire, and Walsh-Bowers (1992) interviewed 66 participants in southwestern Ontario living in three different housing types: 1) group homes (i.e., housing type with structured support and more “home-like”), 2) supportive apartments (i.e., housing type with support that is more needs based and facilitates independent living), and 3) board-and-care homes (i.e., housing type with mandate to provide accommodation and meals). The researchers found that residents living in group homes and supportive apartments had higher levels of community integration than those living in board-and-care homes. Additionally, participants living in supportive apartments and group homes also presented greater independence and self-empowerment. Although the findings of this research showed better outcomes for supportive apartments and group homes than board-and-care homes, the researchers pointed out that the small sample size limits conclusions on the effectiveness of different housing programs (Nelson et al., 1992).

In a qualitative study, Yanos, et al. (2004) interviewed 80 participants living in independent apartments and staffed settings such as group homes, transitional housing, and single-room occupancy in New York City. The researchers found that participants with long periods of homelessness had improvements in community integration once they were housed. Overall, participants in both independent apartments and staffed settings were pleased with being housed and described feeling “normal”. Participants also described having an improved sense of safety and feeling like they fit into their communities. Factors such as a match between ethnic/racial makeup of the individual and neighbourhood, a match between the individuals’ and neighbourhoods’ values, and whether the individual felt accepted by the neighbourhood were important variables for fitting in the community (Yanos et al. 2004).

The relationship between neighbourhood characteristics and community integration was also explored by Yanos et al. (2007). In their study, participants living in independent apartments with off-site services and congregate settings (i.e., community residences and single room occupancy hotels with or without on-site staff) were interviewed in New York City. The researchers did not find any relationship between housing type and community integration outcomes. However, neighbourhood cohesion was strongly associated with community integration outcomes such as perceived choice, sense of community, and sense of “fitting in”. The study also showed that the proportion of foreign-born individuals in the neighbourhood was negatively associated with sense of community. Participants with greater activity oriented toward their buildings, neighbourhood or job had a higher sense of community and better sense of “fitting in”, suggesting that housing type such as independent apartments would give participants more opportunity to exercise their choice in how they would like to spend their time. The researchers pointed out that participants living in congregate housing had a greater sense of fellowship, however, were limited on the activities they can pursue on their own in and outside the program. Participants living in independent apartments also showed higher social functioning and a greater sense of choice (i.e., choices in areas such as who can visit them, what kind of meals to eat, and how they spend their time) than those living in congregate housing.

In an innovative study investigating contexts and factors that encourage or hinder community integration, Townley et al. (2009) interviewed 40 adults with serious mental illness living in the southeastern United States. Of the 40 participants in the study, 21 lived in supported housing, and 19 lived in non-supported housing (i.e., not with a guardian or in housing with on-site staff support). Using mixed methods, which included participatory mapping and Geographic Information Systems (GIS), the researchers were able to analyze the areas people moved in or

travelled daily. The researchers found that for the majority of the participants their home was the most important location, where they spent most of their time, and where they had the greatest sense of belonging. Seventeen of the participants chose locations other than their home, showing larger activity space for these participants. The researchers interpreted these findings as suggesting that participants with smaller activity spaces had a greater sense of community in their neighbourhoods, while feelings of disconnection may be experienced by those who moved beyond their residence and living space.

Supportive and supported housing without a control group. A control group was not included in several studies examining community integration, which focused exclusively on supportive and supported housing. One of these was a study by Kennedy (1989), which examined community integration for 159 residents living in supervised community residences (N = 59), supportive apartments (N = 82), and single room occupancy hotels (N = 18) in New York City. The different housing types were collapsed for the analysis. The researchers found that for participants with high level of social competence or emotional support, more participation in the community was associated with greater sense of well-being. Whereas for participants with less social competence or emotional support, participating more in the community was not associated with an increase in their sense of well-being. The researchers explained that community integration might not be the goal for all mental health consumers and that community integration should be seen on a continuum, where for some people less is more desirable.

Examining specifically supported housing, a qualitative study done in southwestern Ontario by Walker and Seasons (2002a), looked at housing experiences among 31 participants. Regarding community integration, participants living in low-income housing expressed a desire to not associate with people with serious mental illness living in their building. Participants also

felt that they could not relate to others in the building especially with life goals and felt discriminated against because they were living in housing that was dedicated to mental health consumers. Furthermore, because of their desire for privacy, participants experienced loneliness, which is often a criticism of supported housing (Walker & Seasons, 2002a).

Townley and Kloos (2011) examined psychological sense of community for 402 residents of supported housing in South Carolina. The researchers looked at variables such as neighbourhood experiences (i.e., neighbourhood relations, neighbourhood safety, and neighbourhood satisfaction) and factors often experienced by individuals with serious mental illness (i.e., being diagnosed, housing type, and neighbourhood's acceptance of mental illness). Findings of the study showed that neighbourhood experiences accounted for a significant variability in sense of community ($F(3, 399) = 44.21, P < 0.001$). Neighbourhood relations accounted for the largest amount of variance in the model (13.2%). Factors relevant to people with serious mental illnesses also significantly explained variability in sense of community ($F(3, 399) = 24.45, P < 0.001$). Neighbourhood tolerance for mental illness (9.1%) and housing type (6.2%) also accounted for a small amount of variance. For housing type, participants living in congregate housing reported having a greater sense of community than participants in non-congregate housing.

Tsai and Rosenheck's (2012) study examined whether supported housing leads to social integration in 550 adults in 11 communities in the United States. Participants were interviewed over a year at three-time points after receiving supported housing. Social integration was defined by six domains: 1) the number of nights participants spent in their own home, 2) the average number of hours participants worked weekly, 3) the number of people participants counted on for social support, 4) the number of community activities participants took part in the past 2 weeks,

5) whether participants have taken part in civic activities such as voting in a local election, and 6) the role of religion in participants life including attending religious services. Unlike Burns and Patrick's (2007) findings, the researchers for this study found that social integration was weakly associated with life satisfaction. Additionally, social integration was independent of clinical symptoms, which means that participants' clinical symptoms did not affect social integration levels.

Townley, Miller, and Kloos' (2013) study examined community support, also termed distal support, among 300 participants with psychiatric disabilities living in independent housing in the southeastern United States. Distal support is defined as casual and routine interactions with people in the community (Wieland et al., 2007). The researchers categorized distal support into social support categories of 1) tangible support, 2) emotional support, and 3) informational support (Barrera & Ainlay, 1983). The researchers found that pharmacies were reported as the common distal support among participants (58%). Participants described receiving tangible support (e.g. money loan, transportation, free food, free medication) rather than emotional (e.g., warmth/affection) or informational support (e.g., advice) from distal support systems. The researchers also found that women and older participants reported having more distal support than men or younger participants. When examining predictors of community integration, the researchers found that distal support accounted for 3.1% of the variance in community integration ($F(1, 293) = 10.85, p < .01$).

More recently, Coltman et al. (2015) examined community integration in the day-to-day life of 14 participants in the Housing First (HF) program in Canada's At Home/Chez Soi project in Toronto. Participants discussed being involved in different activities that were of interest and available to them; however, taking part in these activities did not always link to positive

experiences of community integration. Some participants continued to feel bored and lonely even when they were involved in these activities. Participants also discussed community integration through their involvement in their communities. Their involvement in their communities included places they go for support such as drop-in-centres and places where they shared similar identities and experiences with other people. Participants' housing also connected them to their surroundings, including people living close to them. Although participants were happy with their housing, they did not like the neighbourhoods they lived in because violence and drugs were common in their neighbourhoods. The researchers concluded that because participants' past experiences still impacted their present-day lives, they approached community integration in their own way and that integration was a complicated and non-linear process.

Another important factor associated with community integration is community participation (Chang, Helfrich, Coster, & Rogers, 2015; Patterson, Moniruzzaman, & Somers, 2014). Using longitudinal qualitative design, Kidd and colleagues (2016) examined community participation in 30 people with schizophrenia living in supported housing in Toronto. Participants discussed a range of different spaces in their community where they felt welcomed, some of these included places where participants engaged with people similar to themselves (e.g., along ethnic, mental illness identity lines). Factors that had an influence on community participation included living with a mental illness, victimization, poverty, discrimination and social marginalization. Poverty and victimization were especially influential as were participants' financial circumstances, which forced participants to stay in their buildings and restricted them from using resources. Past traumatic experiences of victimization also shaped participants' use of space and particularly for women restricted their travel especially during the night.

Supportive and supported housing with a control group (i.e., community members or treatment as usual (TAU)). There are several such studies examining community integration outcomes in supportive and supported housing and how they compare to community residents and participants receiving treatment as usual. Aubry and Myner's (1996) study examined community integration and quality of life among 51 people with psychiatric disabilities living in community mental health housing programs (i.e., board and care residence and housing programs that offered support and rehabilitation services) in the Ottawa-Carleton area. Fifty-one community residents were matched with the sample on the variables sex and the location of residence. Psychiatric patients reported levels of physical and psychological integration that were comparable to community residents. After controlling for physical integration, community residents had higher levels of social integration than persons with psychiatric disabilities. A closer examination of the results showed that community residents reported infrequent social contact with their neighbours, whereas psychiatric patients described "never" and "rarely" having contact with their neighbours. The researchers were surprised to find that although both groups differed on their level of social integration, psychological integration levels were the same for both groups. The authors interpreted these findings as suggesting that both psychiatric patients and community residents had similar attachments to their place of residence and neighbourhoods. For psychiatric patients living in congregate housing, there was an attachment to other residents, while community residents were attached to their neighbourhoods because of their neighbours.

In another study, Gulcur, Tsemberis, Stefancic, and Greenwood (2007) examined the dimensions and predictors of community integration among 183 participants in New York City. Eighty-two of the participants were in the Housing First program, and 101 of the participants were in the control group (i.e., participants living in drop-in centres, single-room-occupancy, and

institutions). The researchers found that consumer choice, such as where participants lived or how they spent their day in independent scatter-site housing, were predictors of psychological and social integration. Participants with greater psychiatric symptoms also had lower levels of psychological integration, however higher baseline symptomology was associated with greater integration along the social and self-actualization dimensions. Participants in substance use treatment services had greater physical integration, but lower social integration. The researchers reasoned that participants in treatment programs were taking part in more formal organizations, which limited their socialization within their communities and neighbourhoods.

Abdallah et al. (2009) interviewed 198 persons with schizophrenia and 113 community residents in New York. Using Wong and Solomon's (2002) conceptual framework, the researchers developed a 12-item integration scale with four components: 1) independence, 2) psychological integration, 3) physical integration, and 4) social integration. Personal and environmental factors related to community integration were also examined using Moos' (1997) ecosystem model. The overall ecosystem model explained 49% of the variance for community integration. The researchers found that older adults with schizophrenia had lower rates of community integration than similarly aged peers in the community. Furthermore, female participants and participants with higher personal income had better community integration levels. Lower levels of positive or negative symptoms and lower levels of depressive symptoms were also associated with greater community integration levels. Participants' level of community integration was also lessened when participants had abnormal body movements; however, surprisingly, the researchers found that participants with a history of alcohol problems had better levels of community integration.

Specifically looking at psychological integration, Yanos, Stefancic, and Tsemberis (2011) interviewed 60 mental health consumers living in scatter-site apartments and 63 general community residents in New York. The results indicated that for mental health consumers both demographic variables and symptoms were not associated with participants' sense of community, however, both objective and subjective neighbourhood characteristics especially neighbourhood quality was the strongest predictor for sense of community. Additionally, for the mental health consumers, immigrant concentration was positively associated with psychological community integration. Among the community sample group, age and symptom severity predicted sense of community, however objective neighbourhood characteristics were not related to sense of community. Similar to mental health consumers, subjective neighbourhood characteristics were also strongly related to sense of community for the community sample group. The researchers felt it was noteworthy that mental health consumers had comparable levels of psychological integration and life satisfaction as their community counterparts.

Using the same sample, Yanos, Stefancic, and Tsemberis (2012) further examined physical and social integration and citizenship among the two groups. When comparing the two samples, the researchers found that mental health consumers had lower mean scores for physical integration, social integration, and citizenship activities. Among mental health consumers being African-American was associated with higher physical integration scores. Higher levels of education and longer length of residency were associated with higher social integration scores. Counterintuitively for the mental health consumer group, having more psychiatric symptoms was associated with higher social integration scores. For the community sample, none of the same demographic or psychiatric variables was significantly associated with community integration. Similar to their 2011 findings, Yanos et al. (2012) established that mental health consumers

living in supported housing were able to achieve similar community integration outcomes as community members and that symptoms were not a significant factor impacting integration levels.

In the Vancouver At Home Study, Patterson et al. (2014) study examined community integration among participants in Housing First (HF) (i.e., independent apartments or congregate residence) with support services (i.e., Assertive Community Treatment (ACT) or Intensive Case Management (ICM)) and participants in the treatment as usual groups in Vancouver, British Columbia. Participants were categorized according to level of need (i.e., high need and moderate need). Community integration was examined at 6-months (n = 457) and 12 months (n = 444) after being assigned to a group. Overall, the researchers found that participants in the HF group reported moderate levels of physical and psychological integration. Psychological integration scores were higher in the moderate need participants who were in the HF group and had received Intensive Case Management than participants in the moderate need treatment as usual group. Furthermore, compared to the treatment as usual group, participants in independent housing in the HF group agreed with the emotional components of community integration, such as feeling at home and belonging where they lived, however participants living in congregate housing in the HF group knew their neighbours, but did not interact with their neighbours or agreed with the emotional component of community.

Similarly, in another At Home/Chez Soi study, Stergiopoulos and colleagues (2015) examined housing stability and quality of life for homeless adults with mental illnesses in 4 Canadian cities (i.e., Vancouver, Winnipeg, Toronto, and Montreal). Participants were assigned to either the scattered-site supportive housing with Intensive Case Management (ICM) services group (n = 689) or the treatment as usual group (n = 509). For both physical and psychological

integration, the mean change from baseline did not differ significantly between the intervention and treatment as usual group at 24-month follow-up.

More recently, in a qualitative study for the At Home/Chez Soi project, Macnaughton and colleagues (2016) examined the recovery process in 119 participants in the HF program and 76 participants in the treatment as usual group across five Canadian cities (i.e., Vancouver, Winnipeg, Toronto, Montreal, and Moncton). Overall, participants in the HF group reported having an increased sense of community and a greater sense of belonging. For some participants, being in their own home also increased their sense of citizenship and led them to take part in more activities in their community. In the study, a small number of participants reported challenges with social connection and community integration. The researchers described participants going through three transitions in their recovery: 1) the transition from street to home, 2) the transition from home to community, and 3) the transition from the present state to where they would like to be in the future.

In another study Aubry and colleagues (2016) studied the effectiveness of HF with assertive community treatment (ACT). The study was conducted in five Canadian cities (i.e., Vancouver, Winnipeg, Toronto, Montreal, and Moncton). Participants were either assigned to receive HF with ACT (n = 469) or treatment as usual (n = 481). The researchers found that for both HF with ACT and treatment as usual groups, there were no significant changes in physical integration, however, both groups did show a significant increase in psychological integration.

Summary of Community Integration Research

The experience of community integration for mental health consumers has been well documented in the literature. Changes in housing models for this population came with the

assumption that the experiences of community integration would be different for each type of housing. Although our literature review found studies that support this claim (Nelson et al., 1992; Patterson et al., 2014; Yanos et al., 2007, 2004), it is worth noting that from our review, housing alone does not predict community integration and there are other determinants that may be equally important. Some of these determinants included having lower psychiatric symptoms (Abdallah et al., 2009; Gulcur et al., 2007), being financially stable (Abdallah et al., 2009; Kidd et al., 2016), having support from family, friends and neighbours (Kennedy, 1989; Trute and Segal, 1976; Townley et al., 2013), and living in safe neighbourhoods (Coltman et al., 2015; Kidd et al., 2016; Nikkonen, 1996). Our review supports using Wong and Solomon's (2002) multidimensional conceptual framework where both individual and environmental factors are used to understand community integration. The application of the multidimensional conceptual framework for our study will be discussed in the next section.

Although a significant effort was made to have a comprehensive review of community integration literature, there are some gaps in the review especially related to how women cope with integrating in their communities after leaving homelessness. This oversight has been historically present in the literature, which has often included women's experiences of homelessness within the category of the "undifferentiated he" (Huey & Berndt, 2008). One of the reasons for this oversight has been that unlike their male counterparts, women are less likely to be visibly homeless, which complicates the monitoring of their progression out of homelessness in an already fragmented system of services (Baptista, 1990; Bukowski & Buetow, 2011, May et al., 2007). Thus, the purpose of this thesis is to explore the nature of women's experiences of community integration as expressed through their own words and activities in their neighbourhoods.

Chapter 3: Study One

Individual and Environmental Predictors of Community Integration Among Vulnerably Housed Women

*The current study used secondary data from a sample of participants recruited for the Health and Housing in Transition (HHiT) study. Amandeep Bassi developed the research presented in this manuscript and was responsible for data cleaning and analysis under the supervision of Dr. John Sylvestre. Dr. Tim Aubry served as a co-Principal Investigator for the HHiT study and provided guidance throughout the present research. Dr. Veronika Huta was consulted for statistical guidance in the study. Funding for the Health and Housing in Transition (HHiT) was provided by the Canadian Institute of Health Research (CIHR).

Community integration is based on the premise of common citizenship, which means that people with disabilities should have opportunities equal to their non-disabled counterparts to live, work, engage with others, and take part in activities (Wong & Solomon, 2002). A multidimensional model of community integration with the following components has been proposed: 1) physical integration, which involves participating in community activities and using community resources, 2) social integration, which includes social interactions and receiving positive support from ones' social network, and 3) psychological integration, which refers to a sense of belonging and feeling accepted in the community (Aubry & Myner, 1996; Wong & Solomon, 2002).

Based on a broadened definition of community integration by Aubry and Myner (1996) and Moos' (1997) ecosystems perspective, Wong and Solomon (2002) proposed a multidimensional conceptual model to understand community integration for residents living in supportive independent housing. Wong and Solomon's (2002) conceptual framework outlines the importance of considering the effects of both personal and environmental factors on community integration. Researchers have tested this conceptual model by using scales that measure both individual and environmental factors specific to independent housing (Abdallah et al., 2009; Ecker & Aubry, 2016; Gulcur et al., 2007). In this study, we used a similar ecological model for understanding the predictors of community integration. In the following section, the literature on community integration examining the proposed individual and environmental predictors for our study will be discussed.

Predictors of Community Integration

The literature reviewed in this section focuses on research findings related to individual and environmental predictors of community integration for formerly homeless people in different housing types and is not specific to vulnerably housed formerly homeless women.

Individual Predictors

In past research, individual predictors of community integration have included age, mental health functioning, problematic substance and alcohol use, finances, social support, and involvement in programs.

Age. Being older has been associated with lower levels of physical integration for participants with early-onset schizophrenia (Abdallah et al., 2009; Kruzich, 1985; Nagy, Fisher, & Tessler; 1988). Previous research has not investigated the effects of age on social integration for formerly homeless people, but theorists agree that as people age there is a decline in social interactions due to both social and physical barriers (Carstensen, 1992). As for psychological integration, researchers have found that older age is associated with higher levels of psychological integration (Brodsky, O'Campo, & Aronson, 1999; Ecker & Aubry, 2016).

Health. Research examining the relationship between physical health and physical, social and psychological integration for formerly homeless people is limited. One can expect that having physical health problems would limit a person's activity levels, which would affect both physical and social integration and subsequently a person's level of psychological integration in their neighbourhoods. With regards to mental health functioning, researchers have found that having better mental health functioning facilitates greater physical integration (Kidd, Karabanow, Hughes, & Frederick, 2013; Segal & Everett-Dille, 1980; Timko & Moos, 1998).

For social integration, researchers have found an association between having a psychiatric disability and lower levels of social integration (Aubry & Myner, 1996; Burchard, Hasazi, Gordon, & Yoe, 1991). However, Gulcur and colleagues (2007) found that for both groups (i.e., participants in Housing First (HF) programs and those in care as usual groups) higher baseline symptomatology was associated with greater social integration. The researchers reasoned that having these symptoms may have led participants to engage in seeking more support resulting in greater satisfaction with interactions. Consistent with other researchers, Gulcur and colleagues (2007) also showed that higher psychiatric symptoms were negatively associated with psychological integration (Cherner, Aubry, & Ecker, 2017; Kidd et al., 2013; Prince & Prince, 2002). Overall, people with mental illness may experience feelings of rejection from community members, which would consequently impact all dimensions of community integration.

Problematic substance and alcohol use. The study by Cherner and colleagues (2017) is the only study we are aware of that has examined the association between problematic substance and alcohol use and physical integration among homeless adults. Although in their research there was no association among these variables, we think it would be useful to examine this same relationship specifically for vulnerably housed formerly homeless women. As for social integration, not many studies have examined the relationship between social integration and problematic substance and alcohol use. One study by Abdallah and colleagues (2009) found a positive relationship between alcohol problems and social ties. However, it is possible that these participants mostly interacted with people with similar addiction problems. For psychological integration, researchers have not found a relationship between addiction problems and psychological integration among formerly homeless people who are vulnerably housed or in the HF program (Cherner et al., 2017; Ecker & Aubry, 2016). Although there has been some research

exploring addiction problems and community integration, overall there has not been any research examining the relationship between problematic substance and alcohol use and community integration among vulnerably housed women.

Finances. The association between having enough spending money and physical integration has been explored by researchers (Abdallah et al., 2009; Borg & Kristiansen, 2008; Ornelas, Martins, Zilhao, & Duarte, 2014; Segal & Aviram, 1978; Segal & Everett-Dille, 1980). Overall, researchers have found that higher income is associated with higher levels of physical integration (Borg & Kristiansen, 2008; Ornelas et al., 2014; Segal & Aviram, 1978). Researchers have not examined the relationship between participants' income and social and psychological integration. However, it is reasonable to expect that not having enough spending money would limit participants' activities with their social networks and would be a barrier to their sense of belonging in their neighbourhoods.

Social support. Overall, having greater social support has been associated with greater involvement in community activities (Cherner et al., 2017; Prince & Prince, 2002). As pointed out by Cherner et al. (2017) explanation for these results may be that people spend more time in their communities when they have people to spend it with and that being in the community also facilitates new relationships. This rationalization would also explain the relationship that having higher levels of social support is associated with higher levels of social integration (Chan et al., 2014; Townley et al., 2013). Researchers have also found a relationship between greater social support and psychological integration (Ecker & Aubry, 2016; Prince & Prince, 2002; Shumaker & Brownell, 1984).

Involvement in programs. There is insufficient research examining the relationship between formerly homeless peoples' involvement in organized activities and community

integration. Gulcur and colleagues' (2007) findings showed that people who took part in substance use treatment programs had greater physical integration than people who were not in the treatment program. Greater participation in these activities would possibly increase the likelihood of social contacts (i.e., social integration) and increase sense of belonging (i.e., psychological integration) in neighbourhoods. However, it is also possible that feelings of disconnection would occur if people move beyond their neighbourhoods to take part in these activities.

Environmental Predictors

Environmental predictors of community integration include stable housing and positive neighbourhood impact.

Stable housing. For environmental predictors, research shows that length of residency is an important predictor of community integration. Living in a community for a longer period can help residents overcome distrust, anxiety, and isolation that are often found in some communities (Clampet-Lundquist, 2010). Keene and colleagues' (2013) study examined the relationship between the length of residency and community integration in poor neighbourhoods. The researchers found an association between longer residency and larger social networks, greater access to social support, and stronger relationships with neighbours. Counter to Keene and colleagues' (2013) findings, Nemiroff et al. (2010) found that longer length of residency predicted lower levels of psychological integration for women participants. An explanation for this finding was that participants were hopeful when they were first housed, however over time they were not able to achieve a sense of belonging with others in the neighbourhood, which resulted in lower levels of psychological integration. We can speculate that there would be a

positive relationship between stable housing and physical integration and a negative relationship between stable housing and psychological integration.

Neighbourhood impact. The relationship between neighbourhood impact and physical and social integration among formerly homeless people has not been examined, however among a community sample research shows that social integration with neighbours may buffer negative impacts of the neighbourhood (Ross & Jang, 2000). For psychological integration, a strong relationship between a positive perception of neighbourhood quality is associated with greater psychological integration (Ecker & Aubry, 2016; Townley & Kloos, 2011; Yanos et al., 2011).

The Present Study

Research shows that women fall into a cycle of unstable housing and live in stressful environments (Kidd et al., 2013). However, a closer examination of factors that are associated with formerly homeless women's experiences in their neighbourhoods is still missing in the literature. The goal of the current study was to expand our understanding of community integration for vulnerably housed women by exploring predictor variables associated with physical, social, and psychological integration. Secondary data from a sample of vulnerably housed women participants in the Health and Housing in Transition (HHiT) study was used. The HHiT study was a prospective cohort study that tracked the health and housing status for homeless and vulnerably housed individuals in three Canadian cities (i.e., Ottawa, Toronto, and Vancouver). Women included in the study were in their 2nd and 3rd year of participating in the HHiT study (i.e. follow-up 2 (FU2) and follow-up 3 (FU3)).

In the current study, individual predictors encompass participants' socio-demographic characteristics and participants' behaviour regarding their wellbeing (i.e., age, physical health, mental health, substance use, alcohol use, social support, income, and school enrollment and

training program). Environmental predictors include factors that describe participants' neighbourhood environment and housing situation (i.e., city, housing stability, and neighbourhood impact) (see Figure 1 for a conceptual model of factors influencing community integration). Specifically, based on the existing literature on community integration, the present study examined the following research questions and associated hypotheses:

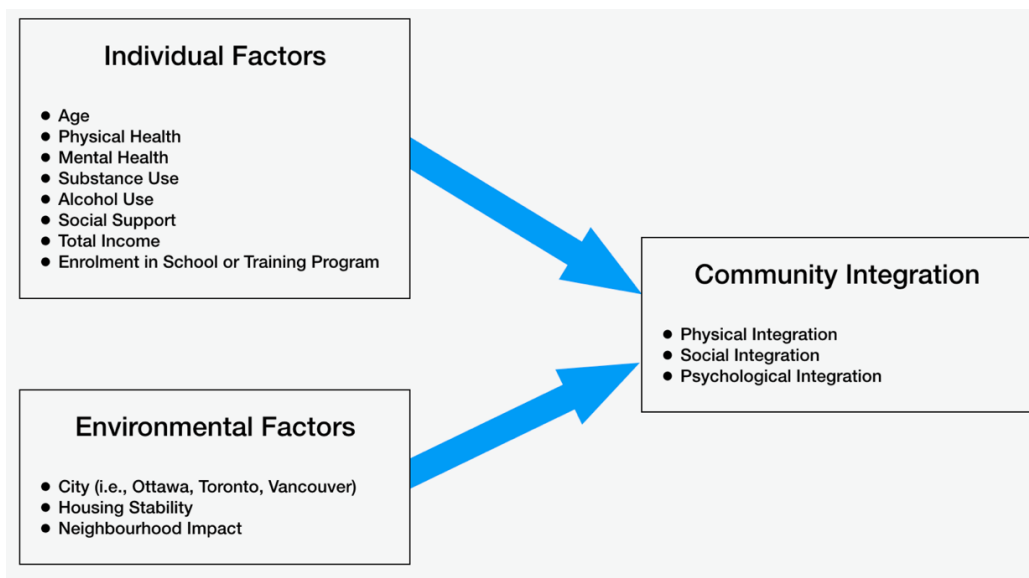


Figure 1. A conceptual model of factors influencing community integration for vulnerably housed women.

What are the individual (i.e., age, physical health, mental health, substance use, alcohol use, social support, income, and school enrollment and training program) and environmental (i.e., city (Ottawa, Toronto, and Vancouver), housing stability, and neighbourhood impact) predictors of integration for formerly homeless women who are vulnerably housed?

Hypothesis 1: Regarding individual predictors, it is expected that older participants will have lower levels of physical and social integration and higher levels of psychological integration. Participants with better physical health, better mental health, non-problematic

substance use, non-problematic alcohol use, greater social support, higher income, and enrollment in school or training program will have higher levels of physical, social, and psychological integration.

Hypothesis 2: In terms of environmental predictors, it is expected that there will be same level of community integration across the three cities (i.e., Ottawa, Toronto, and Vancouver), and that participants who have been stably housed and have reported positive neighbourhood impact will have higher levels of physical, social, and psychological integration.

The study will also answer the following question: Which individual-level variables (i.e., age, physical health, mental health, substance use, alcohol use, social support, income, and school enrollment or participation in a training program) are associated with an increase in community integration in a population of vulnerably housed women over time?

Hypothesis 3: It is expected that older participants, with better physical health, better mental health, non-problematic substance use, non-problematic alcohol use, greater social support, higher income, and enrollment in school or participation in a training program at FU2 is associated with higher levels of physical, social, and psychological integration at FU3.

Method

Research Design

Participants were recruited for the HHiT study between 2009 and 2014. After the baseline interview, four follow-up interviews (i.e., FU1, FU2, FU3, and FU4) were conducted every 12 months (Hwang et al., 2011). For our study, only vulnerably housed female participants at FU2 and FU3 from all three sites (i.e., Toronto, Ottawa, and Vancouver) were included in the analyses. Researchers for the HHiT study defined vulnerably housed participants as those who 1)

lived in their own room or apartment, but had been homeless in the past 12 months, 2) in the past 12 months had two or more moves, 3) were precariously housed, which refers to people whose primary residence is a Single Room Occupancy (SRO), rooming house or hotel/motel room (Goering et al., 2011), or 4) spent more than 30% of before tax income on shelter (CMHC, 2008). Although there may be differences between Toronto, Ottawa, and Vancouver regarding climate, population size, and housing market, females from all sites were grouped together for these analyses to achieve greater statistical power. The city variable was used as a control variable in the study.

Participants and Procedure

Between 2009 and 2014, a total of 1,190 participants who were vulnerably housed and homeless were followed and interviewed in Ottawa, Toronto, and Vancouver. For our study, FU2 and FU3 data was only included because participants' level of social integration was not collected at baseline and at FU1 interview. The total number of female participants varied, with FU2 having 319 participants, and FU3 having 318 participants. Only female participants who were vulnerably housed (as defined above) were selected for our study, which resulted in 217 participants at FU2 and 208 participants at FU3. That is 96% of the same participants from FU2 took part in the FU3 interview.

Participants were eligible for the HHiT study if they were 18 years or older and did not live with a partner or dependent child. Only homeless and vulnerably housed participants were recruited for the HHiT study. The researchers for the HHiT study determined participants to be homeless if they lived in a 1) shelter, 2) public place, 3) a vehicle, 4) abandoned building, or 5) place that was not their own.

A two-stage cluster strategy was applied for recruiting participants. In the first stage, homeless participants were recruited from primary sampling units which included shelters and meal programs, SRO hotels, and rooming houses. In the second stage, participants were randomly selected from the primary sampling locations. Because of the challenges associated with recruiting participants from SROs and rooming houses, the sampling strategy was changed to only include drop-in centres, community health centres, and meal programs (Hwang et al., 2011).

Ethics approval for the HHiT study was obtained from the Research Ethics Boards of the University of Ottawa, St. Michael's Hospital in Toronto, and St. Paul's Hospital in Vancouver. Interviews for the study were conducted by research assistants with graduate level education in psychology or social work or who had previous experience working with or conducting interviews with homeless populations. Participants were approached by research staff. Selected individuals were told about the nature of the study and were assessed on the eligibility criteria. The study procedure was explained to eligible participants, and written consent was obtained from participants who were willing to participate. Consent was also obtained from participants to retrieve updated contact information for follow-up interviews from municipal social services departments, hospitals, homeless shelters, prisons, and treatment centres. Duplicate interviews were identified during recruitment and were replaced with another randomly selected individuals' interview. Structured in-person interviews were conducted in French or English (the majority in English). The duration of the interviews was approximately 50 to 90 minutes, and participants were reimbursed \$20 for their time at each interview.

Measures

The HHiT study used psychometrically validated measures that were selected based on relevancy to the homeless population (See Appendix A for the HHiT measure). The predictor variables consisted of both individual predictors (i.e., age, physical and mental health functioning, substance use, alcohol use, social support, income, and school enrollment and training program) and environmental predictors (i.e., city, housing stability, and neighbourhood impact). A demographic questionnaire was also included to assess age, gender, ethnicity, education level, marital status, housing situation, employment status, psychiatric diagnosis, and health conditions.

Measures for predictor variables.

Individual predictors. Individual predictors included socio-demographic and clinical characteristics and personal choices that participants made regarding their wellbeing.

Age. Participants' age was documented in the baseline demographic questionnaire. For FU2 and FU3 interviews, age was computed by calculating the difference in days between the baseline interview and the FU2 and FU2 interviews. Then the number of years between the baseline interview and the FU2 and FU3 interviews were added to the participants' reported date of birth at baseline.

Physical and mental health functioning. SF-12 Physical and Mental Component Score. The SF-12 is a shorter version of the SF-36 Health Survey, which was designed to measure homeless populations' physical health and mental health status for the past four weeks (Larson, 2002; Ware, Kosinski, & Keller, 1995). The SF-12 includes eight dimensions: physical functioning, role limitations because of physical health problems, bodily pain, general health perceptions, vitality, social functioning, role limitation because of emotional problems, and

general mental health. Results for the SF-12 was given as a meta-score for the Physical Component Summary (PCS), which examined physical health functioning, and the Mental Component Summary (MCS), which examined mental health functioning. Scores for PCS and MCS were weighted producing scores that ranged from 0 to 100. Scores higher than 50 indicated above average physical and mental health functioning.

Test-retest reliability for SF-12 components has been shown to be strong for both PCS (ICC = .73) and MCS (ICC = .80) among seriously mentally ill patients (Salyers, Bosworth, Swanson, Lamb-Pagone, & Osher, 2000). Among the general population in the United States, the test-retest reliability was also strong for both PCS (ICC = .86) and MCS (ICC = .76). The SF-12 showed satisfactory convergent validity (ranging from 0.62 to 0.88): subscales that measured physical health correlated more highly with the PCS than with the MCS and vice versa (Larson, 2002). For the current study, the internal consistency rating for the PCS was .89 at FU2 and .88 at FU3, and the internal consistency rating for the MCS was .82 at FU2 and .88 at FU3.

Substance abuse. Drug Abuse Screening Test (DAST-10). A 10-item version of the DAST-10 was used to identify problematic drug use in the past 12 months. Total scores range from 0 to 10, with scores 3 and above indicating problematic drug use and a score of 6 or more indicating substantial drug problems (Skinner, 1982).

The DAST-10 has demonstrated good internal consistency: 0.86 (Cocco & Carey, 1998), 0.92 (Skinner, 1982), and 0.94 (Carey, Carey, & Chandra, 2003). The DAST-10 has also shown good concurrent validity (Cocco & Carey, 1998). The DAST-10 has also shown good test-retest reliability of ICC = .71 in a sample of psychiatric patients (n = 45; Cocco & Carey, 1998). For discriminant validity, Carey et al. (2003) examined the sensitivity and specificity of the DAST-10. The sensitivity of the test, which examines the accuracy of the identification of diagnosed

drug abusers, ranged from 41% to 95% (Carey et al., 2003). The specificity of the test, which examines the accuracy in identifying nondrug abusers, ranged from 68% to 99% (Carey et al., 2003). The internal consistency rating in the current study was .78 at FU2 and .78 at FU3.

For the current study, the variable was dichotomized into problematic and non-problematic drug use. Non-problematic drug use was defined by a score of 2 or less and was coded as a "0". Problematic drug use corresponded to a score of 3 or more and it was coded as "1".

Alcohol Use Disorders Identification Test (AUDIT): The AUDIT, which is a 10-item self-reported instrument, was used to identify individuals with problematic alcohol use (Maisto, Carey, Carey, Gordon, & Gleason, 2000). The AUDIT scores ranged from 0 to 40, with total scores of 0-7 indicating low-risk level, 8-15 indicating hazardous risk level, 16-19 indicating harmful risk level, and a score of 20 or higher indicating dependence risk level (Babor, Higgins-Biddle, Saunders & Monteiro, 2001; Piccinelli et al., 1997).

The psychometric properties of the AUDIT have been shown to be adequate and stable. The AUDIT has demonstrated high internal reliability ($r = .86$; Barry & Fleming, 1993) and adequate test-retest reliability ($r = .64$, Maisto et al., 2000; $r = .81$, Daeppen, Yersin, Landry, Pécoud, & Decrey, 2000). The internal consistency rating in the current study was .92 at FU2 and .91 at FU3.

For the current study, the variable was dichotomized into problematic and non-problematic alcohol use. Non-problematic alcohol use was defined by a score of 7 or less and was coded as a "0". Problematic alcohol use corresponded to a score of 8 or greater and it was coded as "1".

Social support. The Social Provisions Scale (SPS) is based on six relational provisions identified by Weiss (1974): 1) attachment, where a person has a sense of security and safety with others, 2) social integration within a social network, where interests and concerns are shared, 3) reassurance of worth within a network where a person's skills and abilities are recognized, 4) being able to receive guidance from others, 5) being able to depend on others for assistance, and 6) having the opportunity to be responsible for other people's well-being (Russell, Altmaier & van Velzen, 1987). The SPS is a 24-item self-report scale that was designed to examine if a person's social relationship provided each of the provisions identified by Weiss (1974) (Cutrona & Russell, 1987). Cutrona and Russell (1987) demonstrated proper alpha coefficients ranging from .66 to .76. For concurrent validity, significant relationships between social provision scores and variables such as social network, satisfaction with various social relationships, and loneliness have been found (Cutrona & Russell, 1987). The SPS also demonstrated a test-retest reliability coefficient ranging from .37 to .66 (Cutrona, Russell & Rose, 1984).

A shortened 8-item version of the SPS was used in the HHIT study (four positively worded and four negatively worded items). Responses were scored on a four-point Likert scale (1 = strongly agree to 4 = strongly disagree) with total summed scores ranging from 8 to 32, with higher scores indicating a stronger social support system for the participant. The internal consistency rating in the current study was .82 at FU2 and .75 at FU3.

Income. This variable was assessed with the question: "In the past 12 months, what were your sources of income? What did you do to get money?" Participants were given options for different sources of income (e.g. government, employment, prostitution, selling drugs) and were asked to give the amount of monthly income for each source that was reported. Total income produced within the past month was used for this study.

School and training program. This variable was assessed with one item: “In the past 12 months, have you been enrolled in a school or a training program?” The variable was a dichotomous variable, coded as no = 0 and yes = 1.

Environmental predictors. Environmental predictors included variables that are characteristic of participants’ living environments.

City. The interviews were conducted in three different cities. This variable was coded as “1” indicating Vancouver, “2” Toronto, and “3” Ottawa. This variable was used as a control variable in the current study.

Housing stability. This variable was defined by the amount of time the participant had been stably housed at the time of interview. The participant was stably housed if 1) their residence at interview point was functionally housed and 2) they had lived in the same residence for at least 180 days at the point of the interview (Nisenbaum, 2014) (see Figure 2 for residential state).

The housing status was determined using the Housing Timeline Follow-Back Calendar (HTFBC), which has been validated (Tsemberis et al., 2007). A housing timeline, using the move-in and move-out date was created for each participant. The number of days that participants lived in their residence was calculated for each participant’s interview date. The housing stability variable was dichotomized into unstably housed (i.e., coded as “0”) and stably housed (i.e., coded as “1”).

Neighbourhood impact. Participants were asked to rate the kind of impact the neighbourhood had on them. The question was a subjective measure based on a single item from the Quality of Life for Homeless and Hard-to-House Individuals scale (Hubley, Russell,

Gadermann, & Palepu, 2009). Responses were scored on a seven-point scale (1 = large negative impact to 7 = large positive impact). The reliability statistics for this scale has not been documented.

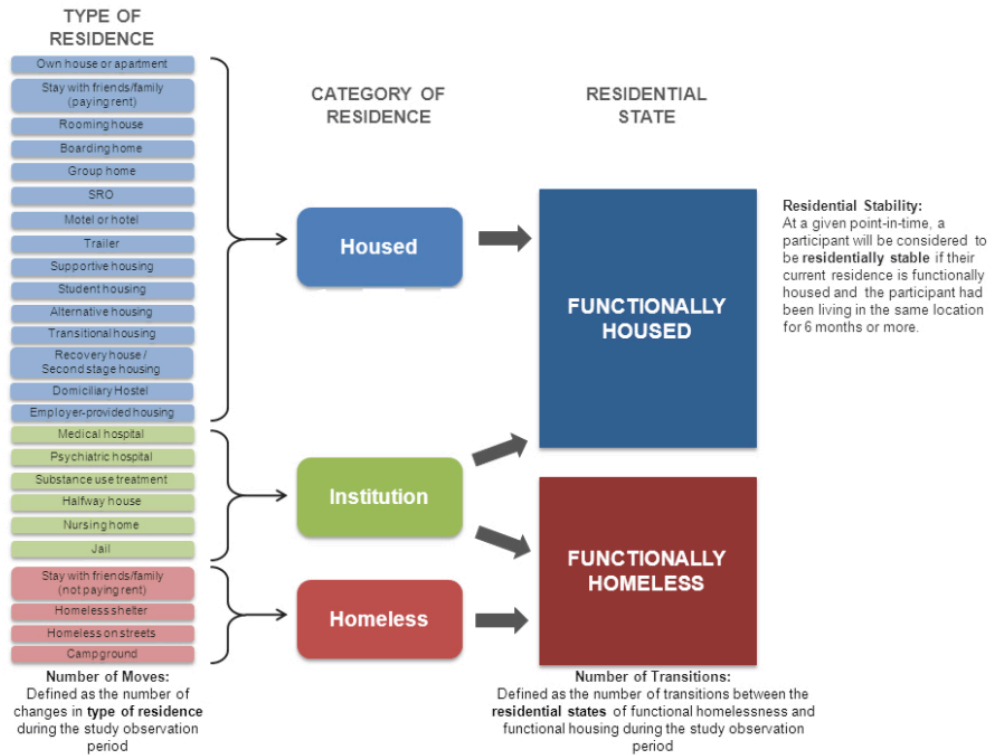


Figure 2. Type of residence, residence category, and residential state (Source: Derivation of HHiT housing outcomes: Definitions and descriptive statistics, Rosane Nisenbaum, 2014).

Predicted variables.

Measures of community integration. The predicted variable, community integration, included three measures: 1) physical integration, 2) social integration, and 3) psychological integration.

Physical integration. Physical integration is defined as an individual's presence in ordinary settings, activities, and contexts (Segal, Baumohl, & Moyles, 1980). The measure to assess physical integration is adapted from Segal and Aviram's (1978) access to community resources subscale. Segal and Aviram (1978) reported high internal consistency ($\alpha = .91$) and a high average item-to-subscale correlation ($r = .71$) on the access to community resources subscale. For the HHiT study, the scale was reduced to 8-items, which included questions about participants' volunteering and participation in sports activity, and whether participants have gone to a movie or concert, restaurant or café to meet friends, place of worship, and library in the past month. The response options ranged from never (1) to very often (5). The internal consistency rating in the current study was .68 at FU2 and .68 at FU3.

Social integration. Social integration refers to being present, accessing resources, and participating in activities both outside and within the home (Segal & Aviram, 1978). In the HHiT study, a 7-item social integration scale was adapted from the 13-item scale by Aubry, Tefft, and Currie (1995). Cronbach's alpha for the scale was 0.87 for people with psychiatric disabilities and 0.92 for community residents (Aubry & Myner, 1996). Participants were assessed on their interactions with their neighbours, which ranged from greeting their neighbours to being invited to visit their neighbours' home for socializing. Response was measured on a 5-point Likert scale, anchored at 1 (Never) and 5 (Frequently). The internal consistency rating in the current study was .88 at FU2 and .87 at FU3.

Psychological integration. Psychological integration is defined as having membership in a community, being emotionally connected to others, and having needs met in the community (Aubry & Myner, 1996; McMillan & Chavis, 1986). The 6-item psychological integration scale was adapted from a 12-item Sense of Community Scale by Perkins, Florin, Rich, Wandersman,

and Chavis (1990). Participants were asked to answer questions about their sense of belonging, availability of help, their influence in their neighbourhood, and their emotional investment to their neighbours and neighbourhood. Responses were measured on a 5-point Likert scale, anchored at 1 (strongly disagree) and 5 (strongly agree). Aubry and Myner (1996) reported a Cronbach's alpha of 0.71 for persons with psychiatric disabilities and 0.71 for community residents. The internal consistency rating in the current study was .62 at FU2 and .59 at FU3.

Data Analysis

Cross-sectional analysis: Hierarchical multiple regression analysis (HMRA).

Recognizing that longitudinal data were available, cross-sectional analyses were conducted in order to analyze the stability of the individual and environmental predictors at FU2 and FU3. For FU2 and FU3 interviews, six HMRA were performed with physical, social, and psychological integration as the dependent variables and two predictor variables: 1) individual predictors (i.e., age, physical and mental health functioning, substance use, alcohol use, social support, income, and enrollment in school and training programs) and 2) environmental predictors (i.e., city, housing stability, and neighbourhood impact). In the study, the set of individual predictors were entered into the regression model first (block 1) and subsequently, environmental predictors were entered into the model (block 2).

Longitudinal analysis: Univariate general linear model (GLM) analysis. A

longitudinal analysis was also conducted to examine the contribution of individual predictors at FU2 for predicting community integration at FU3, while controlling for FU2 community integration levels. Three univariate GLM analyses were performed to examine the predictive relationship of FU2 predictor variables (i.e., age, physical and mental health functioning, substance use, alcohol use, social support, income, and enrollment in school and training) with

the FU3 variables of physical, social, and psychological integration. FU2 physical, social, and psychological integration were included as covariates to control for their effects.

To avoid Type I error a Bonferroni correction may be justified. However, there has been increased criticism of this statistical technique (Lieberman & Cunningham, 2009; Nakagawa, 2004). In particular, the use of Bonferroni procedures has shown to reduce power which in turn increases Type II errors (Lieberman & Cunningham, 2009; Nakagawa, 2004). In place of reporting significant findings, the standardized effect size and exact p-value will be reported for the HMRA and GLM analysis.

Data Screening

Meeting assumptions of HMRA and GLM. Before conducting the HMRA and GLM analyses, the assumptions for the statistical analyses were tested. Using the formula provided by Tabachnick and Fidell (2007) $N > 50 + 8m$ (where $m = 12$ independent variables), the minimum N of 146 participants is required. It can be assumed that an adequate sample size was achieved for the analysis as our N ranged from 187 to 198 for each level of integration at FU2 and FU3. A priori power analysis using the G*Power (Faul, Erdfelder, Buchner & Lang, 2009) was also used to justify the number of predictors. A G* Power (Faul, Erdfelder, Land & Buchner, 2007) analysis showed that for 12 predictor variables with medium effect size ($f^2 = .15$), power = .80, and an α set at .05, a total sample size of 127 participants is needed. Our sample size for FU2 and FU3 was adequate for the analyses. Each of the variables also did not have more than 10% missing values.

Normal Probability Plot (P-P) of the Regression Standardized Residual and Scatterplots were used to check for outliers, normality, linearity and homoscedasticity. Transformations were

performed to address outliers in the dataset, however, the transformation did not result in more normalized variables. Non-normal variables were then winsorized, which is the process of removing outliers with z-scores above 2.5 standard deviations to the next highest or lowest score (Dixon & Yuen, 1974). Overall, the winsorized variables did result in more normalized distributions.

To meet the assumption of multicollinearity, bivariate correlations were calculated to examine strongly correlated variables (see Appendices B to G for correlation matrices), the variance inflation factor (VIF) and tolerance value were examined for each predictor variable (Field, 2005). The tolerance value for the data was not less than .10 and the average VIF value was well below the cut-off of 10 (Field, 2005). Bivariate correlations were also conducted between the three predictor variables, physical, social, and psychological integration. A weak positive relationship ranging from .209 to .376 was found (see Appendices H and I) (Tabachnick & Fidell, 2007).

Respondents versus non-respondents. Approximately 96% of the participants from FU2 completed the FU3 interview. A nonresponse bias analysis was not necessary as the unit response rate is greater than 80% (National Research Council, 2013).

Results

Descriptive Statistics

Sample characteristics. A summary of the demographic data for the participants is presented in Table 1 (FU2) and Table 2 (FU3).

Table 1.

Sample Characteristics: FU2 (N=217) Participants.

Variable		M (SD) or %
City	Vancouver	N = 48
	Toronto	N = 84
	Ottawa	N = 85
	Total	N = 217
Ethnicity	White	57%
	First Nations	26%
	African-Canadian	12%
	South Asian, Hispanic, mixed race categories	5%
Born in Canada		84%
Age	Range	20 – 82 years
	Mean	41.20 years
	Standard Deviation	11.83
Housing	Own Apartments	65%
	Lived with Friends or Relatives	12%
	Rooming House	12%
	Supportive Housing	11%
	Nursing Home	1%
Individual Factors	Physical Health	42.22 (11.35)
	Mental Health	40.27 (12.62)
	%Problematic Drug Use (Yes)	42%
	%Problematic Alcohol Use (Yes)	29%
	Total Monthly Income (Median)	\$904.71
Environmental Factors	Social Support	24.38 (3.91)
	Enrollment & Training Program	19%
	Stably Housed	72%
	Neighbourhood Impact	4.95 (1.80)

Table 2.

Sample Characteristics: FU3 (N=208) Participants.

Variable		M (SD) or %
City	Vancouver	N = 56
	Toronto	N = 75
	Ottawa	N = 77
	Total	N = 208
Ethnicity	White	56%
	First Nations	27%
	African-Canadian	12%
	South Asian, Hispanic, mixed race categories	5%
Born in Canada		84%
Age	Range	20 – 82 years
	Mean	41.20 years
	Standard Deviation	11.83
Housing	Own Apartments	69%
	Lived with Friends or Relatives	8%
	Supportive Housing	15%
	Rooming House	7%
	Nursing Home	1%
Individual Factors	Physical Health	42.61 (11.29)
	Mental Health	42.34 (12.88)
	%Problematic Drug Use (Yes)	36%
	%Problematic Alcohol Use (Yes)	30%
	Total Monthly Income (Median)	\$939.50
	Social Support	24.59 (3.29)
	Enrollment & Training Program	11%
Environmental Factors	Stably Housed	73
	Neighbourhood Impact	5.30 (1.50)

FU2 interview. At FU2, the sample consisted of 217 vulnerably housed female participants (i.e., Vancouver N = 48, Toronto N = 84, Ottawa N = 85). A majority of the participants identified as White (57%). Participants' age ranged from 20 to 67 years (M = 43.13, SD = 11.55). A majority of the participants were born in Canada (84%). More than half of the women participants lived in their own apartments (65%), and 72% of the participants were stably housed (i.e., are functionally housed and have been living in the same house for 6-months or more).

The physical health (M = 42.22, SD = 11.35) and mental health (M = 40.27, SD = 12.62) of the participants were poorer than the general population norms for the U.S. population (M =

50, SD = 10) (Ware et al., 1996). More participants had problematic drug use (42%) than problematic alcohol use (29%). The median monthly income for participants was \$904.71. Participants had moderate levels of social support (a mean score of 24.38 (SD = 3.91) out of a possible total score of 32). Only 19% of the participants were enrolled in school or were in training programs. Participants rated their neighbourhoods as having a small positive impact (Hubley et al., 2009). Out of a total score of 7, the sample had an average score of 4.95 (SD = 1.80).

FU3 interview. At FU3, the sample consisted of 208 vulnerably housed female participants (i.e., Vancouver N = 56, Toronto N = 75, Ottawa N = 77). A majority of the participants identified as White (56%). Participants' age ranged from 21 to 68 years old (M = 44.88, SD = 11.50). A majority of the participants were born in Canada (84%). Similar to the FU2 sample, the majority of the sample were living in their own apartments (69%), and 73% of the participants were stably housed.

The FU3 sample also had poorer physical health (M = 42.61, SD = 11.29) and mental health (M = 42.34, SD = 12.88) compared to the general population norms (M = 50, SD = 10) (Ware et al., 1996). Thirty-six percent of the participants had problematic drug use, and 30% of the participants reported problematic alcohol use. The median monthly income for participants was \$939.50. Participants in this sample also reported moderate levels of social support (a mean score of 24.59 (SD = 3.29) out of a possible total score of 32). Only 11% of the participants were enrolled in school or were in training programs. Participants rated their neighbourhoods as having a small positive impact (M = 5.30 (SD = 1.50) out of total score of 7) on their lives.

Integration levels.

Physical integration. For physical integration, scores for the measure ranged from 8 to 40. At FU2, participants’ mean physical integration score was 13.90 with a standard deviation of levels 5.23. In the FU2 interview, 21 (9.90%) participants had the lowest possible total score, and two (0.90%) participants had the highest possible total score. At FU3, participants’ mean physical integration score was 13.41 with a standard deviation of 5.00. In FU3 interviews, 25 (12.0%) participants had the lowest possible score, and one (0.5%) participant had the highest total score. Overall, the means of both FU2 and FU3 indicate that physical integration levels were below the mid-range of the scale. See Figure 4 for the “often” and “very often” combined categories for physical integration at FU2 and FU3.

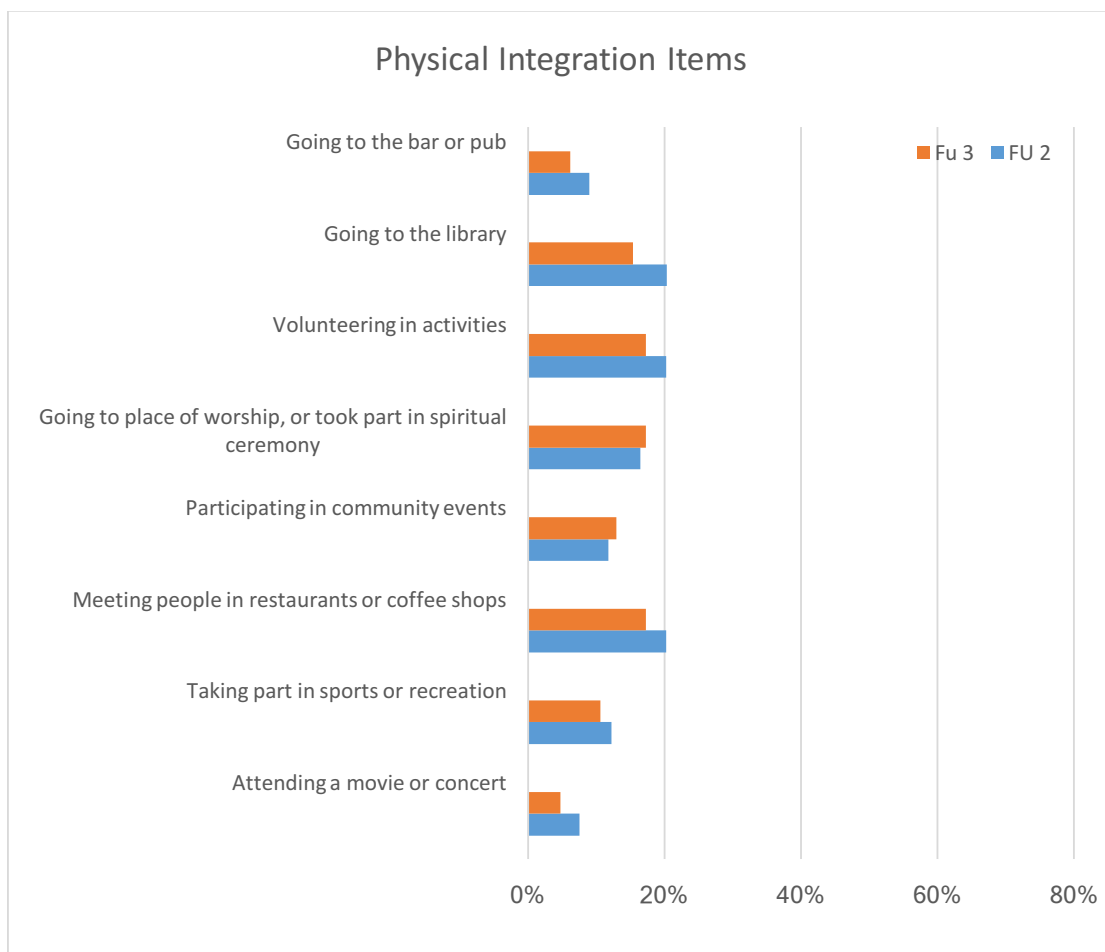


Figure 3. Physical integration “often” and “very often” categories.

Social integration. The total scores for the social integration measure ranged from 7 to 35. At FU2, the mean social integration score was 16.27 with a standard deviation of 6.78. In the FU2 interview, 14 participants (6.50%) had the lowest possible score, and 5 participants (2.30%) had the highest possible score. For FU3 interviews, participants' mean social integration score was 15.80 with a standard deviation of 6.34. For the FU3 interviews, 12 (5.90%) of the participants had the lowest possible score, and one (0.50%) participant had the highest possible score. Overall, the means of both FU2 and FU3 indicate that social integration levels were within the mid-range of the scale. See Figure 5 for the “fairly often” and “frequently” combined categories for social integration at FU2 and FU3.

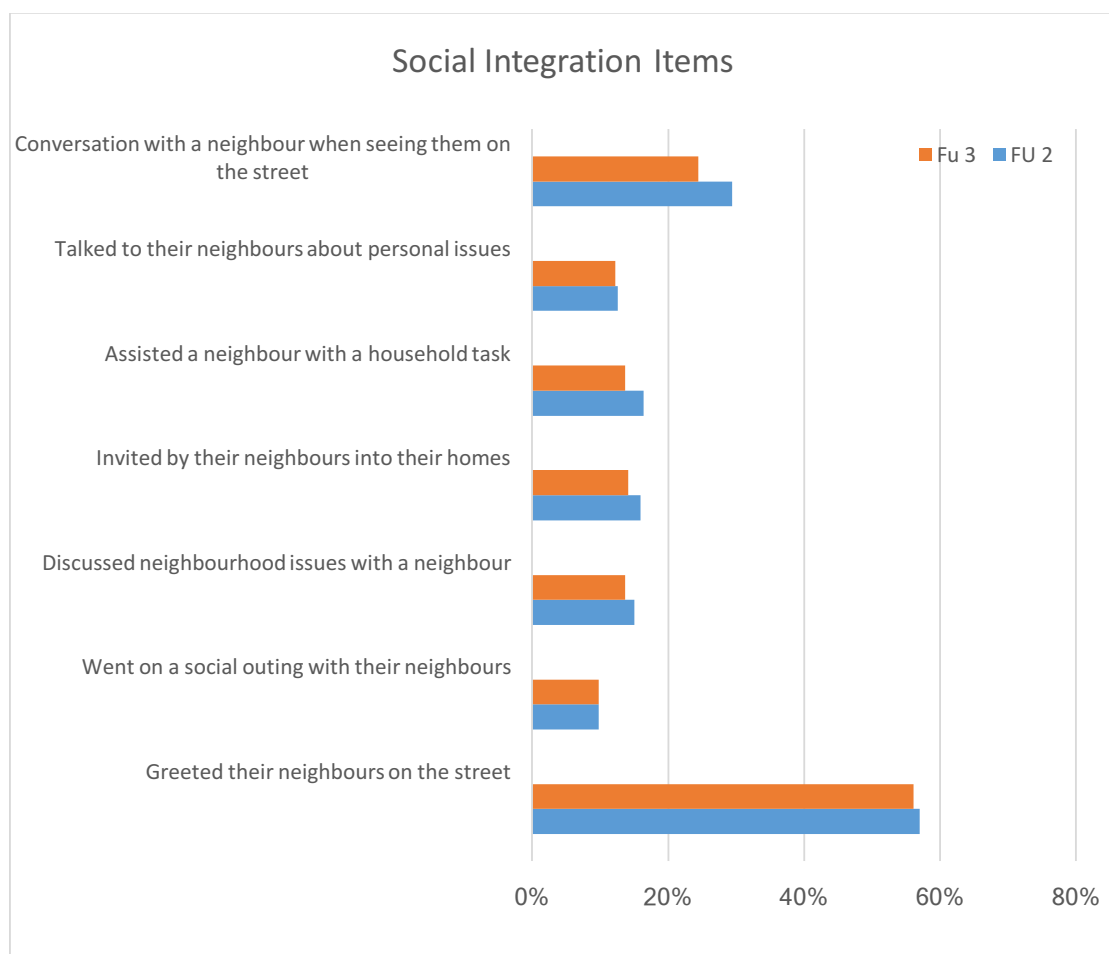


Figure 4. Social integration “fairly often” and “frequently” categories.

Psychological integration. The total scores for the psychological integration measure ranged from 6 to 30. For FU2, participants’ mean psychological integration score was 19.53 with a standard deviation of 5.33. In the FU2 interview, 1 (0.50%) participant had the lowest total score, and one (0.50%) participant had the highest total score. For FU3, participants’ mean psychological integration score was 20.28 with a standard deviation of 4.32. In FU3 interviews, 1 (0.40%) participant had the lowest total score, and one (0.40%) participant had the highest possible score. Overall, the means of both FU2 and FU3 indicate that psychological integration levels were slightly above the mid-range of the scale. See Figure 5 for the “agree” and “strongly agree” combined categories for psychological integration at FU2 and FU3.

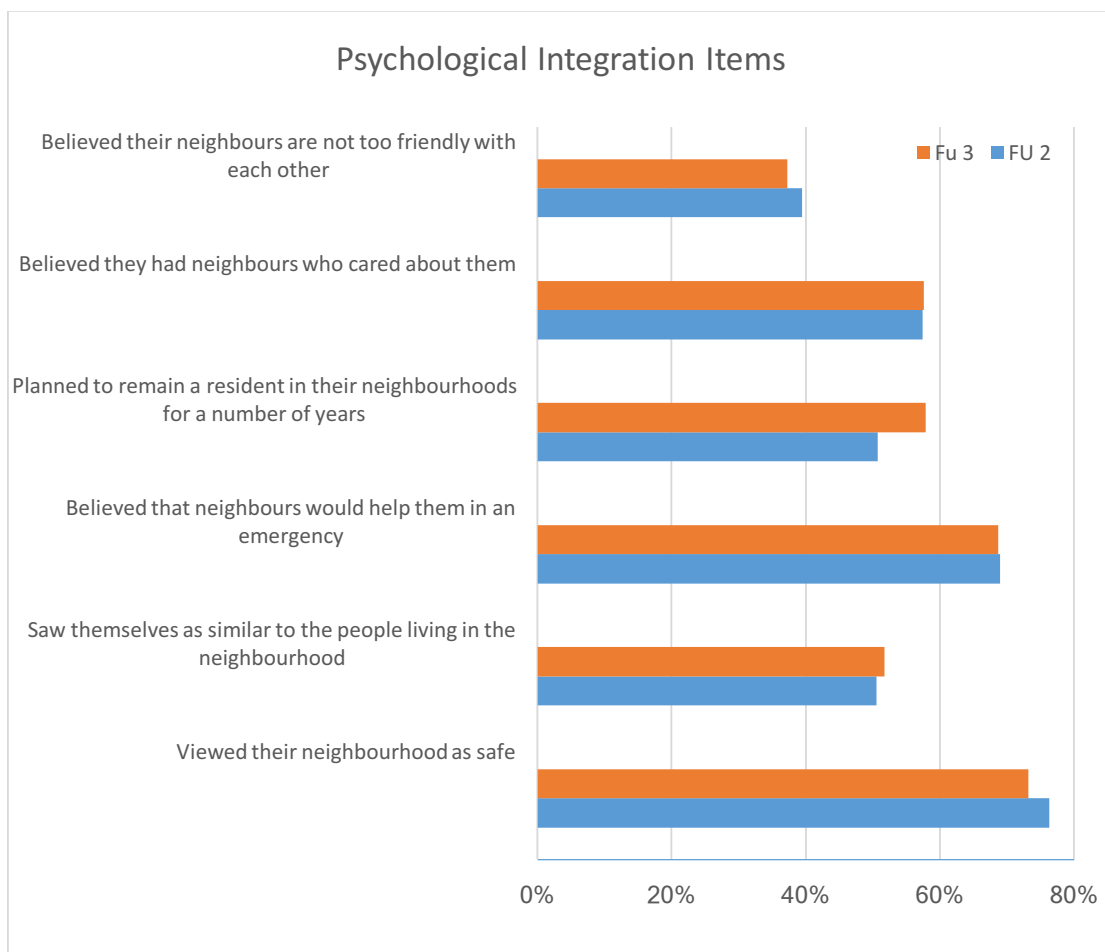


Figure 5. Psychological integration “agree” and “strongly agree” categories.

Cross-Sectional Analysis: Hierarchical Multiple Regression Analysis (HMRA)

In the following section, the results of HMRA will be discussed (see Tables 3 to 5 for the summary of HMRA results). The findings are organized according to the follow-up interview and each type of community integration (i.e., physical, social, and psychological integration).

Individual predictors (i.e., age, physical and mental health functioning, substance use, alcohol use, social support, income, and enrollment in school and training) and environmental predictors (i.e., city, housing stability, and neighbourhood impact) were entered into the regression model.

Research question. What are the individual level (i.e., age, physical and mental health functioning, substance use, alcohol use, social support, income, and enrollment in school and training) and environmental (i.e., city, housing stability, and neighbourhood impact) predictors of integration for women who are vulnerably housed?

Predictors of physical integration (FU2). Individual variables were entered in the first block and it accounted for $R^2 = .24$, $F(8, 175) = 6.85$, $p = .000$ of the variance for physical integration. Participants who were enrolled in school or training programs ($\beta = .30$, $t = 4.37$, $p = .000$) and had higher physical health functioning ($\beta = .22$, $t = 3.18$, $p = .002$) had higher levels of physical integration.

Environmental factors were entered in the final block of the regression analysis. However, they did not account for additional variance in physical integration scores beyond that explained by individual variables in the previous block ($\Delta R^2 = .02$, $\Delta F(4, 171) = .85$, $p = .498$). Two individual predictors continued to contribute to the variance: enrolment in school or training program ($\beta = .30$, $t = 4.30$, $p = .000$) and physical health function ($\beta = .24$, $t = 3.38$, $p = .001$).

The model explained 25% of the variance for physical integration ($F(12, 171) = 4.83, p = .000$). It was a large effect size (Tabachnick & Fidell, 2007). Almost all the variance was explained by the individual variables in the first block (24%) while environmental variables only explained an additional 1.50% of the variance for physical integration.

Predictors of physical integration (FU3). Individual variables were entered in the first block and they accounted for $R^2 = .12, F(8, 187) = 3.17, p = .002$ of the variance for physical integration. Participants who were enrolled in school or training programs ($\beta = .15, t = 2.16, p = .032$), and had higher income levels ($\beta = .15, t = 2.09, p = .038$) had higher levels of physical integration.

In the final block, the addition of the environmental variables did not contribute to the variance in physical integration scores beyond that explained by individual variables in the previous block ($\Delta R^2 = .01, \Delta F(4, 183) = .36, p = .837$). The individual variable enrolment in school or training program ($\beta = .14, t = 1.98, p = .049$) continued to contribute to the variance.

The model explained 13% of the variance for physical integration ($F(12, 183) = 2.20, p = .013$). It was considered to have a moderate effect size (Tabachnick & Fidell, 2007). Almost all the variance was explained by the individual variables in the first block (12%) while environmental variables only explained an additional .70% of the variance for physical integration.

Predictors of social integration (FU2). Individual variables were entered in the first block and they accounted for $R^2 = .14, F(8, 176) = 3.68, p = .001$ of the variance for social integration. Participants with greater social support ($\beta = .31, t = 4.18, p = .000$) had higher levels

of social integration. Interestingly, participants with problematic drug use ($\beta = .20$, $t = 2.74$, $p = .007$) also had higher levels of social integration.

In the final block, the addition of the environmental variables did not contribute to the variance in social integration scores beyond that explained by individual variables in the previous block ($\Delta R^2 = .16$, $\Delta F(4, 172) = 1.07$, $p = .375$). Two individual variables continued to explain the variance for social integration: greater social support ($\beta = .30$, $t = 3.91$, $p = .000$) and problematic drug use ($\beta = .18$, $t = 2.46$, $p = .019$).

The model explained 16% of the variance for social integration ($F(12, 172) = 2.81$, $p = .002$). It was considered to have a moderate effect size (Tabachnick & Fidell, 2007). Almost all the variance was explained by the individual variables in the first block (14%), while environmental variables only explained an additional 2% of the variance for social integration.

Predictors of social integration (FU3). Individual variables were entered in the first block and they accounted for $R^2 = .16$, $F(8, 186) = 4.31$, $p = .000$ of the variance for social integration. Participants with problematic alcohol use ($\beta = .24$, $t = 3.43$, $p = .001$) and greater social support ($\beta = .23$, $t = 3.27$, $p = .001$) had higher levels of social integration.

In the final block, the addition of the environmental variables did not contribute to the variance in social integration scores beyond that explained by individual variables in the previous block ($\Delta R^2 = .19$, $\Delta F(4, 182) = 1.84$, $p = .123$). Two individual variables continued to contribute to the variance: problematic alcohol use ($\beta = .23$, $t = 3.24$, $p = .001$) and greater social support ($\beta = .21$, $t = 2.90$, $p = .004$).

The model as a whole explained 19% of the variance for social integration ($F(12, 182) = 3.54$, $p = .000$). It was considered to have a moderate effect size (Tabachnick & Fidell, 2007).

Individual variables entered in block 1, explained 16% of the variance, while environmental variables only explained an additional 3% of the variance for social integration.

Predictors of psychological integration (FU2). Individual predictors were entered in the first block and they accounted for $R^2 = .23$, $F(8, 176) = 6.64$, $p = .000$ of the variance for psychological integration. Participants with greater mental health functioning ($\beta = .28$, $t = 3.93$, $p = .000$), who were older ($\beta = .23$, $t = 3.21$, $p = .002$), with greater social support ($\beta = .19$, $t = 2.73$, $p = .007$), and with problematic drug use ($\beta = .15$, $t = 2.17$, $p = .032$) had higher levels of psychological integration.

In the last block, environmental variables explained $\Delta R^2 = .33$, $\Delta F(4, 175) = 31.92$, $p = .000$ of the variance for psychological integration over and above the variance explained by individual predictors. Participants who rated their neighbourhoods as having a positive impact ($\beta = .62$, $t = 10.98$, $p = .000$) had higher levels of psychological integration. For individual predictor variables, both social support ($\beta = .17$, $t = 3.01$, $p = .003$), and participants who were older ($\beta = .13$, $t = 2.33$, $p = .021$) continued to contribute to the variance. A new individual variable enrollment in school or training program also contributed to the variance. Participants who were not enrolled in school or training programs ($\beta = -.12$, $t = -2.18$, $p = .030$) had higher levels of psychological integration.

The model explained 56% of the variance for psychological integration ($F(12, 172) = 18.17$, $p = .000$). It was considered to have a large effect size (Tabachnick & Fidell, 2007). Individual variables entered in block 1, explained 23% of the variance, while environmental variables explained an additional 33% of the variance for psychological integration.

Predictors of psychological integration (FU3). Individual variables were entered in the first block and they accounted for $R^2 = .24$, $F(8, 187) = 7.17$, $p = .000$ of the variance for psychological integration. Participants with greater mental health functioning ($\beta = .34$, $t = 5.01$, $p = .000$) and greater social support ($\beta = .21$, $t = 3.07$, $p = .002$) had higher levels of psychological integration.

In the last block, environmental variables accounted for $\Delta R^2 = .20$, $\Delta F(4, 183) = 15.69$, $p = .000$ of the variance for psychological integration over and above the variance explained by individual predictors. Participants who rated their neighbourhoods as having a positive impact ($\beta = .45$, $t = 7.21$, $p = .000$) had higher levels of psychological integration. The two individual variables greater mental health function ($\beta = .24$, $t = 4.03$, $p = .000$) and greater social support ($\beta = .16$, $t = 2.63$, $p = .009$) continued to contribute to the variance. A new variable income also contributed to the variance. Participants who had less income ($\beta = -.17$, $t = -2.93$, $p = .004$) had higher levels of psychological integration.

The model explained 43% of the variance for psychological integration ($F(12, 183) = 11.51$, $p = .000$). It was considered to have a large effect size (Tabachnick & Fidell, 2007). Individual variables entered in block 1, explained 24% of the variance, while environmental variables explained an additional 20% of the variance for psychological integration.

Longitudinal Analysis: Univariate General Linear Model (GLM) Analysis

In the following section, the results of the univariate GLM analysis will be discussed (see Table 6 to 8 for the summary of univariate GLM results). The findings are organized according to each type of community integration (i.e., physical, social, and psychological integration).

Research question. Which individual variables (i.e., age, school enrollment and training program, income, physical health, mental health, substance abuse, alcohol use, and social support) are associated with community integration in a population of vulnerably housed women in FU3, while controlling for physical, social, and psychological integration at FU2?

The covariates physical, social, and psychological integration at FU2 were related to the participants' level of community integration at FU3. There was an effect of FU2 levels of physical integration on levels of physical integration at FU3, $F(1, 205) = 56.86, p = .000, \eta^2 = .22$. FU2 levels of social integration also had an effect on levels of social integration at FU3, $F(1, 204) = 43.26, p = .000, \eta^2 = .20$. Additionally, there was an effect of psychological integration at FU2 on levels of psychological integration at FU3, $F(1, 206) = 39.21, p = .000, \eta^2 = .16$. All three levels of community integration had a moderate effect size (Tabachnick & Fidell, 2007).

For social integration, there was a small main effect of alcohol use at FU2 on social integration at FU3 ($F(1, 204) = 5.61, p = .019, \eta^2 = .03$). Participants with problematic alcohol use at FU2 had higher levels of social integration ($M = 17.31$) at FU3 than compared to people with non-problematic substance use ($M = 15.23$).

Table 3.

Hierarchical Regression Analysis of predictors on Physical Integration.

	FU2					FU3				
	<i>B</i>	<i>SE</i>	β	<i>R</i> ²	ΔR^2	<i>B</i>	<i>SE</i>	β	<i>R</i> ²	ΔR^2
Block 1				.238	.238***				.119	.119**
Age	.036	.031	.082			.031	.032	.070		
Physical Component Score	.103	.032	.223**			.055	.032	.123		
Mental Component Score	.046	.028	.113			.055	.028	.141		
DAST	-.166	.739	-.016			-.141	.754	-.014		
AUDIT	-.355	.792	-.030			.022	.778	.002		
Total Income (Per Month)	.001	.001	.107			.001	.000	.145*		
Social Provisions	.156	.095	.116			.188	.112	.122		
Enrolment in School	3.951	.904	.301***			2.38	1.10	.153*		
Block 2				.253	.015				.126	.007
Age	.040	.033	.091			.029	.033	.064		
Physical Component Score	.112	.033	.243***			.056	.032	.125		
Mental Component Score	.036	.030	.088			.047	.029	.122		
DAST	-.318	.751	-.030			-.042	.777	-.004		
AUDIT	-.461	.804	-.039			-.023	.802	-.002		
Total Income (Per Month)	.001	.001	.068			.001	.000	.137		
Social Provisions	.165	.096	.123			.198	.117	.128		
Enrolment in School	3.966	.921	.303***			2.224	1.121	.143*		
Vancouver (vs Ottawa)	1.263	.978	.103			.535	.957	.048		
Toronto (vs Ottawa)	-.192	.840	-.018			.397	.901	.038		
Stably Housed	-.645	.811	-.056			-.512	.821	-.045		
Neighbourhood Impact	.110	.215	.038			.117	.252	.036		

Note. * $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

Table 4.

Hierarchical Regression Analysis of predictors on Social Integration.

	FU2					FU3				
	<i>B</i>	<i>SE</i>	β	<i>R</i> ²	ΔR^2	<i>B</i>	<i>SE</i>	β	<i>R</i> ²	ΔR^2
Block 1				.143	.143***				.156	.156***
Age	.050	.043	.086			.043	.040	.075		
Physical Component Score	.039	.044	.066			-.007	.040	-.012		
Mental Component Score	.022	.039	.041			-.024	.035	-.048		
DAST	2.774	1.012	.204**			1.255	.936	.096		
AUDIT	.120	1.078	.008			3.304	.964	.241***		
Total Income (Per Month)	.000	.001	-.043			.001	.000	.114		
Social Provisions	.544	.130	.312***			.453	.139	.233***		
Enrolment in School	-1.69	1.242	-.100			2.028	1.361	.103		
Block 2				.164	.021				.189	.033
Age	.045	.045	.078			.037	.040	.066		
Physical Component Score	.044	.045	.074			.001	.040	.001		
Mental Component Score	.013	.042	.024			-.035	.036	-.072		
DAST	2.423	1.028	.178*			1.086	.951	.083		
AUDIT	.380	1.093	.025			3.161	.977	.230***		
Total Income (Per Month)	.000	.001	-.033			.001	.000	.079		
Social Provisions	.516	.132	.296***			.413	.143	.213**		
Enrolment in School	-2.09	1.263	-.123			1.999	1.365	.102		
Vancouver (vs Ottawa)	.349	1.341	.022			1.886	1.165	.133		
Toronto (vs Ottawa)	-1.14	1.148	-.081			-.028	1.112	-.002		
Stably Housed	1.469	1.105	.099			1.677	1.001	.118		
Neighbourhood Impact	.353	.295	.094			.441	.315	.104		

Note. * $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

Table 5.

Hierarchical Regression Analysis of predictors on Psychological Integration.

	FU2					FU3				
	<i>B</i>	<i>SE</i>	β	<i>R</i> ²	ΔR^2	<i>B</i>	<i>SE</i>	β	<i>R</i> ²	ΔR^2
Block 1				.232	.232***				.235	.235***
Age	.100	.031	.228**			-.001	.026	-.002		
Physical Component Score	.058	.032	.127			.007	.026	.019		
Mental Component Score	.111	.028	.277***			.113	.023	.337***		
DAST	1.586	.732	.153*			-.712	.607	-.080		
AUDIT	-1.48	.780	-.129			-.201	.626	-.021		
Total Income (Per Month)	-.001	.001	-.071			-.001	.000	-.111		
Social Provisions	.257	.094	.193**			.277	.090	.208**		
Enrolment in School	-.700	.899	-.054			.073	.886	.005		
Block 2				.559	.327***				.430	.195***
Age	.058	.025	.133*			-.023	.023	-.060		
Physical Component Score	.045	.025	.098			.006	.023	.015		
Mental Component Score	.028	.023	.069			.082	.020	.243***		
DAST	.914	.570	.088			-.359	.542	-.040		
AUDIT	-.907	.607	-.079			.149	.559	.016		
Total Income (Per Month)	.000	.000	-.029			-.001	.000	-.169**		
Social Provisions	.221	.073	.166**			.215	.082	.161**		
Enrolment in School	-1.53	.701	-.118*			-.356	.782	-.026		
Vancouver (vs Ottawa)	.461	.745	.038			.564	.667	.058		
Toronto (vs Ottawa)	-.006	.637	-.001			.897	.628	.100		
Stably Housed	.500	.614	.044			.301	.573	.031		
Neighbourhood Impact	1.797	.164	.622***			1.266	.176	.445***		

Note. * $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

Table 6.

GLM Analysis of FU3 Physical Integration.

Variables	<i>F</i>	η^2
Enrolment in School of Training	.70	.003
DAST	.70	.003
AUDIT	.15	.001
Age	.81	.004
Total Income (Last Month)	2.25	.011
Physical Component Score	.00	.000
Mental Component Score	.26	.001
Social Provisions	1.57	.008
FU2 Physical Integration	56.86 ***	.217

Note.* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

Table 7.

GLM Analysis of FU3 Social Integration.

Variables	<i>F</i>	η^2
Enrolment in School of Training	.00	.000
DAST	2.61	.013
AUDIT	5.61 *	.027
Age	2.68	.013
Total Income (Last Month)	.731	.004
Physical Component Score	.01	.000
Mental Component Score	.03	.000
Social Provisions	.17	.001
FU2 Social Integration	43.26 ***	.175

Note.* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

Table 8.

GLM analysis of FU3 Psychological Integration.

Variables	<i>F</i>	η^2
Enrolment in School of Training	.82	.004
DAST	.99	.005
AUDIT	.00	.000
Age	.06	.000
Total Income, last 12 months	.16	.001
Physical Component Score	.01	.000
Mental Component Score	.63	.003
Social Provisions	1.06	.005
FU 2 Psychological Integration	39.21 ***	.160

Note.* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

Discussion

The present study extends previous findings on community integration by focusing on vulnerably housed women's experiences in their communities. In the primary analysis, hierarchical multiple regression analysis (HMRA) was used to investigate the contribution of individual and environmental predictors to participants' level of community integration. Specifically, it was hypothesized that individual level variables such as being older will predict lower levels of physical and social integration and higher levels of psychological integration. Furthermore, having good physical and mental health functioning, non-problematic substance and alcohol use, greater social support, higher income, and being enrolled in school or training program will predict higher levels of physical, social, and psychological integration. The hypothesis for environmental variables was that participants would have the same level of community integration across the three cities (i.e., Ottawa, Toronto, and Vancouver). Other predictions in the study were that participants who have been stably housed and participants who reported positive neighbourhood impact would have greater levels of physical, social, and psychological integration.

The second study goal was to use longitudinal data to explore the relationship between FU2 individual variables on FU3 community integration levels while controlling for FU2 community integration levels. It was hypothesized that individual level variables such participants' age, physical and mental health, the level of substance and alcohol use, social support, income, and enrollment in school or training program FU2 would predict participants' level of integration at FU3.

In the following section, findings for the hierarchical multiple regression analysis will be discussed according to physical, social, and psychological integration levels.

Physical Integration

Participants reported low physical integration at FU2 and FU3. The overall model accounted for 25% of the variance at FU2 and 13% of the variance at FU3. Individual variables such as enrollment in school or training program and physical health functioning explained the majority of the variance in the model.

Participants taking part in activities outside of their homes such as being enrolled in school or a training program had a positive relationship with physical integration. Although there has not been previous research looking specifically at enrollment in school or a training program, participation in a program such as a substance use treatment has also been shown to positively influence physical integration (Gulcur et al., 2007). Perhaps taking part in school or training program encourages people to establish new friendships, which increases participants' activity levels outside of their homes.

Participants with greater physical also had higher levels of physical integration. While the relationship between physical health outcomes and physical integration has not been previously explored, it is reasonable to see the link between better physical health functioning and higher levels of physical integration. Having health problems such as nutritional deficiencies, hypertension, and arthritis, which are common to homeless women (Ambrosio, Baker, Crowe, & Hardill, 1992; Whitzman, 2010), would limit mobility, and consequently, physical integration.

Social Integration

Moderate levels of social integration were reported by participants at both FU2 and FU3. Overall, the final regression model accounted for 16% of the variance at FU2 and 19% of the variance at FU3. This regression model is considered to have a medium effect size (Tabachnick

& Fidell, 2007). Individual variables such as social support and drug and alcohol use explained the majority of variance for social integration.

Specifically, participants with higher levels of social support had higher levels of social integration. This finding is similar to past research that also examined social support (Chang et al., 2014; Townley et al., 2013). Having social support entails relationships in which participants often engage in reciprocal support, which perhaps leads to engagement in social activities.

A contradictory finding in our study was that participants with higher problematic drug and alcohol use had higher levels of social integration. Although a small effect size, our findings were also supported by the longitudinal analysis, which indicated that having problematic alcohol use at FU2 predicted higher levels of social integration at FU3. Findings of positive relationships between drug and alcohol use and community integration have not been consistent. While Gulcur and colleagues (2007) found a negative association between substance use and social integration, Abdallah and colleagues (2009) found a significant positive relationship between alcohol problems and social ties (i.e., having at least three reliable social contacts). It would be useful to examine these variables further by exploring the types of interactions participants have in their neighbourhoods. A possible explanation for the results is that participants may be primarily interacting with a homogeneous social network with similar substance abuse problems. Often, these interactions for vulnerably housed people are for meeting their own survival needs (Rowe & Wolch, 1990). Furthermore, studies have also found that even if men and women have a similar severity of substance abuse, women tend to be more socially connected than men (Brunette & Drake, 1998), which may explain higher levels of social integration in our participants.

Psychological Integration

Participants reported high levels of psychological integration at FU2 and FU3. The model accounted for 56% of the variance at FU2 and 43% of the variance at FU3, which are considered to be large effect sizes (Tabachnick & Fidell, 2007). Individual variables such as higher mental health functioning, older age, lower income, greater social support, and not enrolled in school or training program contributed to the variance. For the environmental variable, neighbourhood impact explained 20 to 33% of the variance for psychological integration at both time points.

Higher mental health functioning was associated with higher levels of psychological integration. Previous research among adult and youth living in independent housing shows that higher levels of psychopathology is negatively associated with psychological integration (Gulcur et al., 2007; Kidd et al., 2013a). Prince and Prince (2002) also examined the impact of mental illness on a sense of community among people in an Assertive Community Treatment (ACT) program. The researchers found that participants' perceptions of stigmatization were negatively related to their sense of belonging in their communities. It is important to note that our findings point to an important distinction between mental health functioning and social and psychological integration. Unlike social integration, it is possible that psychological integration is a more complex process, which involves a higher level of mental functioning. In our study, we also found an association between older age and higher psychological integration. This finding has been supported by previous studies, which may indicate that older participants are perhaps spending more time close to their homes because of mobility issues and are consequently forming stronger bonds with their neighbourhoods (Brodsky, O'Campo, & Aronson, 1999; Ecker & Aubry, 2016).

There was a positive relationship between social support and levels of psychological integration. Participants' sense of belonging can be negatively impacted by rejection from

community members (Prince & Prince, 2002), however, social support and social networks are an important source for providing emotional support, which has a positive relationship with community integration (Ecker and Aubry, 2016; Nelson et al., 1992; Prince & Prince, 2002; Reitzes, Crimmins, Yarbrough, & Parker, 2011).

It was surprising to find that participants who were not enrolled in school or training programs, and had low income and problematic drug use also had higher levels of psychological integration. Previous research on psychological integration does not support these findings, however it is possible that participants were living among and engaging with people with low income and similar substance abuse problems, which may have created a sense of belonging and community in their surroundings. Additionally, not being enrolled in school or training programs perhaps allowed participants to spend more time with people in their neighbourhoods, which created a greater sense of community.

Among the environmental variables, positive neighbourhood impact was the only variable associated with high psychological integration. Our finding is consistent with other research that has also examined the impact of environmental factors on psychological integration within a Canadian sample (Cherner et al., 2017; Ecker & Aubry, 2016). Safety in the neighbourhood and living in a neighbourhood perceived as being better quality has been positively related to sense of community in homeless adults (Cherner et al., 2017; Ecker & Aubry, 2016). Additionally, among formerly homeless individuals diagnosed with severe mental illness, researchers found that neighbourhood relations, safety, quality, satisfaction, and tolerance for the mentally ill played important roles in psychological integration (Townley & Kloos, 2011; Yanos et al., 2011; Yanos et al., 2004). This consistency in the literature points to the importance of context for psychological integration.

Future Considerations

The current study can serve to stimulate future inquiries examining vulnerably housed women's experiences of their community. Further research is needed to understand neighbourhood characteristics such as socioeconomic factors, neighbourhood design, urban versus rural locations, and housing type that have been shown to be important variables in previous research (Marcus, Echeverria, Holland, Abraido-Lanza, & Passannante, 2015; Wood, Frank, & Giles-Corti, 2010). Additionally, a re-examination of how we conceptualize and measure community integration for individuals who are vulnerably housed would be worthwhile. Factors such as the definition of neighbour for people who are not living in independent housing, participants' preference for the type of people they would like to interact with in their neighbourhoods, and the stigma and discrimination directed towards people with mental and substance use issues need to be considered. It would also be useful to assess participants' reasons for engaging in community activities and whether community integration is important in their life.

It can be argued that to understand the complexities of community integration, approaches beyond quantitative methodologies must be applied. Future research examining community integration need to be modeled after previous research that have used innovative methods such as Geographic Information System (GIS) to track participants' activity space (Chan et al., 2014), participatory mapping (Townley et al., 2009), walk-along interviews (Kloos & Shah, 2009), and photo-elicitation methods (Klitzing, 2004; Sylvestre, Bassi, & Bendell, 2017).

Limitations

A limitation of the study was the use of secondary data. The HHiT study was not solely focused on the experiences of community integration for participants. Having a study, which specifically focused on variables such as locus of meaningful activity, the number of friends and family that provide support to participants in the neighbourhood, would have generated richer content on community integration. Although the strength of this cohort study is the large geographically diverse sample of women (i.e., Ottawa, Toronto, and Vancouver), generalizability for the study is still restricted to these cities. With the current study, we cannot be certain that the facilitators and barriers to community integration are generalizable to other women and whether or not the findings are unique to women. Furthermore, much of the data collected was self-reported, which inherently carries biases such as inaccurate reporting due to social desirability (Podsakoff, MacKenzie, & Lee, 2003). Recruitment was also restricted to participants who could communicate in English or French only, making it possible that the sampling strategy may have overlooked diverse vulnerably housed populations from different ethnic and cultural backgrounds.

It is also important to note the likelihood of false-positive findings for the cross-sectional analysis. It can be speculated that the large number of predictor variables in the multiple regression analysis could have resulted in a loss of power for each predictor variable, which led to different results for FU2 and FU3. The cross-sectional nature of our data also limits the direction of the relationship in our findings. It is possible that being more socially integrated into the neighbourhood increased participants' problematic alcohol use. It is also important to note that participants were living in different housing types (e.g., own apartment, rooming house, nursing home), which could have impacted participants' integration levels differently. For instance, participants living in their own apartment may have interpreted the meaning of

neighbour differently from another participant living in a rooming house. Participants may have defined their neighbours as those living next door in the same building. Furthermore, it is possible that the questions used in the survey, such as going to the park and café, did not represent the lives that vulnerably housed women lived in their neighbourhoods. It would be pertinent that for future research, survey questionnaires are created with the assistance of vulnerably housed women who have experienced homelessness.

Policy Implications

Our findings have implications for service delivery for women who are vulnerably housed. The results suggest that service providers should take into account individual factors particularly those that benefit women's physical and social integration such as involvement in organized activities (e.g., enrollment in school or training programs) and social support. Furthermore, when considering housing for women, service providers need to consider the impact the neighbourhood has on the person's life. Choosing good quality housing and neighbourhoods where women feel safe and comfortable is key to integration. Furthermore, people given housing should have a neighbourhood orientation before moving into their apartments so that they can express their concerns and are aware of amenities and services in their neighbourhood.

Surprisingly, our findings showed that problematic drug and alcohol use predicted higher levels of social integration for participants. It is possible that living in high-risk neighbourhoods and engaging with people with similar addiction problems would foster greater levels of social integration for these participants. As researchers and service providers we need to be aware that although part of the recovery process involves interactions between the vulnerably housed and the general community, people still tend to interact with those who they perceive as similar to

themselves (Cummins & Lau, 2003). Instead of ignoring and devaluing these interactions as not being an aspect of community integration, we must examine what it is that these forms of interactions provide for these individuals that contact with the general public does not.

Chapter 4: Study Two

Community Integration Experiences of Women in the Housing First Program:

Neighbourhood Walk and Photo-Elicitation Interviews

*The data for the study were collected as part of the *Supportive Housing for People with Problematic Substance Use* (SHARPE) evaluation study in Ottawa. Dr. Tim Aubry and Dr. John Sylvestre served as Co-Principal Investigators for the SHARPE study. Dr. John Sylvestre also supervised the doctoral thesis research presented in this manuscript. Amandeep Bassi developed the research presented in this manuscript and conducted the interviews with the participants for the study, as well as conducted the data analysis. Funding for SHARPE was provided by the Ontario Ministry of Health and Long-Term Care as part of the Supportive Housing for Ontario Addictions Programs.

There are four central elements of the Housing First (HF) model: 1) consumer choice of housing and goals, 2) housing is not contingent on sobriety and treatment acceptance, 3) treatment goals are made by consumers, and 4) promotion of community integration, where consumers live in normal apartments (Tsemberis, 2010). The three elements of community integration (i.e., physical, social, and psychological integration) have been explored in several programs using an HF approach. The HF model was first put into practice by the Pathways to Housing program in New York City (Tsemberis & Eisenberg, 2000). Yanos and colleagues' (2007) study examined HF using quantitative and qualitative methods. The researchers looked at community, individual, and program factors that contribute to community integration for formerly homeless people (N = 44). The researchers found that participants' housing type (i.e., independent apartments or congregate settings) was not significantly associated with community integration outcomes. However, from the qualitative analyses, the researchers found that locus of meaningful activity, which impacts people's sense of community, was strongly linked to housing type. That is, those living in independent apartments were exercising independence and making choices that gave them more opportunities to take part in meaningful activities outside of the program.

Another study with Pathways to Housing also evaluated community integration among adults with psychiatric disabilities and histories of homelessness (Gulcur et al., 2007). The study participants were divided into two sub-groups: the service as usual (n = 126) and HF group (n = 99). The researchers found that consumer choice (i.e., choosing where they live and how they spend their day) and living in independent scatter-site housing were strong predictors of psychological and social integration. On the other hand, Tsai, Mares, and Rosenheck (2010) also examined community adjustment for chronically homeless adults (N = 709) and did not find any

difference between HF and Treatment First groups (i.e., where individuals must remain sober and participate in mental health treatment; Tsai et al., 2010) on measures of community adjustment.

In the Vancouver At Home Study, Patterson et al. (2012) examined community integration for homeless adults (N = 497) 6 and 12 months after being assigned to the HF with support services or to treatment as usual group. Although physical integration levels did not change for any of the participants, there was an increase in psychological integration for participants with less severe needs. In particular, the HF group was more likely to agree with statements that were related to emotional components of community (i.e., feeling at home and a sense of belonging where they lived), but were less likely to agree with statements that were related to neighbouring.

Coltman and colleagues' (2015) study, however, found that community integration is a more complicated and non-linear process. In the qualitative sub-study of the larger At Home/Chez Soi project, which was a Canada-wide randomized controlled trial study conducted in five cities (i.e., Vancouver, Winnipeg, Toronto, Montreal, and Moncton), the researchers specifically looked at the HF program and treatment as usual group in Toronto. The researchers rated 14 interview transcripts as either high integration or low integration levels. Overall, three themes emerged related to participants' experiences of community integration. For participants, community integration was defined by how they: 1) organized their lives, 2) functioned in a society that is usually not accepting, and 3) became more self-sufficient or independent. Participants also described both positive and negative experiences in their neighbourhoods. Violence and drugs were a concern for some participants, while others described having access to amenities as being important for community integration. The researchers also found that having housing or specific services relevant to participants needs did not change participants' lives

because they were still experiencing past trauma, substance use, the legal system, disability, and food and money security issues.

A quantitative sub-study of the larger At Home/Chez Soi study examined HF with assertive community treatment (ACT) for participants with serious mental illness (N = 950) for 21 or 24 months (Aubry et al., 2016). Participants were randomly assigned to either the HF with ACT or treatment as usual group. The findings showed no significant change in physical integration; however, there was an increase in psychological integration for both groups. Another sub-study of the At Home/Chez Soi study applied qualitative methods to understand the link between HF and recovery for 195 participants with histories of homelessness and mental illness (Macnaughton et al., 2016). The researchers found that participants experienced more isolation after being housed. Some participants also described being involved in unhealthy relationships and not feeling like they belonged in their new neighbourhoods. These findings reflect outcomes related to both social and psychological integration.

Research on HF has yet to conclusively determine whether or not HF programs contribute to increased community integration. From our literature review of research applying the HF model, quantitative research indicates that HF improves participants' psychological integration levels (Gulcur et al., 2007; Patterson et al., 2015). From the qualitative studies, we see that participants have a non-linear progression in community integration (Coltman et al., 2015). That is, although participants in HF are more likely to take part in meaningful activities outside of the services provided to them, they also face several challenges such as past trauma, the presence of violence and drugs in neighbourhoods, and feeling isolated that often set them back from fully integrating in their communities (Coltman et al., 2015; Macnaughton et al., 2016; Yanos et al., 2007).

Participatory Methods

Participatory Mapping

In participatory mapping, participants are asked to identify the boundaries of their neighbourhoods and amenities that are available within them (Townley et al., 2009). Researchers have used maps to help identify themes, questions, and build theories in qualitative research (Knigge & Cope, 2006). A substantial amount of information is produced through participatory mapping, in which the participants are seen as experts on their environments (Cornwall & Jewkes, 1995).

By using a shared medium such as a map, participants can contribute to the research process by taking a lead role in revising, reviewing, and examining the data with the researcher (Cornwall & Jewkes, 1995). The benefits of participatory mapping include its ease of implementation, its effectiveness in engaging participants in a task, and its affordability over other approaches such as GIS mapping. The simplicity can, however, be a disadvantage, as additional mapping tools may be required for complex projects in which comprehensive information such as relationships between different variables (e.g., income levels within neighbourhoods) are needed for understanding neighbourhoods (Al-Kodmany, 2010). Additionally, by using traditional paper mapping techniques, participants are limited to the scale of the region that is available to them on paper and cannot zoom in or out to look at specific areas within a neighbourhood (Al-Kodmany, 2010).

Walk-along Interviews

Over the years, researchers have used various measures to understand the experience of a place (Aubry & Myner, 1996; McAndrew, 1998; Shamai & Ilatov, 2004; Townley et al., 2009).

Some projects examining neighbourhoods have also used walking as a method to generate both quantitative and qualitative data (Carpiano, 2009; Emmel & Clark, 2009; Evans & Jones, 2011; Kloos & Shah, 2009). Unlike research outside of a fixed setting, the walking method produces quantitative data from the routes taken by the participant and qualitative data from the participant's discussion of the location and the role of the location in their life (Evans & Jones, 2011). Although there are other terms used to describe the walking method (e.g., go-along, walking tours, walk along, walking interviews or guided tours), for the purpose of this thesis, the term *walk-along* will be used.

In the walk-along method, the researcher accompanies the participant in a walk-along, a ride-along, or a combination of both methods (Carpiano, 2009). The design of the walk-along is such that it allows participants to talk about their past experiences, future possible experiences within an environment, and their present experience (Kusenbach, 2003). The interviewing style used during the walk-along can have either an open-ended or semi-structured format.

There are several strengths to using the walk-along method in research. First, the walk-along method can combine the benefits of both field observation and sit-down qualitative methods (Carpiano, 2009). The walk-along method also compensates for the limitations in both field observation and sit-down qualitative methods such as giving the participant an active role in the research and providing a more contextual understanding of the participants' living environment. A limitation of more typical field observation is that it is the researcher's interpretation of the environment that is at the forefront (Lipinski & Nelson, 1974). The walk-along interview compensates for this limitation by incorporating a lead role for the participant. This lead role includes the participants actively describing their neighbourhoods and their experiences in neighbourhood settings (Carpiano, 2009). Sit-down interviews pose the risk of

missing the participants' contextual experiences in their neighbourhoods. This gap occurs because participants often only speak about key events in their lives instead of their daily experiences with people or objects in their environments (Carpiano, 2009). Information about their daily experiences is difficult to generate because the sit-down interview does not stimulate context-sensitive reactions. The walk-along interview contributes by giving the researcher the context for participants' comments and by presenting their identity and role in their environment (Elwood & Martin, 2000). Walk-along interviews are especially useful in mapping social ties, as well as interactions that are often ignored, such as a participant being greeted by a passerby on the street (Kusenbach, 2003). These social interactions that occur in a neighbourhood contextualize the comments made by the participant, which would not have been possible in a sit-down interview (Carpiano, 2009).

Second, the walk-along interview nicely complements other research methods (Carpiano, 2009). Fink (2011) combined the walk-along method with photography, calling it a photography walk-along. Participants were not only creatively engaged in the process, but they also led the path taken during the walk-along and determined the focus of the research by the photos they captured (Fink, 2011).

Third, the walk-along method pays attention to power relations. The power dynamics between the interviewer and the participant can influence how data are generated (Jones, Bunce, Evans, Gibbs, & Hein, 2008). For example, if the participant feels intimidated by the interviewer, there is a risk that the participant will not elaborate on their thoughts. By travelling to a participant's neighbourhood, the interviewer goes through an unfamiliar space to which the participant has access and acts as the tour guide. The interviewer's dependence on the participant for sharing her knowledge about the neighbourhood is helpful in engaging the participant in the

study and in creating a more egalitarian relationship, which is also beneficial in establishing a rapport with the participant (Carpiano, 2009).

Fourth, walk-along interviews provide detail about particular situations and they are also sensitive to context. In walk-along interviews, the blending of strengths for both field observation and sit-down qualitative methods gives the researcher a unique perspective on the participant's experiences in their context (Carpiano, 2009).

Along with strengths, the walk-along method also has challenges that must be considered. Carpiano (2009) has presented five challenges to conducting the walk-along interview, which includes safety, weather, time, equipment, and analysis. The first is safety. Neighbourhoods with high crime rates and drug activity can be especially challenging for both the researcher and participant (Carpiano, 2009; Jones et al., 2008). In Carpiano's (2009) study, some community members saw researchers as being connected to the police and participants were often seen as snitches walking around the neighbourhood with an outsider (Carpiano, 2009). Having this view can become a challenge as participants are more reluctant to join in the walk-along and it also risks the safety of both the researcher and participant. The second is the time of the day and weather conditions. Conducting interviews in very hot or cold weather can be challenging for both the researcher and participant. Carpiano (2009) points out that weather may also have an influence on the participant's action space. Each participant's path and destination in a neighbourhood can especially be influenced by weather conditions. In addition to weather, time of day also has an influence over the experience of the walk-along interview. For instance, the experience of doing the interview in the morning will be different from doing the interview midafternoon when people are returning from work. The quality of the interview can also be affected if the participant has had a long night and is no longer in a condition to walk. Time of

day also has a direct effect on safety for certain neighbourhoods: walking around in the dark, which can be as early as 5 pm in the winter can be dangerous.

The third is the recording equipment used during the walk. The walk-along interview's recording quality depends heavily on the quality of the microphone being used during the interview (Carpiano, 2009). Challenges to hearing participants can be significant when walking on busy streets or in areas where construction is underway. The fourth is analyzing the interviews. Analysis of transcribed interviews can be difficult especially if location information is not identified during the interview (Carpiano, 2009). It is imperative that the researcher takes note of the locations during the walk-along interview either orally or in a written format. This is not only helpful for locating the path taken during the walk-along, but it also lets the researcher take note of any particular issues raised by the participant at specific points during the walk. Carpiano (2009) also suggests doing a mapping activity to establish the walking route and keeping detailed field notes.

In summary, the walk-along method challenges sit-down research that is often used in the social sciences (Sheller & Urry, 2006). The walk-along has the capability of offering the interviewer a richer perspective by providing context to the participant's comments. In this section, the strengths of the walk-along methodology were discussed, including those related to both field observation and qualitative research. Other strengths included the walk-along method's contribution to the research process, the method being complementary to other research methods, and the sensitivity of the methods to power relations. Some challenges of the walk-along method that were mentioned included safety issues within neighbourhoods, the time and weather conditions the method employed, and recording equipment and data analysis. In the next section, the photo-elicitation method will be described in greater detail.

The Photo-Elicitation Method

Since the 1870s, photography has been used in social science research to capture subjects, environments and artifacts (Blinn & Harrist, 1991). It was not until the 1980s that the Photo-Elicitation Method (PEM) gained acceptance through Collier and Collier's (1986) work (as cited in Hurworth, Clark, Martin, & Thomsen, 2005). PEM uses photographs in interviews to generate discussion (van Auken, Frisvoll, & Stewart, 2010). During this interview process, the interviewer gains an understanding of the participant's lived experiences as the participant explains the meaning of the photograph, what experiences have led the participant to have this view, and what elements are missing in the photograph or the sequence of photographs (Harper, 1986).

The photographs used in PEM range along a continuum (Harper, 2002). At one end, there are photographs that take a realist position, which include documentation of people, objects, and artifacts. At the midpoint of the continuum are narrative photographs that depict events in a subject's life or those in a work, school or institutional setting. The other end of the continuum includes reflexive photos that are used to elicit personal insights. These may comprise photos of family, social groups or photos of one's body.

PEM has been used across disciplines in a variety of studies to understand the participant's perspective on issues relating to social organization/social class/family, community, identity, and culture (Bricker, 2009; Hodgetts, Hodgetts & Radley, 2006; Hulko et al., 2010; Kerstetter & Bricker, 2009; O'Connell, 2012). Photographs provide a medium to understand the transactional view of settings and PEM has the potential to provide a unique approach to conducting interviews, but it is not a remedy to all challenges. The following section will examine the strengths and challenges raised with PEM in more detail.

There are four primary advantages of PEM: accuracy, depth, participant-driven approach, and rapport building. Researchers have pointed out that compared to the traditional method of conducting interviews, research using PEM has been shown to produce richer and more focused interviews by acting as “memory anchors” for descriptions of places or events in the past (Harper 2002; Loeffler, 2005; Stewart and Floyd, 2004). Qualitative methods are enhanced with PEM because photographs have the capability of activating feelings, thoughts, and sensations, providing a better understanding of the topic in hand (Loeffler, 2005). Along with precision, in a review looking at photo-interviewing techniques in three case studies, Hurworth and colleagues (2005) also noted that the photo method provided more detailed and longer interviews. By using the photographs, the discussion moves beyond just listing the objects in the photograph. Through the participant’s reflection on the photograph, the researcher receives a better understanding of what the photographs mean to the participant (Harper, 1986).

In PEM, a participant-driven approach is often used, in which the participant selects the images that they would like to discuss (van Auken, Frisvoll, & Stewart, 2010). The participant-driven approach breaks down barriers between the researcher and participant and gives the participant more control over the data being collected (Clark-Ibáñez, 2004). This control, therefore, reduces the power imbalance between the participant and researcher (Zainuddin, 2009). A collaborative effort between the researcher and participant is created, with both trying to come to a common understanding of the topic (Harper, 2002).

By having this collaborative approach, PEM also assists in building trust and rapport between the participant and researcher (Hurworth et al., 2005). Meo (2010) found that PEM created a comfortable environment for an interview because participants were used to looking at and talking about photos about their friends and relatives, which made it acceptable to ask more

detail about topics. She further notes that this may have been difficult to conduct in a more traditional interview. Furthermore, the photographs can also ease the awkwardness of interviews by being the focal point of the discussion, and it also provides an interview agenda so that the interview maintains its focus (Clark- Ibáñez, 2004).

There are, however, some potential issues that have been raised with PEM. These include the limitations of presenting reality through photography, and the method being expensive and time-consuming. One of the criticisms of using photography in research is how much of the photo represents reality (Ball & Smith, 1992). Ball and Smith (1992) view photographs as being a reality for the viewer, which is influenced by the viewer's cultural knowledge. The researchers point out that the interpretation of the photograph cannot be fully exhausted by the viewer because the photograph can have multiple meanings. Furthermore, photographs also have the limitation in not being able to capture context and abstract concepts fully. This limitation was seen by van der Does and colleagues (1992) who used PEM to examine Dutch neighbourhoods. The researchers found that with photographs it is impossible to visualize elements missing in a neighbourhood (e.g., missing trees). Also, abstract concepts such as ethnic integration in neighbourhoods were difficult to capture.

Regarding practical challenges, PEM can be time consuming (Meo, 2010). Meo (2010) points out that more preparation time is needed to organize the photos before the interview and discuss procedures with participants.

While there are some challenges with PEM, such as the presentation of reality in the photos and the practicality of PEM in terms of expense and time, these challenges are often outweighed by the positive qualities of PEM. One of the strengths of PEM is that the photograph plays some unique roles such as providing more detail on the participant's experience, allowing

for a participant-driven approach to research, and helping in building rapport between the participant and researcher. PEM offers a medium by which the researcher can have a better understanding of the participant's worldviews and culture, and it allows for further exploration of content that has been revealed during the interview process.

The Present Study

The current study is a qualitative study of how context and participation in a HF program in Ottawa shaped community integration for formerly homeless women. It adopted a critical realist perspective which assumes that our knowledge of reality is imperfect and that some knowledge of reality in the form of participants' experiences will bring us closer to the greater reality compared to other forms of knowledge (Fletcher, 2017).

There is substantial evidence that women with serious mental illness have unique experiences when living in the community (Cook, 1994; Forchuk et al., 2009; Kidd et al., 2013; Manuel et al., 2012). However, research has seldom examined how women adjust to life in independent apartments when they have a history of challenges with their mental health, substance abuse, and homelessness. In light of these gaps, the present study explored the experiences of women living with serious mental illnesses and addictions as they adapted to their communities after having gained access to an apartment and community-based intensive case management (ICM) support. Participants were recruited from the larger Supported Housing Addiction Recovery Program Evaluation (SHARPE) in Ottawa.

Research Questions

The study will address the following research questions:

- 1) How women in the SHARPE program perceive their local neighbourhoods, regarding:

- a) their interest and ability to participate in these neighbourhoods, and
 - b) the facilitators and barriers to participating in these neighbourhoods.
- 2) How women in the program integrate into their neighbourhoods. Specifically related to:
- a) How they use their local resources in their neighbourhoods (physical integration),
 - b) Their social interactions with neighbours (social integration),
 - c) Their sense of belonging (psychological integration), and
 - d) The role of housing in their life and how it has affected their integration into neighbourhoods

Method

The current study used a qualitative design with mapping, neighbourhood walk-along, and photo-elicitation methods to understand the experiences of community integration for formerly homeless women. All of the participants in the study were taking part in the larger SHARPE study. Participants who took part in the SHARPE study were enrolled in an HF program with Intensive Case Management (ICM) at the Sandy Hill Community Health Centre. The program worked in partnership with the Ottawa Branch of the Canadian Mental Health Association (CMHA) to provide housing and support to people who are homeless, have serious mental illness, and have substance abuse disorders. The participants in the program had case managers with whom they worked to build skills and develop resources in areas of housing, health, and the legal system. Rent supplements were provided to program clients.

To be eligible for the current study, participants had to meet the following criteria:

- a. Gender: All participants were female.
- b. Housing Status: Participants had to be housed in their own apartments provided through CMHA in Ottawa.

- c. **The Length of Occupancy:** At the time of the first meeting for the study, participants had to be living in their apartments for five to ten months. This length of time was selected to accommodate the adjustment period for people to establish themselves and know their neighbourhoods.

Procedure

Interviews took place from November 2011 to May 2013. Meeting times with participants were arranged through the program case managers, or participants were contacted directly by the researcher after they consented to have their contact information passed along to the researcher. Following recruitment, two meetings were held with each participant: 1) a neighbourhood walk-along interview (5-10 months after being housed) and 2) a semi-structured photo elicitation interview (1-2 weeks after the first interview). Participants were interviewed five months after moving into their apartments to adjust for an initial “adjustment” period. Participants were asked to give consent at the beginning of each interview (see Appendices J and L for consent forms) and were paid \$20 honorarium for each interview.

The primary method of data collection was semi-structured interviews using participatory mapping, walk-along interviews, and photo-elicitation methods. Two interview protocols were created (see Appendices K and M for the neighbourhood walking-along and photo-elicitation interview protocols). Protocols were used as guides for discussions during the interviews, and the exact wording and order of the questions remained open. This study received approval from the research ethics board at the University of Ottawa. The two interviews are explained in greater detail in the next section.

Meeting 1: Neighbourhood walk-along interview. There were several objectives for the neighbourhood walk-along. The first was to gain a firsthand understanding of the

neighbourhoods the women lived in Ottawa. It was an opportunity for the interviewer and interviewee to develop a shared understanding of the neighbourhood's layout and the interviewee's use of the neighbourhood. The second purpose of the tour was to generate stimuli (e.g., maps, photos, and field notes) that served as the basis for more detailed interviewing in the photo-elicitation interview. The third objective of this interview was to build relationships of trust and to engage the participant in the research.

In the neighbourhood walk-along interview, a participatory approach similar to the one taken by Kloos and Shah (2009) was followed. The interviewer met the participant (between 10 am and 5 pm) in a public place in the participant's neighbourhood or at her apartment building, depending on the participant's preference. The consent forms were signed after they were reviewed by the participants and questions were answered about the study. The interview began with general questions relating to the participant's housing situation. Before the walk-along in the neighbourhood, participants listed the places they regularly visited, places they would like to go to but have not yet, places they have gone to and did not want to go again, and places they have never visited. A printed Google map of the participant's neighbourhood was used to identify the locations mentioned by the participants and the map was also used as guidance for locations to visit during the walk-along. The locations in the neighbourhood mentioned by the participant included places for errands, social and leisure activities, services, and locations for meeting other daily needs.

The participant was given the option of either using the camera to take photos or have the interviewer take the photos. A Fujifilm camera (Fujifilm Holdings Corporation, Tokyo) and an iPhone 4S (Apple Corp., Cupertino CA) was used to take pictures. Before the neighbourhood walk began, examples of photo subjects were given to participants. Participants were encouraged

to take pictures or identify subjects related to themes of physical (e.g., physical quality, location), social (e.g. relationships, safety), and psychological (e.g., belonging, discrimination) qualities of the neighbourhood. During the tour, the interviewer asked questions relating to these themes. The neighbourhood walk-along interview took one to two hours to complete, and the interview was audio-recorded and transcribed verbatim. Three participants did not join the interviewer for a neighbourhood walk-along interview because of their physical health limitations. For these interviews, the interviewer alone took pictures of the different locations mentioned by the participant.

Meeting 2: Photo-elicitation interview. An approach similar to van Auken et al. (2010) was followed in the photo-elicitation interview. The consent forms were signed after they were reviewed by the participants and questions were answered about the study. The photo-elicitation questions probed the meaning of community integration for the participant. More specifically, the photo-elicitation questions addressed the physical, social, and psychological integration of individuals living in a neighbourhood setting. The meeting with the participant occurred within two weeks of the neighbourhood walk-along, either in the participant's neighbourhood or a meeting room at the University of Ottawa. This time frame ensured that the researcher did not lose contact with the participant and it helped the participant and researcher recall the pictures taken during the walk-along.

The purpose of this meeting was to learn, in a more in-depth way, about the participant's views of her neighbourhood. The map and photos from the neighbourhood walk-along were shown to the participant as stimuli to further discuss her neighbourhood. Each photo was presented individually on a laptop. If there were too many photos to go over during the interview, the participant was asked to select five photos that she felt best represented her neighbourhood.

These photos were then used for the interview. Questions about the physical (e.g., physical quality, location), social (e.g., relationships, safety) and psychological dimensions (e.g., belonging, discrimination) were asked. In this semi-structured interview approach, new questions also emerged as personal experiences and feelings were recounted during the photo-elicitation process.

Measures

Meeting 1: Neighbourhood walk-along interview. The neighbourhood walk-along protocol (see Appendix K for interview protocol) covered five areas: 1) neighbourhood impression, 2) use of places within the neighbourhood, 3) mapping and route plan, 4) neighbourhood walking tour, and 5) walking tour photo pointers. The qualitative questions were open-ended with follow-up probes to extend or clarify answers. The questions were based on the definitions for physical integration (Segal & Aviram, 1978), social integration (Aubry et al., 1995), and psychological integration (Perkins et al., 1990) and the Health and Housing in Transition (HHiT) community integration questionnaire.

Meeting 2: Photo-elicitation interview. The photo-elicitation interview protocol (see Appendix M for interview protocol) covered four areas: 1) transition to the neighbourhood, 2) photo-ranking, 3) photo questions, and 4) community integration questions. The qualitative questions were based on the definitions for physical integration (Segal & Aviram, 1978), social integration (Aubry et al., 1995), and psychological integration (Perkins et al., 1990) and the Health and Housing in Transition (HHiT) community integration questionnaire.

Sample Characteristics

Demographic information (e.g., country of birth, date of birth, ethnic identity, and level of education) were taken from The *Supportive Housing for People with Problematic Substance Use* (SHARPE) evaluation study. At the time of the current qualitative study, participants were asked to provide their address or location of residence.

The Ottawa Neighbourhood Study (ONS; 2011) was used to gather neighbourhood socioeconomic levels. The ONS data comes from the 2011 Canada Census Profile (Statistics Canada, 2011a). The ONS calculated the socioeconomic index for each neighbourhood using: 1) percent of residents aged 24-65 with no high school degree or diploma, 2) percent of residents living in low income, 3) unemployment rate, 4) percent of families that are lone-parent, and 5) average household income (after tax). A socio-economically advantaged neighbourhood was identified with a score of 1 and a score of 5 indicated a least socio-economically advantaged neighbourhood. It is important to note that for some neighbourhoods the ONS data may be out of date, given the urban redevelopment activities in these neighbourhoods.

Walk Score[®], is a publicly available tool, which provides information on a neighbourhood's walkability based on proximity to amenities (e.g., retail, food, schools). Multiple data sources including Google, Education.com, and Open Street Map are used to determine a neighbourhood walk score. Maximum points are given to amenities within a 5-minute walk (.25 miles), and a decay function is used for more distant amenities, with zero points given to distances requiring a 30-minute walk. A neighbourhood's pedestrian friendliness is also measured for walk score. Walk scores are divided into the following ranges: 90-100 walker's paradise (daily errands do not require a car), 70-89 very walkable (i.e., most errands can be accomplished on foot), 50-69 somewhat walkable (i.e., some errands can be accomplished on

foot), 25-49 car-dependent (i.e., most errands require a car), and 0-24 car-dependent (i.e., almost all errands require a car).

Transit score examines how well a location is served by public transit. Data provided by public transit agencies are used to calculate transit score. A “usefulness” value is given to nearby neighbourhood transit routes based on the frequency, type of route (rail, bus, etc.), and distance to the nearest stop on the route. The “usefulness” value is summed and normalized to score between 0-100. Transit scores are divided into the following ranges: 90-100 rider’s paradise (i.e., world-class public transportation), 70-89 excellent transit (i.e., transit is convenient for most trips), 50-69 good transit (i.e., many nearby public transportation options), 25-49 some transit (i.e., a few nearby public transportation options), and 0-24 minimal transit (i.e., it is possible to get on a bus).

Data Analysis

Qualitative data were generated primarily from transcribed audio-recordings of the two interviews. Transcribed interviews were stored as text files and analyzed. Qualitative Data Analysis (QDA) Miner (Provalis Research, 2015) was used to facilitate the analysis of the coded transcripts. Additional data were obtained from field notes, neighbourhood maps, digital photos, documents listing neighbourhood locations visited and not visited, and reflexive journal entries. The analysis followed steps recommended by Miles, Huberman and Saldaña (2014).

Initially, three interview transcripts were reviewed with another coder to gain a deeper understanding of the data. A coding scheme which was informed by community integration theory was initially used to identify themes related to community integration (Miles et al., 2014). Then through the process of inductive coding, emerging themes related to community integration (i.e., physical, social, and psychological integration) were identified. The coding process included

reading transcripts line-by-line, which was useful for extracting recurring themes and for organizing data into categories (Charmaz, 2006). After the initial categories had been identified, a third reviewer reanalyzed a single transcript to ensure that the codes fit the coded elements of the transcripts and that there was consistency. The codes were reviewed at several stages of the analysis and feedback was given to the categories and definitions.

A codebook was created, and codes were clarified, added, collapsed, or deleted, which gradually refined the codes and made it possible to see overarching themes in the interviews (Miles et al., 2014). Key themes for each level of community integration (i.e., physical, social, and psychological integration) emerged. The validity of the codes was ensured through inter-coder agreement. Using the codebook, we were able to see if the reviewer assigned the same or different codes for the interviews (i.e., both walk-along and photo-elicitation interviews). The revised coding scheme was re-applied to all transcripts and changes were made to the codes until no further refinements were required. The final codebook included participants' 1) demographics (e.g., health issues, experiences with family and friends, and financial challenges), 2) goals and choices (e.g., priorities in life, things participant avoids, thoughts on integration), 3) integration levels (i.e., physical, social, and psychological integration), 4) housing experiences (i.e., both past and present) and 5) experiences with the research method (see Table 1 for full list of qualitative codes and sub-codes). A case-level matrix display, which presents the data in a summary table, was also created to organize and verify the community integration themes (Miles et al., 2014).

Neighbourhood data. Each participant's neighbourhood was located by using her home address on Google Maps. The location of neighbourhood on Google Maps was then compared to the online map provided by the Ottawa Neighbourhood Study. The socioeconomic status of each

neighbourhood was then taken from the ONS database. The neighbourhood walk score and transit score were extracted from www.walkscore.com using the participants' addresses.

Results

Sample Characteristics

Sixteen women took part in the neighbourhood walk-along interview and 15 women participated in the photo-elicitation interview. Participants' ages ranged from 22 to 55 years, with the mean age being 39.63 years. The majority of the participants in the study identified as White Canadian. Eleven of the participants had attended, but did not complete high school. Majority of the participants lived alone in a one-bedroom apartment. Prior to moving into their apartment, participants' median longest single period of homelessness was a year. Participants reported spending a median of \$675.00 dollars per month on rent.

Participants lived in eleven different neighbourhoods, which were generally characterized as having low socioeconomic status. Eight participants lived in very walkable neighbourhoods (i.e., most errands can be accomplished on foot), five lived in somewhat walkable neighbourhoods (i.e., some errands can be accomplished on foot), and three participants lived in walker's paradise neighbourhoods (i.e., daily errands do not require a car). Seven of the participants lived in neighbourhoods with excellent transit (i.e., transit is convenient for most trips), seven had good transit in their neighbourhoods (i.e., many nearby public transportation options), and two participants had some transit in their neighbourhoods (i.e., a few nearby public transportation options).

Physical Integration

The concept of physical integration refers to activities that are initiated by the individual, and that occur outside of their home (Segal et al., 1980a). There are three components of physical integration: 1) the amount of time an individual spends within their community, 2) the activities that the individual is involved in within their community, and 3) the extent to which an individual uses goods and services in their community.

For the most part, participants in this study did not talk much about physical integration in their neighbourhoods. Overall, participants reported spending most of their time inside their home, or in downtown Ottawa where they previously lived, rather than in their current neighbourhoods. When participants did describe activities in their current neighbourhoods, these were usually restricted to day-to-day tasks such as going to the pharmacy for their medication, grocery shopping, or getting items from a convenience store. Walking was their primary mode of travel in their neighbourhoods. Because of familiarity and availability of services only in downtown Ottawa, participants described engaging in more activities there, regardless of having high walkability scores in their neighbourhoods. For downtown activities, participants described using services at shelters, attending appointments at health care services and banking. To go outside of their neighbourhoods, participants usually relied on their caseworker for transportation, or used public transportation. Overall, participants mentioned being pleased about living in neighbourhoods where there was a greater frequency of bus services because it gave them more flexibility with travelling in and out of their neighbourhoods.

In the following section, personal and environmental factors that related to participants' physical integration in their neighbourhoods will be discussed.

Personal factors.

Health. All participants spoke about how health influenced their level of participation in their neighbourhoods. Participants spoke about their health in terms of both physical and mental health, as well as the challenges associated with their substance use. Five participants discussed their physical health as inhibiting them from exploring their neighbourhoods. Physical health problems that were commonly discussed by participants included those that prevented them from walking long distances (e.g., hip problems, asthma symptoms, back problems, and knee pain). One participant with a knee injury explained her difficulty walking to places:

Oh no. I don't go hardly anywhere...I've never made it past this road [road in neighbourhood]. So, I didn't even know there was a [retail store] out there. But uh, I just go to [local corner store] and my home because of my kneecap.

For another participant past health problems also limited her level of physical integration:

...I'm tired all the time. And, and I can't walk very much because I'm in pain all the time. ...My back, and I had a spinal fusion and hip replacement...And I have heart infection and I had blood infection...Like I'm still recovering from it... I'm recovering and I, I get tired very easily.

Thus, some participants' capacity to explore their neighbourhoods was limited by their physical health, which sometimes restricted them to only use amenities that were available close to home.

All participants discussed their struggles with mental health and substance use problems. Some participants spoke about feeling too anxious or depressed to leave their apartments. When asked about the places she might go to in her neighbourhood, one participant elaborated on her

limited daily activity because of her anxiety: “No. Like I said, I’m a hermit. [laughs] Like, I’m, I’m scared to go outside. So, I watch my TV, or go to [a friend’s] building.”

The women interviewed for this study struggled with addiction and therefore described avoiding places and people who put them at risk of being “triggered”. Participants were afraid to explore their neighbourhoods because they feared their substance use would worsen once they found out where drugs were available in the neighbourhood. One participant explained this fear:

I don’t want to think anything about my neighbourhood because when I think in my mind it’s like no, I am not triggered. I don’t know any crackheads in my neighbourhood. I don’t want to know... I want to stay invisible, and I don’t want to know my neighbourhood, and I don’t want to get out too much because I will... Yeah, and so far, no triggers. So far, it’s good that way. And I want to keep it that way.

Often participants described avoiding people who were associated with drugs in their neighbourhoods:

... I’m trying to avoid the bad crowds, you know what I mean? Like they’re not bad people, it’s the drugs that I wanna stay away from...Yah, I’m trying my best not to run into...it’s a small world, you bump into everybody eventually, but so far, I’ve been out of it.

In summary, mental health challenges including addiction problems were the biggest contributor to limiting participants’ level of physical integration. Some participants also described physical health problems that impacted how much they walked, especially in their neighbourhoods.

Poverty. Even when participants had amenities in their neighbourhoods, their use of services was typically limited by their financial situation. Six participants made statements about not being able to go to restaurants, grocery stores, and museums in their neighbourhoods because they did not have enough money. Often with the help of case managers, participants made cost-effective choices by going to less expensive grocery stores outside of their neighbourhoods and choosing fast food restaurants instead of sit-down restaurants.

One participant, who was living in a neighbourhood with plenty of restaurants, shops, and cafés, felt that she would enjoy what the neighbourhood offered if she only had money. Most participants indicated that the use of their neighbourhood, including buying groceries and going for coffee, depended on how much money they had spent over the month. A participant explained, “Like I don’t...go anywhere right now because I don’t, financially, I don’t have the sources to take buses left and right whenever I want to...And financially, I don’t have money to, to put in to things yet.”

One of the biggest and often unpredictable expenses that participants had over the month was the costs associated with illegal drug purchases. A participant spoke about her struggles with her finances during the month:

...Usually I would smoke crack cocaine because I was angry at not being able to have enough groceries. You get \$300 one day, you buy cigarettes at the grocery store, you might even buy a hundred dollars’ worth of groceries. But two weeks later you’re starving, you’re got nothing, and there’s no new money coming in.

In summary, participants typically found it to be a struggle to live in the community with limited funds. They talked about going to different fast food restaurants and the corner store or

grocery store when there was enough money left for the month. This use of neighbourhood spaces became a lot more restricted when they had little money left, often leading them to stay inside their apartments. For some participants, limited funds led them to rely on the food bank, panhandle, sell drugs, and prostitute to supplement their incomes.

Environmental factors.

Accessible neighbourhood and familiarity in downtown Ottawa. A significant factor that participants said promoted their physical integration in a neighbourhood was conveniently located amenities. Eleven out of the sixteen participants felt that their apartments were close to resources important to them, such as corner stores, grocery stores, fast food restaurants, and pharmacies. Nevertheless, participants continued to make frequent trips to downtown Ottawa.

Being situated close to amenities was considered to be an asset for participants. During the mapping exercise one participant, who lived in a very walkable neighbourhood where most errands can be accomplished on foot, pointed out, “See this is my whole area. Right here. This square right here, is my whole area...for living, for working, for groceries.” For some participants, the cost of convenience was higher grocery bills. Another participant, who lived in a somewhat walkable neighbourhood where some errands can be accomplished on foot, explained, “...It’s more expensive than other grocery stores, but...[it] doesn’t matter. It’s still close. It’s convenient.” Some participants used stores close to home just to supplement their grocery needs. A participant who lived in a very walkable neighbourhood pointed out, “Yeah, this [corner store] is probably faster to get to than the other [stores]...But I go there for quick things.” Overall, participants were happy to have services close to their apartments, however, familiarity and availability of services only in downtown Ottawa led them to make frequent trips to downtown Ottawa.

Although the majority of the participants chose to live away from downtown Ottawa, all of the participants left their neighbourhoods, if not every day then at least a few times a week, to access services they were familiar with and that were only available in downtown Ottawa (e.g., meal and clothing programs in shelters, drop-in support programs). Although a participant lived in a somewhat walkable neighbourhood, she explained how support programs that existed in downtown were not available in her neighbourhood:

...Unfortunately, there's no community center around me and I wish there was. That way I can access like, like anything I need. Like I know a lot of people in my area of town. Like you know, but there's no community center we can go and sit and have coffee. There's no drop in that I can actually go and meet people, you know. Like I wish there was something.

Said one participant, who lived in a somewhat walkable neighbourhood and with many public transportation options:

If I was gonna go grocery shopping, I would go downtown. Just because they're open 24 hours and I don't know like, I can't usually get things done like at normal times you know? So, like I'm usually awake from, I don't know, 3 [pm] and on.

Another participant, who also lived in a somewhat walkable neighbourhood with excellent transit, described her experience with her doctor who was only available in downtown Ottawa:

Unfortunately, I go to the [downtown shelter], um, 'cause that's where my doctor is located. But I don't wanna have to go there, but I got no choice...I think between the

[downtown mall] and [parkway], it's kind of, you know, where I don't wanna be because I had, I have a, you know, I have an addiction.

Similarly, another participant, living in a somewhat walkable neighbourhood with excellent transit system, described her daily trip to downtown Ottawa for her medication. She explained, "...When I'm on the methadone, I go every day... You can't get any methadone anywhere else but downtown."

Overall, although most of the participants lived in walkable neighbourhoods, where they lived close to amenities and errands can be accomplished on foot, certain services and programs were only available in downtown Ottawa, which led participants to visit downtown Ottawa regularly even if they wanted to avoid the area. Our findings show that for participants in this study, having access to good public transit was also important, especially to receive support services in downtown Ottawa. These factors however impacted participants' physical integration levels, which overall appeared to be low.

Safety. Participants described feelings of uneasiness in their neighbourhoods, despite describing their neighbourhood as quieter and safer than downtown Ottawa where they spent most of their time. This feeling was related for some to their own past experiences of abuse and to the criminal activities present in their current neighbourhoods. Participants also discussed steps they took to avoid threats to their safety.

Although participants generally described their neighbourhoods as being safer and quieter than downtown Ottawa, occurrences of criminal activities in the neighbourhood affected them. All participants described feeling unsafe either in their apartment or neighbourhood. One participant explained:

Yeah, there's gang wars too and you can feel it, even if you're not part of it...Like I know some older people are feeling, they feel nervous, you know? There was like a stabbing when I first moved in, there was a stabbing on the second floor...the police are there quite a bit...

Participants were aware of illegal activities in their neighbourhoods, and they were often confronted by problems when they walked in their neighbourhoods. A participant, who had recently been physically abused, explained, "I'm always watching my back, you know? I'm always kind of looking around. I'll just stop and I'll look around, then I'll walk again." Participants also described occasions where they have had to make changes within their own apartments to create a safer space. One participant discussed how she makes sure nobody can come into her apartment through the back window:

...I know this window here, it's easy to open it. That's why I have a weight in there so people can't come in there...One day I was in my apartment and sometimes I don't answer the door even if I'm there...He [a friend] went into the back and started opening...I put a note on the window saying if I catch anybody going through my window, I'll call the cops.

Most participants avoided walking in their neighbourhoods after dark. One participant spoke about her experience as a female walking in her neighbourhood and being approached by men at night:

It's not safe to walk in the 'hood area by yourself at night. Like towards [a large grocery store] and stuff. I don't feel comfortable as a girl walking around there by myself because

you've got some men and they'll come up to you and say, "Who are you?" And it kind of scares me. Because you don't know what's gonna happen, right?

Another participant also explained why she was afraid to walk in the night:

This place at night, I don't like this place at night. Well just to me it's just...well I dunno it's really dark, no lights...There's a lot of wackos, sickos out there. I know, I've been on the streets for almost four years when I lived on the streets.

For one participant walking from the food bank the dark was a risk she was not willing to take. She explained, "...Food bank side, late at night I don't like walking over there, no. It can get a little creepy. You can get caught up in something illegal there."

Despite feeling unsafe, some of the participants felt that their lives prior to being housed, especially during the time they were homeless, has given them a better perspective on how to survive dangerous situations. A participant described this in more detail:

Nobody's gonna touch me anyways though...So, yeah, I'm safe...If I can go out in my neighbourhood on 400 grams of OxyContin and not be raped or touched or robbed in any way then I feel safe. I don't recommend it for any woman to be going out at like 2 or 3 in the morning...or have a few beers. I don't recommend it for anybody, but for me and the way I grew up I feel safe.

In summary, participants' level of physical integration was affected by unsafe neighbourhood environments. Beyond the risk that participants felt walking in downtown Ottawa, participants also described feeling uneasy walking in their own neighbourhoods. Participants were aware of criminal activities in their apartment building and neighbourhood, which led some to take precautionary measures to avoid unsafe situations.

Social Integration

There are two dimensions to social integration: 1) one related to an individual's interactions with community members in normal community settings (Wolfensberger & Thomas, 1983) and 2) one related to an individual's social network size, structure, functions, and capacity to provide support (Storey, 1993). With respect to the first dimension, participants typically preferred to have social interactions with people either living in the same apartment building or business owners and their employees in the neighbourhood. For the second dimension of social integration, participants were most likely to identify people living in the same apartment building and friends living in the same neighbourhood as people in their social network. Participants regularly went to downtown Ottawa, when they wanted to be in the company of others, such as friends and family. Within their neighbourhoods, participants interacted with people from their past to a greater extent than with other community members.

In the following section, the amount and types of interactions participants have in their neighbourhood will be discussed. More specifically, participants' social interactions are separated into those that occurred within participants' apartment building and those that occurred outside of the apartment building. Furthermore, participants' choice regarding the amount of social interactions they preferred in their life and their reasons for not interacting will be discussed.

Making choices about social interactions. Generally, participants were reluctant to socialize in their neighbourhoods. Three reasons participants gave for not interacting with their neighbours were: 1) protecting their new life from bad influences; 2) wanting to have privacy; and 3) not seeing social interactions in the neighbourhood as a priority for them.

When discussing their level of social integration in their communities, participants generally expressed that expanding their social network was not a priority at this point in their life. One participant explained, “I’m not going out anywhere too much...I’ll go get my beer. I’ll bring it here. I’ll get food. I’ll bring it here...I’m not socializing really too much...I’m not doing the community thing too much.”

Other participants spoke about keeping a distance from people in their building and were often reluctant to form close relationships with them because of their desire to protect their privacy. One participant explained:

There’s a couple of people I’ll talk to and that’s as far as I go, but not like going into my life or anything. Just like “How’s the weather?” and “How are the kids doing?” and how my day was, and stuff like that. Just general conversation.

Similarly, another participant explained, “...I don’t make friends in my building...I don’t want to be bothered in my building...I don’t want people knocking on my door, “Can I borrow this, can I borrow that...” No, I can’t live with that.”

Another participant also described the importance of privacy in her life.

Good so far. Um, except that one, one thing about when you move into neighbourhoods, people tend to “Ah, who is she?” and all that. Yeah, they’re very nose-y and, you know? And they want to get to know you...And I’m kind of shy about that, you know?

Participants also emphasized protecting their home and neighbourhood in order to maintain their sobriety and health. In neighbourhoods where others were also struggling with substance abuse, participants were particularly restrictive about who they interacted with in their neighbourhood or let into their apartments. One way participants protected their home from drugs

was by not revealing the location of their apartment to people they know. This was often difficult to do in neighbourhoods where there was a high concentration of people from participants' past lives. One participant explained:

No, I'm happy, but I don't let... I'm not into drugs anymore so I don't want anybody at my house. And I've made it clear to a lot of people I see on the street: Don't bother coming to my house.

Similarly, another participant described why it was important for her to protect her apartment:

From the past, yah. Like if I'm going to use I'll go down there [downtown] and use. You're not going to come to my house, that's where I live. You don't shit in your backyard. It's my home. I have to sleep there. I cook dinner there. I have a cat. I don't want bullshit there. If anybody's gonna cause bullshit it'll be me. I'm not gonna bring somebody in that I used to use with and have everybody at my front door. It's my safe zone it's away from the bullshit.

Those participants who were open to making friends in the community were careful with their choices. Said one participant:

I've met a couple of people at a bus stop, but like more meet them at methadone [clinic], which a lot I don't want to hang out with...unless they're being serious about their sobriety.

This participant was open to making friends in her neighbourhood, but her prospects for making new friends were limited. A majority of the participants felt it was safer to keep their distance from people they did not know.

Participants generally spoke about not trusting people they came across in their neighbourhoods. A participant described this:

Just because I don't want to get to know them. You never know. You never know these days who you're getting to know or talking to, you know? Myself, I trust no one. I trust no one. And I will take that to my grave. I trust nobody but myself. ...I'm trying to like leave my past where it is. And I'm still at the point where I'm trusting no one.

Another participant with a similar experience described how she does not have the social skills to meet people:

I've lost it. I've lost it a long time ago because I've isolated myself. I don't trust anybody. I think everybody out there wants something from me and part of it's because maybe I took advantage, but I know I'm a good person.

An absence of a safe environment in which to have social interactions over the years have led many participants to be distrustful towards people they did not know.

In summary, participants did not socialize with people in their neighbourhoods for the following reasons: 1) not a priority for them to expand their social network; 2) wanting to maintain their privacy; and 3) wanting to protect their new life from bad influences.

Interactions with people in the neighbourhood. Unlike their life in shelters with little privacy and choice about whom they interacted with, participants described having more choice regarding the amount of socialization they wanted after being housed. The following section describes the choices participants made concerning social interactions in their neighbourhoods.

Socialization in the form of transactions. Participants' interaction with community members outside of their apartment building was limited. When there were interactions, they

were brief and often in the form of a greeting or a business exchange. Four participants described not being able to relate to the neighbours because of their different lifestyles. One participant described their neighbours outside their apartment building as people busy with their lives who mostly kept to themselves. One participant spoke about this in more detail: “You know, like they don’t, they don’t talk much with each other. They get into their cars and go. I find that sad, you know.”

Another participant also explained why it was hard for her to relate to her neighbours:

...They [neighbours] seem like the kind of people that my parents would talk to, the kind of neighbours like I grew up around, you know like normal people. Like I say people with morals and values and I think that I wouldn’t talk to and associate with them just because of who I am now.

For those who did interact with their neighbours, most of the interactions occurred when participants were carrying out their daily activities and using businesses in their neighbourhoods. One participant spoke about such an interaction, when she went to her pharmacy:

Um, I don’t really know the people, except at the pharmacy I go to. And the people there are awesome. They’ve done a lot for me, since the time that I started going there, about three months ago. They actually one day, when I didn’t get my medicine, they called me, like 16 times throughout the day. They thought something happened to me. And they stayed open an extra half an hour just so I can get my medicine.

The participant did not interact with people living outside of her apartment building, but she found her interactions with the staff at the pharmacy in the neighbourhood enjoyable.

For another participant, her interaction with a corner store owner turned unpleasant after she did not comply with the sexual favors he was expecting:

He tried to pick me up one night. I just gave him ten bucks to take me down to [store]. I was looking for a cab and he picked me up instead. I knew what he wanted... I just gave him ten bucks and said, "Thanks for the ride" and that was it. Ever since that day his nose turned on me. I can't tell anybody, I don't want it getting around, know what I mean?

Another form of interaction participants had in their neighbourhoods was either buying or selling drugs. One participant described her interaction with her dealer. She explained, "Since she [drug dealer] got raided, she's very quiet. She's a nice lady. I like her. You know? And when I go see her, I don't have money or whatever, she gives me everything. You know?"

Participants also spoke about their experiences in their neighbourhoods where they were approached to sell drugs or medication they received from the pharmacy. This participant found this experience embarrassing because it occurred in a grocery store where other neighbours, who were not looking to buy drugs, were also present:

...Guys like can you not get me crack? I'm like oh my god I'm like buying freaking potatoes and green peppers. He goes "Do you have any food?" I'm like, "Aren't you in a grocery store?" But I'm being a bitch right, 'cause I know what he means; crack means food right.

In summary, other than business interactions, participants had little interactions with community members. Some participants saw the difference between their lifestyle and their neighbours' lifestyle as a barrier to social interaction.

Interactions with people living in the apartment building. Interactions with people living in the same apartment building were much more common for participants than with those living in the community. Participants described both instances of conflict and neighbourliness with people living in the apartment building. Often participants interacted with people from their building in common areas such as the front entrance, pool, or elevator. When participants were asked to describe the people living in their building, they typically described them as being ethnically diverse, seniors, people from their past, and people who have substance abuse problems and have been in trouble with the law.

Negative interactions with apartment neighbours. Although interactions with others in their buildings were more common, they were not always positive. Eight of the 16 participants spoke about having some kind of conflict with people living in their apartment building. Conflicts with people in the building were generally attributed to other tenants gossiping about the participants, inappropriate requests made to the participant, noise, or substance use. Said one:

And I heard him, like this was a month ago, one night saying hi to me and then passing me and then telling his friend she's a crackhead. ...But I confronted him, I said, "You know what", I said, "I got my problems." I said, "Do you have a problem with me? Do you have an issue because if you..." And he goes, "Oh no." Totally denying it.

Another participant described an incident in her apartment building:

...She's like only a couple of doors down from me...on the same side. And she was like screaming and yelling and the cops ended up coming and I ended up going out there. I'm like... All I said was, "Do you mind? Like I'm trying to sleep." [Neighbour said] "That stupid fucking lady...", and blah, blah, blah, blah. I was like whoa like I don't know if this

girl's gonna attack me or whatever. So, I was like, okay. I just turned around and came back in my apartment.

Still another participant described being harassed by a neighbor:

Some people there are nice and some people are ignorant and ...so how can I put it?

There's this old man that lives downstairs and he asked me if I wanted to...if I had a boyfriend and all this and I didn't like the situation.

The participant was advised by her case manager to call the police if she was harassed again by this neighbour.

In summary, participants described having conflicts with their apartment building neighbours. In general, conflicts were related to rumors that were being spread about the participant, inappropriate requests made to the participant, noise or substance use problems that were causing disturbances in the building.

Positive interactions with apartment neighbours. Despite the conflicts that arose with some residents, five participants were grateful when they received help from people living in the building. Participants were helped by receiving food, furniture, and talking to their neighbour during difficult times. A participant described the help she received from an anonymous neighbour in her building. The participant said, "Well, my neighbours we don't talk too much, but I noticed that they're leaving me peanut butter sandwiches in the laundry room, which helps." Two other participants also spoke about receiving help with furniture for their apartment. A participant explained:

The one downstairs [person living below participant's apartment], we've talked a couple of times. She's really nice. The, um, her friend across the hall from her gave me a table and a

toaster oven and it's...yeah, and it's, on my floor, they gave me a couch set and a chair and a coffee table.

For another participant, being able to talk to people in her building has helped her through difficult times:

To have friends and stuff in the building? It's important to me. Like, if I didn't have friends and stuff, then I wouldn't have people to hang out with or people to talk to. Like sometimes if I'm feeling really lonely and I need like just a girl or someone to talk to...

In summary, a positive interaction for some participants included receiving help from their apartment building neighbours. All of the participants that discussed receiving help from neighbours did not mention in the interview if they reciprocated the helping behavior to their neighbours. Instead, they appeared to be the beneficiaries of the support from others.

Social integration outside of participants' neighbourhood. Generally, all of the participants continued to keep in touch with their family and friends by visiting them in downtown Ottawa. Four participants described going to downtown Ottawa every day to socialize with people they know. For one participant, going to downtown Ottawa helped her with her loneliness in her neighbourhood. The participant explained, "I go to my cousins...they live downtown, almost every day. And she doesn't live anywhere near [two shelters in downtown Ottawa], thank God." Similarly, another participant explained, "...I go downtown every day." When asked what she can find in downtown Ottawa that is not available in her neighbourhood she explained, "People."

In summary, participants spent a lot of time in downtown Ottawa. For some participants, a daily trip was made to downtown Ottawa to meet with people they know from their past. These

participants described their neighbourhoods as being lonely and that they knew more people in downtown Ottawa.

Psychological Integration

Psychological integration is characterized by an individual's sense of community with neighbours, which is defined by how much an individual 1) views herself as a member of her community, 2) has emotional connection to the people living in her neighbourhood, and 3) meets her needs through her community, while being involved in her community (Aubry & Myner, 1996; McMillan & Chavis, 1986). On the whole, participants described mixed experiences of psychological integration in their neighbourhoods. In the following section, two key themes related to *membership* and *involvement* in neighbourhoods will be discussed. Participants described factors that impacted their community membership in their neighbourhoods. Furthermore, participants also discussed factors that play an important role in how much they become involved in their neighbourhoods.

Factors that impact community membership. Generally, participants did not feel like they belonged in their neighbourhoods. The factors that were related to community membership were: 1) participants not being interested in belonging to a community, 2) not having spent enough time in the neighbourhood, 3) feeling judged by community members about their appearance, and 4) feeling judged by community members about their past and present activities.

Unnecessary to belong in a neighbourhood. One of the characteristics of community membership is having a sense of belonging within a place (McMillan & Chavis, 1986). Belonging in a neighbourhood was seen negatively and unnecessary by five participants. One participant described her thoughts about belonging in her neighbourhood: "I'm a personal private

person. I'm a really private person. I live alone and like I don't care who's in my neighbourhood." Similarly, participants described resisting the need to belong anywhere:

It's not about belonging there. I live there, and it's where I chose to live. And if nobody likes it too bad. You shouldn't have to feel like you belong anywhere. And that's my opinion. If you're... if you have to belong somewhere what the fuck's the point of living.

Time spent in the neighbourhood. Participants discussed the amount of time spent in the neighbourhood as an important factor for community membership. A participant described feeling part of her neighbourhood as something occurring in the future: "...It may take you a few years after you sort of start seeing the same people around, and you get into a kinda cycle...I'm looking forward to it." The participant was optimistic that she would eventually feel part of the community after becoming familiar with the routine of the neighbourhood and people in her neighbourhood. Another participant also spoke about the relationship between not having the chance to participate in her neighbourhood and becoming part of the community:

...I don't believe that I'm really a part of the community because I haven't done anything with the community itself...I feel welcomed most places that I go around here. It is important [to feel part of the community], but it isn't because I don't go out and do a lot and uh...I haven't had the chance yet. Ahh, so it's hard.

Feeling judged about their physical appearance. Many participants described being aware of their physical appearance and how their appearance was different from others in their neighbourhoods. Participants described being treated differently because of their appearance. For one participant, this occurred in her neighbourhood grocery store where she was given poor customer service. The participant explained, "I find them judgmental but...well because I don't

have a lot of money and I don't dress 'cause a lot of people that go there have money and...so yeah they don't treat me ...I don't find them very respectful.”

Similarly, another participant felt that her physical appearance was the reason she was getting unwanted attention in her neighbourhood:

Sometimes they stare at you strangely, especially with me, because I have no teeth. ...And when I'm walking or with my mouth closed, you could not... you can see. Some people say they don't see it at first. Some, most time you do. ...I'm always paranoid that somebody's staring at me.

A road separated a participant's neighbourhood from a neighbourhood with a higher socio-economic status. The participant described how because of her appearance she has had to create street boundaries with where she can go:

The rich live across the street I've got to stick on the other side of the street, that's all. ...I don't have the clothes I used to, I don't have a haircut. ...I get nervous around people too. I'm not use to it anymore.

Two participants also described feeling out of place in their neighbourhoods because of their ethnicity. One spoke about experiencing judgment from other ethnic groups in her neighbourhood:

You know what I find really hard in this neighbourhood? I'm from Saskatchewan, okay? And I find it, I feel really out of place because there's a lot of different ethnic groups here more so than White people...And so I kind of sometimes feel like I'm invading somebody's space.

Along with the experiences of feeling judged about their appearance or feeling different, participants also indicated how these experiences impacted their sense of belonging in their neighbourhoods. Participants feared to have people stare at them and with attracting too much attention. For some, the fear of being rejected led participants to set boundaries on areas to avoid and limiting their overall activity in their neighbourhood.

Feeling judged about past and present activities in the neighbourhood. Another common theme when discussing psychological integration was participants feeling judged about their activities in their neighbourhoods. One participant described her experience of feeling judged by a business because of her choices in the past:

Sometimes people at the liquor store, like the staff, they'll be like... "Oh, she's just a stupid drunk." And I'll be like, "I'm not even like that anymore." And even when I was, you don't call someone a stupid drunk.

For another participant, her past activities had created a hostile environment in her apartment building. The participant explained:

... It's just I have a couple people in there [apartment building] that don't think I should be in there because I sold drugs in the past to their kids. That was my past, today is today. They look down on me quite a bit, but I just walk away and ignore it... Well I actually said something the other day. I said, "I hope I don't become a miserable bitch like you" and I walked in... She doesn't know who I am. She just knows me for my past.

The participant felt that her neighbours were still punishing her for trafficking drugs in the past. Another participant, who identified as a sex worker, explained her frustration about not being accepted and often harassed by her neighbours:

You know, like my area there it's pretty quiet... And also, there is that, the what do you call it? Uh, parental watch, or whatever... And some of them, are bitches. They'll come out and chase you with a broomstick... Would you rather me sit on [a] car and smoke crack with a pack, which a lot of people do or just stand on the corner?

Out of frustration for not feeling accepted by her neighbours, the participant learned to navigate her neighbourhood and to work in the dark to avoid unfriendly neighbours.

In summary, participants described low levels of community membership in their neighbourhoods. Four factors that impacted participants' membership included: 1) participants not being interested in belonging in their communities, 2) not having spent enough time in the neighbourhood, 3) feeling judged by community members about their appearance, and 4) feeling judged by community members about their past and present activities.

Community involvement. An element of a sense of community is the ability to influence or make a difference in a community (McMillan & Chavis, 1986). In general, participants had a minimal level of involvement in their communities. Some participants also described how they were informally involved with creating a safe environment for seniors and families in their neighbourhoods.

Participants' involvement with safety in their neighbourhoods. Participants expressed a sense of responsibility for providing a safe environment for seniors and families with children. One participant, who was otherwise reluctant to take part in community activities, offered to provide her input if it was only related to safety. When asked if she was interested in volunteering she explained:

I'm not really interested. If they need my opinion regarding safety I'll input a bit an opinion, but other than that no. Because there are little kids around there. And if someone lost a little kid on my time, cops would be involved, I would be. That's one thing I believe in. Old women and seniors and little kids you don't touch.

When it came to maintaining a safe environment, some participants took matters into their own hands. A participant, who was open to taking part in community activities, described how she had confronted a sex worker in her neighbourhood:

I said "Look, I told you before not in this area, there's kids. Go down [another street]. There's a school right there. There's lots of kids in the area." And she just started going off hitting herself in the head. And she goes "I got a stem, I'll stab ya!" I was carrying pop and I put the pop down and I said "Yeah, you know what I'm not scared. Come on."

Otherwise resistant to taking part in community activities because of her mental health challenges, a participant joined other tenants in advocating for creating a safe environment for families in her apartment building. The participant and other tenants joined their efforts in evicting a tenant who was making racist comments towards African-Canadian residents. The participant described the incident:

... We put a petition in, and we said this just to get him out of the building 'cause he was every time, "Ah you fuckin n*****, get your little n***** babies out of here." ... Well, we put a petition in to have him moved. Um, we took him to court because of racial slurs.

Participants' involvement in neighbourhood initiatives was often rare, but those who did take part were particularly interested in sharing their expertise and knowledge about safety with community members. Participants also expressed the importance of protecting and creating a safe

environment for seniors and families with children within their neighbourhoods. Participation in the neighbourhood occurred informally where participants were either approached for help by neighbours or the participant chose to intervene when she faced a problem related to safety in her neighbourhood.

Discussion

The current study provided a greater in-depth contextual understanding of community integration for women in the Housing First (HF) program. Community integration for the women was discussed in relation to participants' adjustment to their life in their apartments and neighbourhoods. The results of the study will be examined along with literature findings.

Physical Integration

The majority of the participants in the study had limited physical integration in their neighbourhoods. Generally, participants reported taking part in activities such as using public transit and running errands (i.e., going to the pharmacy and shopping). Participants indicated that both personal and environmental factors impacted their level of physical integration. Personal factors such as physical and mental health limited the distances participants walked, or the activities they took part in, in their neighbourhoods. Some participants distanced themselves from their environments because they were living in a neighbourhood that was not viewed positively within the broader urban context. To avoid the temptation of using drugs or being involved in criminal activities, some participants did not explore their neighbourhoods. Similar to other studies (Borg & Kristiansen, 2008; Kidd et al., 2016; Ornelas et al., 2014) poverty was also a prominent theme in our research. Participants described their frustrations with not being able to use goods and services in their neighbourhood because they did not have enough money or did not have the right appearance.

Two key environmental factors that impacted participants' physical integration in their neighbourhoods included the accessibility of services and businesses, and safety. Participants generally lived in walkable neighbourhoods, where participants were able to do some to most of their errands on foot because they had amenities close to their apartments. Participants were generally pleased when their neighbourhoods included services and businesses such as grocery stores, banks and health facilities. The use of these services was however limited to some participants who were more familiar with services in downtown Ottawa where participants had already established relationships with service and business providers and friends. Previous findings also lend support to our results by examining participants' activity space. Findings from one study showed that participants were more connected to neighbourhoods outside of their own if they had social and family living in these neighbourhoods (Fields, 2011). In another study, researchers found a negative relationship between activity space size and physical integration (Chan et al., 2014). The researchers reasoned that 50% of their participants were still connected to homeless services dispersed throughout the city, which was unfavorable for physical integration efforts in participants' neighbourhood.

Although participants felt that their neighbourhoods were quieter and safer than downtown Ottawa, they still described having safety concerns in their own neighbourhoods. Similar to past research, almost all of the participants restricted their activities outside their neighbourhood at night because they felt unsafe (Kidd et al., 2016; Manuel et al., 2012). Furthermore, participants described being exposed to illegal activities both in and outside their neighbourhood.

The concept of normative and non-normative space is used to explain locations participants spend their time (Fields, 2011). Generally speaking, non-normative space is defined

by dysfunction (e.g. homeless shelter and services where participants are exposed to drugs and previous homeless lifestyle) (Fields, 2011). Most often participants were exposed to non-normative spaces, especially outside of their apartments in their neighbourhoods and in downtown Ottawa where they continued to receive services. However, having an apartment not only provided an escape for participants from the chaotic lifestyle they often encountered, but it also gave participants the flexibility to choose how much time they would like to spend in these non-normative spaces. Since all of the participants were housed immediately from homelessness, perhaps this indicates a process of transition for participants from homelessness to maintaining stable housing.

Although participants were living in independent housing, our findings indicate that housing alone did not facilitate physical integration for the participants in the study. The effectiveness of the HF program, especially in relation to recovery and integration can be lost in a chaotic and unsafe neighbourhood where the participant is surrounded by people with similar life challenges. Although an element of the Housing First program is consumer choice, where participants choose the location of their apartments, the poor housing stock has limited participants' choice in apartment and neighbourhood quality. This, in turn, may impact participants' perceptions of their apartment with seeing it more as a transitional home with some HF qualities.

Social Integration

Overall, participants' level of social integration in their neighbourhoods was low. Reasons for limiting their social interactions in their neighbourhoods included participants: 1) not seeing it as a priority in their life, 2) wanting to have privacy, and 3) protecting their new life from people who did not have similar life goals such as maintaining housing and sobriety. As a result, many

participants distrusted people in the neighbourhood and kept interactions at a distance especially away from their apartment. Similar to other research (Borba et al., 2011; Granerud & Severinsson, 2006; Lindgren, Sundbaum, Eriksson, & Graneheim, 2014) participants also discussed experiencing days that passed very slow and having feelings of loneliness, which impacted their level of social integration.

The term distal support has been used to describe casual and routine interactions with community members (Townley et al., 2013; Wieland et al., 2007). Most participants described distal interactions with the general public, which was brief and occurred primarily in business settings within participants' neighbourhoods. Research shows that among consumers of mental health services and those living in independent housing, women and older participants reported having greater distal supports than men and younger participants (Townley et al., 2013). The source of emotional support (e.g., displays of warmth and affection) for participants came for the most part from case managers, friends and family members. Most participants described leaving their neighbourhood daily and interacting with their friends in a community setting in downtown Ottawa where a wide variety of services (e.g. mental health facilities and services for receiving food and clothing) were provided. Vallée and colleagues (2011) found a relationship between mobility and mental health. The researchers found that participants living in deprived neighbourhoods in Paris had higher rates of depression, especially when participants' activity space was limited to their neighbourhoods. Furthermore, Fields (2011) describes peoples' connection to their former neighbourhoods. The researcher found that not being physically present in a persons' former neighbourhood creates feelings of grief and a yearning to return, which in turn impacts the persons' ability to form new attachments in their current neighbourhoods. Perhaps for our participants leaving their neighbourhoods was a protective

factor related to feeling less depressed; however, this also influenced participants' connection to their neighbourhoods.

For some participants in the study, their social network also included people living in the same apartment building; however, participants described these and other relationships in their life as being volatile. Conflict with people living in the apartment building was often related to noise, substance abuse, and gossiping neighbours. Although participants were appreciative of the help they received from their neighbours, participants did not discuss reciprocating help to their neighbours. Our results may indicate that participants were still in the earlier phase of settling into their apartment and therefore did not have the resources to provide help to those living in their apartment building.

Having a choice in where and with whom participants chose to interact with was an important theme for social integration. While having these choices may be one of the outcomes of living in independent housing, participants were constantly challenged in their chaotic apartment and neighbourhood environments of falling back into a lifestyle (i.e., using more drugs), which would possibly lead them back into homelessness. Although participants were happy that they were no longer living in the shelter, as Klodawsky (2013) points out, the Housing First (HF) program tends to create a "façade of normalcy" by "warehousing" people into housing. This "warehousing" led to participants withdrawing from interactions with their neighbours and only interacting with people away from their residential neighbourhoods.

Psychological Integration

In general, participants had low levels of psychological integration in their neighbourhoods. When participants discussed community membership, they preferred to keep

their lives private and viewed belonging as unnecessary, while some participants rejected the idea of having to belong anywhere. The amount of time spent in the neighbourhood was an important factor for some participants and community membership was seen as a process that would occur naturally after familiarizing themselves to their surroundings. Other participants described feeling like they did not belong in their neighbourhood because of their physical appearance. Participants also felt they were being judged by neighbours and businesses in their neighbourhoods for their past and present-day activities. Although some participants brushed their experiences of feeling judged by their neighbours as something that ultimately did not bother them, other participants confronted people or altered their activities in their neighbourhood to avoid similar experiences. For participants interested in being involved in their neighbourhoods, the majority of the participants discussed their interest in creating a safer neighbourhood for seniors and families.

The dynamics of belonging and community membership may not just be limited to participants' current relationship with their community, but it may also be deeply rooted in the formerly homeless participants' relationship with society and housing as a whole. It is reasonable to suggest from our findings that most participants viewed their space in their apartment as a refuge. However, participants were still in the process of making their apartment their home. This difference between housing and home is examined by Kearns and Smith (1994) where they define having housing as occupying space whereas the concept of a home involves the relationship between people and living places. They further explain that people feel "at home" when they are physically within their residence; however, it's the feelings of safety, security, and the calmness within the home that defines the meaning of home. Participants in the study also discussed the meaning of home, where most of the participants could not fully relate with the

concept mostly because they had a fear of having their apartments taken away from them and because of the absence of safety and security in their environments.

The concept of belonging in society for a formerly homeless individual with mental illness can be a complicated one, especially in a society that has excluded them in the past (Fields, 2011). Although considered to be a non-normative space, participants in the study sought out services in downtown Ottawa where they perhaps felt more accepted by people who shared common experiences. Fields (2011) describes this as belonging from afar (Amin & Thrift, 2002) where a sense of belonging is established through a person's past and present relationships, experiences, and interests, rather than just being tied to a person's residence. Taken together, psychological integration in our study characterizes the complexity of integration, where although participants were seeking a non-homeless status they were still connected to the homeless community where they felt more at home.

Policy Implications

The concept of community integration is guided by the principle of normalization, where people take part in "culturally normative amounts, settings, and activities" (Wolfensberger & Thomas, 1983, p. 18). In our study, participants lived mostly in low-income neighbourhoods, where they were living mainly among others with a similar history of homelessness and health challenges. Thus, participants primarily interacted with people with similar challenges and often in "non-normative" settings. As researchers and service providers we have to acknowledge peoples' bonds to communities from their past and be aware that we do not convey these interactions as being inferior to those interactions that occur with the general public in a more "culturally normative" settings. It was through interactions with past social networks and going to "non-normative" settings that some participants in our study were able to establish boundaries

about what was acceptable behavior with old associates in their new life in their apartments. This is not to say that participants did not risk losing their homes or were not tempted to use drugs again, but it also allowed some participants to re-evaluate their circumstances and seek help to avoid further problems with their housing. Furthermore, it is possible as Fields (2011) suggests that allowing people to have a safe space, where people do not have to fear being judged, may encourage self-acceptance and thereby reinforce peoples' right to take part in other spaces where they would potentially be excluded. People living in the neighbourhoods have to also be educated about people with a history of homelessness, addictions, and mental health issues, which would then create a more accepting environment for already marginalized groups.

As policy makers and researchers, we should also be conducting more evaluations on the true impact the Housing First program has on female residents living in low socioeconomic neighbourhoods. Although participants in our study were happy about living in their own apartments, there remained challenges of living in disorganized neighbourhoods where drugs and violence were prevalent. More resources should be put towards providing better affordable, stable housing for people in safe neighbourhoods and for strengthening health systems to reduce wait times to access treatment for mental health and addiction services. Instead of relying on trafficking and prostitution as a source of income, it is also necessary to provide higher income to residents so that they have sufficient spending money in their neighbourhoods. Furthermore, systematic changes in the decriminalization of drugs and prostitution would protect women from violence and from falling back into the cycle of homelessness.

Limitations

Given that women were only recruited from a single Canadian urban setting, we cannot be certain that the experiences of community integration are generalizable to other women in other

locations and if the findings are unique to women participants. Regarding the methods used, the walk-along and photo-elicitation interviews had some limitations. Interview times occurred between five to ten months after participants moved into their homes; it is possible that participants did not have enough time to settle and establish their roots in their new neighbourhood, which would have impacted our findings. Furthermore, although having the photo-elicitation interview within two weeks of the walk-along interview helped with building trust and rapport between the researcher and participant, it was challenging to track down the participants, which slowed the progression of interviews. However, once contact was made with the participants, they were generally excited about meeting to discuss the photos taken in the first interview.

There were also safety concerns for the researcher especially when interviews were held in the participants' apartment and during the walk-along interview. To mitigate any safety problems, the researcher offered to meet participants at a nearby fast-food restaurant. However, some participants requested a meeting in their apartments because of health problems. For these participants, the case manager also attended the interviews if they felt it was necessary to accompany the researcher. For some interviews where case managers were not present, safety was a real concern as participants had other occupants also present in their apartments. For these interviews, the researcher insisted on conducting the interview in another setting in the building where there was some privacy. Furthermore, the researcher also followed a safety protocol where a colleague waited for the researcher outside the participant's apartment building until the interview was finished. For the walk-along interview, during winter months when it would get dark faster, interviews were set up earlier during the day.

Using Google Maps was also a challenge as some of the neighbourhood amenities were not updated on the map. Furthermore, paper maps also limited the scale of the region making it impossible to focus on particular streets that the participant was interested in viewing. This limitation was mitigated by having a smart phone available for the participant to examine the streets in greater detail. Another methodological limitation was the photo-elicitation method. Some participants described the photos as being boring because of little content variety in the photos (i.e., photos were mainly of buildings and objects in the neighbourhood). Including participants in the photos and taking more photos with content variety created a more enjoyable experience for participants. Additionally, participants were not interested in using the camera to take photos during the walk-along. Perhaps if participants took photos during the walk-along they would have been more interested in explaining the content of the photos. Furthermore, having a more open-ended inquiry without restricting participants' experiences to only their neighbourhoods would have also produced a complete understanding of participants' experiences of community integration.

Future Research

Future research for this population should take into account a longer time period for participants to settle into their new homes and neighbourhoods. Doing this would give participants more time to fully explore their neighbourhoods, which would be more informative for the walk-along interview. Furthermore, it would be important that future research examines community integration beyond the boundaries of the participants' neighbourhood. By doing this, we would be able to examine participants' activity space and have a clearer understanding of the amenities and services important to women in the Housing First program.

Similar to Chan and colleagues (2014) researchers should use Geographic Information System (GIS) mapping to track participants' activity space and make a comparison between the activity space of women in the Housing First program and women in the general public. Using GIS mapping would give us a better understanding of how we can make neighbourhoods more accessible to disfranchised women so that they can exercise their rights associated with citizenship especially in gentrified neighbourhoods such as downtown Ottawa.

Future research using a participatory approach should consider some of the methodological limitations in the current study. A safety protocol should be established for researchers where case managers and other research colleagues are also included in the plan. Furthermore, to apply a more participatory approach for the photo-elicitation method, participants should be given some time to practice with the cameras before the neighbourhood walk-along interview. This would allow participants to gain more confidence with using the camera and as a result more authentic images of the participants' experiences in the neighbourhood would be produced. It would also be valuable if future research compared both men and women's perspectives of their neighbourhood using the walk-along and photo-elicitation methods.

Table 6.

Qualitative Categories and Codes.

Personal
-Past experiences
-Addictions
-Feelings of loneliness
-Family/Partner
-Safety
-Health
-Friends
-Money/Expenses/Poverty
-Crime
-Feelings about herself
-Bad influences surrounding participants
Goals and Choices
-Priorities
-Having a choice
-Things she avoids
-People/Friends/Family
-Rights and responsibilities of being a tenant
-Thoughts on integration
-Exploring neighbourhoods
Housing
-Past housing experiences
-Changes in lifestyle due to housing
-Privacy
-Superintendent/Manager
-Things/Objects
-Description of building
-Transitioning
-Meaning of home to participant
-Future thinking about housing/neighbourhood life
-Description/Feelings about neighbourhood
-Feelings about building
-What would be helpful for woman
Physical Integration
-Outside of neighbourhood
-Things that encourage physical integration
-Things that prevent physical integration
-Regular visit in neighbourhood
-Place wants to go to but haven't yet
-Place she has gone to but doesn't want to go again
-Place she avoids
-Description/feelings about neighbourhoods/Building neighbours/Awareness of what's happening in building
Social Integration
-Store owners and service providers in neighbourhood
-Pets
-Activities
-Social integration outside of neighbourhood
-Superintendent/Manger
-Things that prevent social integration in building
-Things that encourage social integration in building
-Things that prevent social integration in neighbourhood
-Things that encourage social integration in neighbourhood
-Unhealthy social interactions in neighbourhood
-Healthy interactions in neighbourhood
-Social interaction
Psychological Integration

- Fitting in
- Involvement in community
- Things that prevent psychological integration
- Things that encourage psychological integration

Chapter 5: Study Three

Community Integration Experiences of Women in the Housing First Program: 6-Month Follow-Up

*The data for the study were collected as part of the *Supportive Housing for People with Problematic Substance Use* (SHARPE) evaluation study in Ottawa. Dr. Tim Aubry and Dr. John Sylvestre served as Co-Principal Investigators for the SHARPE study. Dr. John Sylvestre also supervised the doctoral thesis research presented in this manuscript. Amandeep Bassi developed the research presented in this manuscript and conducted the interviews with the participants for the study, as well as conducted the data analysis. Funding for the SHARPE study was provided by the Canadian Mental Health Association, Ottawa Branch.

Time-space routines are series of behaviours that are habitual and are formed over a period of time (Buttimer & Seamon, 2015). For people who are homeless, there is a lack of continuity in routines because without having a home, homeless people experience changes in their daily path which are mostly dependent on survival strategies (Rowe & Wolch, 1990). Homelessness also excludes people from being involved both socially and culturally in society. However, the process of having and making a home in the community helps allow people to participate in society (Kellett & Moore, 2003). Rivlin and Moore (2001) describe the process of home-making as being active and being shaped by factors such as personality, demographic factors, and a person's goals. Therefore, resettlement is more than just having a roof over one's head; it also requires permanent housing, house-keeping skills, and the feeling of living in the right place (Rivlin & Moore, 2001). This, however, does not mean that the journey to making a home is linear; formerly homeless people can face setbacks such as relapsing, experiencing the criminal justice system and hospitalization (Fields, 2011). Furthermore, this process of making a home is not entirely dependent on just the individual; poverty levels, a neighbourhood that is accepting of people with mental health and addiction problems is also important (Aubry et al., 1995; Kidd et al., 2016; Wong & Solomon, 2002).

The period of transition from homelessness to being housed can also be confusing, where forming a routine in new surroundings can be affected by a person's connection to their previous life and community (Fields, 2011). Over time, people form routines in their neighbourhoods by having regular routines of visiting places and communicating with other community members (Hargreaves, 2004). These routines and connections develop over time, leading to a possible attachment to a place (Seamon, 2002). People who have an experience of homelessness face a number of challenges such as past trauma, substance use, and chaotic neighbourhoods, which

makes it difficult to form these routines and connections. However, the development of these routines is essential for the recovery process. The multidimensional concept of community integration, which includes physical (i.e., participation in community activities and using community resources), social (i.e., social interactions and support from social network) and psychological integration (i.e., sense of belonging and feeling accepted in the community), has been used by researchers to measure the recovery experience (Aubry & Myner, 1996; Bond et al., 2004; Wong & Solomon, 2002).

The Present Study

Research on community integration has not yet fully considered the importance of gender. Although prior research has shown that women are susceptible to a vicious cycle of unstable housing and stressful living conditions (Kidd et al. 2013), it is yet to fully consider how formerly homeless women adjust to community living over time. The aim of the qualitative follow-up study was to contextualize and provide an in-depth understanding of how formerly homeless women's experiences in their community change and the impact this has on their level of community integration a year after their participation in the Housing First (HF) program.

Research Questions

The study will address if there have been any changes with participants' experiences in the community and community integration since the first interview, which occurred 6-months before:

- (1) How women participating in a Housing First program perceive their neighbourhoods regarding:
 - (a) their interest and ability to participate in these neighbourhoods

- (b) the facilitators and barriers to participating in these neighbourhoods
- (2) How women in the program integrate into their neighbourhoods? Specifically related to:
- (a) how they use their local resources in their neighbourhoods (physical integration)
 - (b) their social interactions with neighbours (social integration)
 - (c) their sense of belonging (psychological integration)
 - (d) the role of housing in their life and how it has affected their integration into neighbourhoods

Method

Research Design and Recruitment Strategy

The current study used a longitudinal qualitative design. A purposive, theoretical sampling plan was utilized in which female participants who were taking part in the larger Supported Housing Addiction Recovery Program Evaluation (SHARPE) also took part in the current study. Before the current study, individual interviews for baseline were conducted with participants from November 2011 to May 2013. The following criteria were used to determine a participant's eligibility for the baseline study:

- a) Gender: All participants were female.
- b) Program Involvement: Participants were enrolled in a Housing First program with Intensive Case Management (ICM) at the Sandy Hill Community Health Centre. The program works in partnership with the Ottawa Branch of the Canadian Mental Health Association (CMHA) to provide housing and support to people who are homeless, have serious mental illness, and have substance abuse disorders. The participants in the program had case managers with whom they worked to build skills and develop resources in areas of housing, health, and the legal system. Rent supplements were provided to program clients.

- c) **Housing Status:** Participants were housed in their own apartments provided through CMHA in Ottawa.
- d) **The Length of Occupancy:** At the time of the first meeting for the study, participants were residing in their homes from five to ten months. This length of time was selected to accommodate the adjustment period for people to establish themselves and know their neighbourhoods.

Procedure

At first contact in the baseline study, an effort was made to create rapport and establish trust with the participants. Meeting times with participants were arranged through the case managers, or participants were contacted directly by the researcher.

Fourteen participants were re-interviewed approximately six months after the baseline study (N = 16). Interviews took place from May 2012 until December 2013. The six-month follow-up examined the participants' experiences in their neighbourhood after living in their apartments for at least a year. The researcher met with the participant either in her neighbourhood or in a meeting room at the University of Ottawa. Participants were asked to give consent at the beginning of each interview (see Appendix N for consent form) and were paid a total of \$20 honorarium for taking part in the study. Each interview lasted approximately one hour to complete, and the interview was audio-recorded and transcribed verbatim. This study received approval from the research ethics board at the University of Ottawa.

The participants were asked questions, using semi-structured interview guides (see Appendix O for interview protocol). Data collected from the first study such as, neighbourhood maps, list of locations that participants identified in their neighbourhoods (i.e., places participant visits regularly, places participant would like to go to but have not yet gone to, places the

participant has gone to and did not want to go again, and places participant has never gone to) and photos taken during the walk-along in the neighbourhood were reviewed with the participant. The purpose of this study was to examine changes in physical, social, and psychological integrations. If there were changes, the participant was asked to discuss what led to these changes. Furthermore, the participant was asked how she felt about these changes and whether these changes have affected her experiences in the neighbourhood.

Data Analysis

Qualitative data was generated primarily from transcribed audio-recordings of the interview. Additional data were also obtained from field notes, neighbourhood maps, digital photos, and documents listing locations in participants' neighbourhoods; all of which were produced in the first interview. Analytic memos were also written throughout the data collection and data analysis process. Transcribed interviews were stored as text files and analyzed in a Qualitative Data Analysis (QDA) Miner (Provalis Research, 2015). The analysis followed steps recommended by Miles et al. (2014).

In first cycle coding, the same coding scheme was used as in the first qualitative study, where the same participants were also interviewed about their level of community integration in their neighbourhoods (Miles et al., 2014). Then using the process of inductive coding, themes related to changes in community integration and any new themes related to community integration were identified. The coding process included reading transcripts line-by-line, and applying the codes to statements made by participants regarding their experiences with community integration (Charmaz, 2006; Miles et al., 2014). Interviews were first examined thoroughly by the lead investigator, who was involved in analyzing all transcripts and in comparing, coding and categorizing the qualitative data. With the help of another researcher,

codes were then sorted and compared until saturation was reached, where no new codes were produced. The revised coding scheme was re-applied to all transcripts and changes were made to the codes until no further refinements were required.

After the researchers arrived at a consensus on the codes used to summarize the data, the second cycle coding or pattern coding method was applied where codes were tied together based on common phrases or differences noted by participants (Miles et al., 2014). At this stage, codes from the first cycle coding were reorganized focusing mainly on changes, particularly in participants' perceptions of their community integration levels (i.e., physical, social, and psychological integration), and lifestyle changes, which could possibly have contributed to changes in integration (see Table 7). Analytic memos were useful for keeping track of the coding process, elaborating on the codes, understanding the possible relationships between the codes, and keeping track of assumptions about the data (Charmaz, 2006).

Data for this study were also organized into a summary table using the case-level matrix display, which was created in study one (Miles et al., 2014).

Results

Sample Characteristics

Fourteen women of the 16 who had also taken part in the baseline study participated in a follow-up interview. The interview of one participant was not included in the analysis as it became apparent during the course of the interview that she was under the influence of substances. The final sample for the current study was 13 participants.

In the 6-month follow-up, the participants' ages ranged from 23 to 56 years, with the mean age being 40.69 years. A majority of the participants in the study were born in Canada and

identified as White Canadian. Eleven of the participants at the time of the baseline interview had attended but did not complete high school. Before moving into their apartment, the median longest single period of homelessness for participants was a year. At the point of 6-month follow-up interview, participants had been living in their apartments, on average, for a year. Participants reported spending a median of \$675.00 per month on rent in the baseline interview.

Physical Integration at the 6-month Follow-up Interview

From the review of the literature, three aspects of physical integration were identified: 1) the amount of time an individual spends within their community, 2) the activities that the individual is involved in within their community, and 3) the extent to which an individual uses goods and services in their community.

From the participants' accounts, there was a small increase in their physical integration because participants were spending more time and accessing more services in their neighbourhoods. Most of the participants, however, continued to spend most of their time in their apartments. Similar to baseline interviews, participants discussed two themes that impacted their physical integration in their neighbourhoods: 1) personal factors and 2) environmental factors.

Personal factors that impacted physical integration. The participants identified two personal factors that affected how physically integrated they were in their neighbourhoods: their health and time spent in their neighbourhoods.

Time spent in the neighbourhood. Since the baseline interview, most participants reported that they spent an increasing amount of time in their apartments and neighbourhoods. The time spent in their apartments and neighbourhoods appeared to be a choice participants made to avoid going downtown, as many of them were doing at the time of the baseline interview. One

participant, who had spent most of her time outside of her neighbourhood at the time of the baseline interview, said when asked during the follow-up interview, “No, no. I’m more at my place than ever”. The participant felt her neighbourhood had many places for her to keep her busy.

When participants did go downtown, it was to go to places they were familiar with and used frequently or to attend appointments. Said another participant who had also previously spent more time downtown:

...I can’t stand going downtown...And when I do, I go into the [emergency shelter] and I say, “Hey” to the staff and that. And they go, “You don’t come here that often.” I say, “You know why, negativity. I can’t stand it.”

Similarly, another participant also explained how much time she spent in downtown Ottawa:

I only come down here [downtown Ottawa] ‘cause I have to go to my...I have appointments...Otherwise, I don’t come down here, I stay at home. Especially with winter now, I definitely don’t go there.

When the participant was asked how she would describe her neighbourhood she said, “My safe haven, yeah.”

For another participant, who lives close to downtown Ottawa, time spent in the city was not her first choice. The participant explained, “I find downtown sometimes with all the drama. And just, I’m afraid of my past. That’s how I lived downtown. I see it all the time. I like to, I like to get away.” Instead of going to the mall and movie theatre close to her apartment in downtown,

the participant described going to another neighbourhood outside of downtown where she knew she would not run into people from her past.

Only one participant described spending most of her time in downtown Ottawa both in the baseline and 6-month follow-up interview. This participant was able to move more confidently through the city space. When the participant was asked if she wanted to feel part of her neighbourhood, she explained:

[Shaking her head no] Because my part's downtown... When I want to get away from it, I can. I just go home and stay at home for a day or two. Because I can spend my day down here [referring to downtown] and if anybody bugs me or threatens me or anything, I say, "Sure no problem." ... A lot of them give me a lot of respect down there [referring to downtown].

The participant's experience in downtown Ottawa was considerably different from other participants' experiences. The participant enjoyed being in an environment where people showed her respect because of her family connections.

Overall, compared to the baseline interview, there was a change in how much time participants spent in their neighbourhoods. In the baseline interview, along with attending services in downtown Ottawa, participants also used downtown as their social outlet, where they connected with people they knew from their past. In the 6-month follow-up interview, participants described downtown as being too stressful, and they avoided going there as much as they could; however, for most participants travelling to downtown continued to be necessary for services.

Health. In contrast to the baseline interview where participants described their physical health as a factor that influenced their level of participation, in this interview participants spoke mainly about their mental health and substance abuse as limiting their participation in their neighbourhoods. However, physical health was still an issue for some participants.

Physical health. Three participants pointed to physical health issues as continuing to impact their level of physical integration in their neighbourhoods. A participant who had described an ailment that limited her ability to explore and use her neighbourhood at the time of the baseline interview also continued to describe her physical health as being a deterrent in the 6-month follow-up interview:

I can't even walk sometimes five minutes now. Because my back is so bad. Which is really not that good because I, I use to love walking...It's hard because I get these panic attacks...or there's too many people. Or I'm worried that I'm going to have a seizure. It's very hard...

New health problems were also common for participants. For one participant, who had enjoyed walking around in her neighbourhood during the baseline interview, a new health condition restricted her activities in the 6-month follow-up. She explained, "I like my walking, but because of my hip I don't know...I take it a day at a time." A long-term illness and an injury that occurred after the baseline interview had required another participant to move to a new apartment. This injury had an impact on how the participant moved around:

Yeah, I need wheelchair accessible housing now...because of this...injury. I'm okay with it. I've come to terms with...having the connected tissue disorder. And knowing that in the future I'm going to have braces on both my legs.

Compared to the baseline interview, participants spoke less about their physical health as restricting them from taking part in activities in the neighbourhood. Beyond the examples given, other women mainly pointed to their mental health and substance abuse issues as the biggest deterrent for physical integration.

Mental health and substance abuse. For some participants, mental health and substance abuse issues were mentioned more often as a limiting factor for physical integration, compared to the baseline interview. Some participants, however, described challenges that were ongoing from the baseline interview. One participant continued to experience panic attacks that she had also described during the baseline interview.

... Well, I don't like to walk by myself because I can't carry it [alcohol] back, and... I get kind of scared. Even during the day, like I just, I don't know what it is... I have really bad anxiety and prefer someone to be with me.

The participant's dependency on others to go to places limited the activities she took part in her neighbourhood.

Another participant described an escalation in her mental health issues that led to avoiding areas in her neighbourhood. When asked if she went to some of the same places she had mentioned in the baseline interview, the participant explained, "Not so much anymore because I'm trying to avoid those people. I still go, but I'm like I find myself like getting very aggravated and become very angry... it feels like it hit me really, like really hard." When the participant was asked what it was like for her to walk outside in the neighbourhood during the night, she explained, "Good. Like I can walk around... I don't have to hear my name being yelled half way down the street."

Compared to the baseline interview, some participants characterized their addictions as becoming worse and consuming more of their daily activities. A participant, who had considered going to rehab in the baseline interview, described her ongoing struggles with having an addiction and the impact it has had on her health and the activities within and outside her apartment:

I just hate it...When I do it, I'm in my apartment, and I do needles, and I don't like it and it's killing me...I'm going out pulling illegal shit like panhandling or even prostitution, even though I do it in my own home. It's still illegal, but I can't get caught because it's in the privacy of my home. They can't do nothing about it. I'm very well aware of that.

For other participants, there were struggles to maintain their sobriety once they stepped outside their apartment and this impacted their daily activities. When asked if she had any temptations to use drugs in her neighbourhood, she explained:

I do. Well if I leave the building then because I used to have to go and pick up from the other buildings. So, if I walk around, even if I go to [friend's house], it's like no, no, no I can't do that...I need to avoid that...It's hard though.

Similarly, another participant, who also struggled with addiction, described how she spent her time in her neighbourhood. The participant explained, "I don't really pay attention to what's going on. I just hide if I'm inside. And then if I'm outside, I just do my own thing, right? ...I'm trying to avoid the bad crowds..."

Compared to the baseline interview, participants' mental health and substance abuse problems limited their activities in their neighbourhoods. Since the baseline interview, participants were more aware of locations they can acquire drugs from in their neighbourhood.

For most participants, who tried to maintain their sobriety, activities in the neighbourhood were often hurried and guarded to avoid any confrontations with people they may know or to avoid temptations to use drugs again.

Environmental factors that impacted physical integration. Three environmental factors that affected participants' level of physical integration were amenities in the neighbourhood, safety concerns, and the changing weather. For these factors, participants discussed what remained the same since the baseline interview and the changes that impacted their level of physical integration in their neighbourhoods.

Amenities in the neighbourhood. Overall, the majority of the participants continued to frequent the same businesses they identified in the baseline interviews. However, two participants in the 6-month follow-up interview sought out and frequented other services that were not mentioned in the baseline interview. One of the participants discussed the youth centre close to her apartment that she discovered with another friend. The participant said, "...I've gotten to know more places in the area. I got another one of my friends, who does live in the building and take me to [youth centre] ...they know who I am..."

For another participant, instead of going to the pharmacy outside of her neighbourhood every day, the participant was able to find a pharmacy closer to her apartment. While describing her daily routine with her dogs, the participant mentioned the pharmacy she now uses in her neighbourhood:

...I take the dogs, and they like coming with me on the walks to the stores and stuff...Right here around the gas meter, there's bars, and I'll tie [dog] up...My pharmacy is here now. I'll tie her to the bench outside.

Participants generally did not feel like they needed to explore their neighbourhoods further for new services because over the months of living in the neighbourhood they had discovered which businesses and services they could use. One participant explained, “I know this whole area back and forth like the back of my hand, so I don’t really need to explore it anymore...”

Similar to the baseline interview, living close to a grocery store and other services such as the pharmacy, bank, and fast-food restaurants continued to be important to participants. For one participant, a significant change in improving levels of physical integration from the baseline interview was moving to a new neighbourhood where she could easily access services:

...I’m closer to everything...The laundromat across the street. [store] across the street. I got my dive joint [neighbourhood bar] there. If I want to go up a class, I go to the grill over here...At the other place, I was isolated. It’s so great. I’ve just got to get dressed, walk to the bar three blocks. No, I mean three minutes’ walk. Boom. If I just want one beer and go right back home, it’s not like...take half an hour to get there and hour to get home.

Nonetheless, some participants continued to be frustrated with the unavailability of amenities in their neighbourhoods. In the baseline interview, a participant had discussed how travelling to downtown Ottawa for services was very anxiety provoking for her. The anxiety continued to be a problem for the participant:

There’s not much in my neighbourhood. Yeah, I’m on the dead end of everything. Like I wish there was a [payday loans place] or bank or like a grocery store or something, so you don’t have to go like downtown.

For another participant, not having access to “normal” services in a predominately Asian neighbourhood continued to impact her level of physical integration:

...At the [bus] stop at [Ottawa street] it always gets packed. There's like 50 of them that come on at certain times. It's overwhelming actually, and it takes you 15 minutes to walk to a normal store. To get like cigarettes or something and certain stores don't even have the hours on it and like on a Tuesday afternoon will be closed.

Overall, participants continued to describe the importance of having services in their neighbourhoods. Except for those circumstances when participants moved to new neighbourhoods or when participants discovered services they were not aware of before in their neighbourhoods, the use of services and thus the level of physical integration remained the same for most participants.

Safety. Similar to the baseline interviews, safety continued to impact participants' level of physical integration in their neighbourhoods. As participants learned more about their neighbourhoods, they learned to avoid areas that they perceived as being unsafe. For one participant, recent events on the news led the participant to view her neighbourhood as unsafe. When the participant was asked if she felt safe walking in her neighbourhood she responded:

...Well not since really, we always have to watch our back since the tragedy that's been around... The one that got [acquaintance's name]. Yeah, the serial killer, there's that one still and plus that one that's pulling people's skirts up...

Like the baseline interview, another participant continued to perceive her neighbourhood as being unsafe during the night:

Not good, with all these people lurking around. I don't like to walk out of my house past 8 [pm]. No, and if I do it's because I'm going with somebody like [friend's name] to the store. And when we get there there's always guys outside, and just sitting by their cars and talking. That's not just a good scene.

Another participant also explained what it was like to be outside at night in her neighbourhood:

...[Neighbourhood] kind of, it has a reputation for drugs... But I've known about it before I even moved there... They have a lot of good people, you just got to stay away from certain people, but at night time it's like, it's not always safe to be wandering around drunk or running around by yourself... I could maybe go up to... my friend's place... because it takes me a minute to get up there. But I don't feel comfortable, I will get my boyfriend to walk me.

For this participant, the fear for her safety also resonated in other areas in the neighbourhood:

I really don't like going to the [mall] because I find, like there's so many young teenagers are out there causing like problems or someone's drinking or a lot of drugs around there... I kind of start thinking about my past. What, what I used to do when I was younger. Or I get afraid that people are going to start a fight with me. And I can't defend myself. So, it's like if I go, I have to go with my boyfriend. Or I have to go with someone I trust.

Similarly, another participant, who also had safety concerns in the baseline interview, discussed her experience of feeling unsafe outside and inside her apartment building in the 6-month follow-up interview:

Outside my building, there's a lot of, like, drug dealers coming out at night and sometimes...one night, I went out, I got back from my friend's place at like two in the morning, and there was blood in the hallway [inside participant's apartment building]. And I was kind of freaked out. It was really scary, and there was like people screaming and yelling.

Overall, safety continued to negatively impact physical integration for participants. Depending on the neighbourhood, safety concerns had worsened for some participants as they lived in their neighbourhoods longer and learned more about the presence of criminal activities in specific areas in their neighbourhoods.

Weather. Throughout the 6-month follow-up interviews, participants pointed out that a change in the weather had affected both their activity level and the number of activities happening in the neighbourhood. Because participants relied mainly on public transportation or walking as their way to navigate both inside and outside their neighbourhoods, the cold weather was often seen as a barrier to their activity levels. A participant described her experiences during the winter. The participant explained, "My back is...very sore lately. Because of this weather and the dampness really does in my back because I had the surgery and everything. But still, the fact is I still have to walk..."

Those participants who were experiencing warmer weather at the time of the 6-month follow-up interview described a more active lifestyle and greater levels of physical integration in

their neighbourhoods. One participant pointed out, “Yeah I think I’m out more often. It’s nice instead of being in the house.” Another participant described the changes in her activity level from colder to warmer weather:

With the winter, I found I kind of hibernate or I don’t go out as much because I don’t like to go out on the ice because with my back it could be dangerous for me to fall...But yeah, now that it’s getting warmer, I find I’m going out more. I find I can feel my energy kind of changing and mood uplifting.

As warmer weather approached, participants also made plans for the activities they wanted to do in the coming months. One participant described:

Yes. I want to go there [neighbourhood park] this summer. That’s for sure. Me and my friend, we have a date to go to the beach and go tanning by the rocks and stuff. I’m really looking forward to that.

Overall, warmer weather positively affected participants’ level of physical integration in their neighbourhoods. Participants described doing more activities outside, feeling healthier, and planning for activities they wanted to take part in outside.

Social Integration at the 6-month Follow-up Interview

Social integration includes two key elements: 1) an individual’s interactions with non-disabled community members in normal community settings (Wolfensberger & Thomas, 1983) and 2) an individual’s social network, size, structure, functions, and capacity to provide support (Storey, 1993). During baseline interviews, participants said that they typically socialized with people in their apartment buildings and friends and staff members of private businesses both inside and outside of their neighbourhoods. In the 6-month follow-up interview, participants

described having fewer interactions with people in the community and in downtown Ottawa. Participants described associating with unstable social networks that were prone to conflicts. Similar to the baseline interview, participants tried to maintain their privacy, and the majority of the participants wanted to distance themselves from others who were using drugs both in their apartment building and in their social network.

Social interactions with community members outside of apartment building. In the 6-month follow-up interview, participants generally kept to themselves when they were in their neighbourhood. Similar to the baseline interview, participants continued to find it difficult to establish new relationships with people living outside their apartment buildings. One participant attributed this to the characteristics of others in her neighbourhood. She explained:

I think it's because people they don't know what it's like to meet new people. It's like...they're always afraid to kind of say hi first, you know? Or they don't know how the other person is going to react. And it's just like are you going to hurt me or are you going to betray me or...I don't really go outside and go around going like, "Hey! Who are you?" [laughing] And the cops will probably be called, this girl is really weird.

Similarly, another participant explained that she does not see any good candidates for friendships because people turn out to be different than what she had expected them to be when she first meets them:

I see people that are working the streets that you would never ever know that they work the streets or smoke crack...Yeah, like you see them one day with a baby you know, and then the next day you see them all fuckin asking for crack and all fucked up and it's like wow, she actually lives in my you know...

Generally, there was not a big change regarding interactions with people in the community since the baseline interview. Participants continued to be guarded with the interactions they had with people in their communities. Although most of the participants tried to avoid people from their past especially in their neighbourhoods, participants did not have much choice but to interact with people in similar life circumstances as themselves.

Contact with social network members. Participants described having fewer interactions with people they spoke about in the baseline interview because of conflicts related to interpersonal and addiction problems. Almost all participants described avoiding areas in downtown Ottawa and people in the neighbourhood who were using substances. This was a significant change from the baseline interview where participants had described spending most of their time with old associates, especially in downtown Ottawa. A participant was asked if she has had contact with a friend in the neighbourhood recently, she replied:

Uh, not anymore at all. I've seen her once in six months because she's still involved with drugs and drug dealers in her house. You know I...can't stop her from doing whatever, but I'm not going to be around it either.

Another common reason for not associating with people in their social networks was because participants had personal items stolen from them. A participant described this change in a friendship she had with a neighbour that she spent a great deal of time with in the baseline interview:

She came into the house, and I made friends with her and [boyfriend]...And she needed help with food and this and that...Not a problem. And then she stole my laundry card, and I had \$47 bucks on my laundry card. She was saying, "No, I did not steal your laundry

card.” All of a sudden, she doing laundry left and right [laughing]. I told her. I said, “I don’t want nothing to do with you. You come into my house... You stole something out of my house...”

Another participant also described a similar incident, which changed her relationship with a friend she had known for a long time.

... I left some dope on the table... I come back and three pieces... Never once I had her steal from me before, and there’s only two. And then I noticed she had gone in my wallet because she knew that’s where I kept it, and it’s funny, I sat there and pretended to go to the bathroom, and I watched... So I told her, “Don’t expect to call me anymore for like say oh come over for a couple pops because it ain’t gonna happen.”

Participants described unstable relationships in their life and for most women, friendships they had in the baseline interview did not exist in the 6-month follow-up interview. The loss of friendships decreased participants’ social interactions both inside and outside their neighbourhoods since the baseline interview. Generally, participants were more isolated as they spent more time in their apartments and were guarded about the interactions they had with residents in the apartment building and acquaintances.

Making choices about social interactions. As in the baseline interview, participants continued to be wary of relationships in their social network and residents living in the apartment building. Participants described how they had to set boundaries with people they interacted with especially when it came to having people over in their apartments. Maintaining a private life was important for one participant both in the baseline and 6-month follow-up interview. When the participant was asked if she had made any friends in her apartment building she explained:

Nope. It's best not to where you live. That's what I think. Because you live there, and if you guys aren't friends, then you know, you don't know how that person's personality is because you've only been friends maybe a couple of months... Like I'll say, "Hi" to them and stuff, but I will not invite them over for coffee...

Similarly, another participant described how she has gotten to know people in her building and that she only associates with residents who are drug-free. She explained:

...I know more people and I know, like, who to stay away from... Like I don't associate with the drugs and all that...I connect with people in the building almost every day. So I chat with people and socialize and ask how they're doing.

Participants continued to protect their lives in their apartment from drug influences, however for some this meant losing friends. One participant explained, "Unfortunately, my friends are still involved in drugs, and I have eliminated myself from that scene." Similarly, two other participants also described how they protected their life in the neighbourhood. The participant explained, "If you're high or drunk do not come here...I don't want to be around [people] who do it...I just don't want people around on drugs...It makes me nervous." When another participant was asked if she brings any of her friends over to her apartment she explained, "Not a lot of them, not a lot from downtown anymore...Just too much trouble."

For another participant, the decision to avoid people who used drugs in her building led to neighbours spreading lies about the participant:

Why put myself in a place where the cops are going to come...People just talk bullshit...And jealousy just makes people...say anything they want, you know? Like I

said, just because I don't want to be in that crowd, you know? ... I have a life now... I could actually do things, and I don't involve myself 24/7 around the clock like before...

However, the same participants explained that not having visitors in the apartment left her feeling lonely. She explained, "Sometimes it makes me feel disappointed, you know? Lonely...that I don't have visitors. But then I think also if I wanted visitors it would have to be the same ones that I left, which I don't want back."

Overall, participants felt strongly about protecting their space and limiting their interactions with people who had substance abuse problems. Compared to the baseline interview, participants' negative experiences with people in their social network and apartment building made them far more reluctant to interact and invite people into their apartments.

Psychological Integration at the 6-month Follow-up Interview

For psychological integration to occur, people have to 1) view themselves as a member of a community, 2) have emotional connection with the people living in the neighbourhood, and 3) have their needs met through the community, while being involved in the community (Aubry & Myner, 1996; McMillan & Chavis, 1986). For the most part, there was no change in participants' psychological integration levels from baseline to the 6-month follow-up interview. In fact, participants had little to say about their community involvement during the 6-month follow-up interviews. Similar to baseline interviews, factors that impacted participant's sense of membership in their neighbourhoods included their intentions to move out of their neighbourhood and whether the participants felt like they were accepted in their neighbourhoods.

Factors that impact community membership.

Short-term stay in the neighbourhood. Compared to the baseline interview, more participants felt that they did not want to invest more time knowing and feeling part of their neighbourhood because they intended on moving away. Typically, participants who intended to move from their neighbourhood felt unsatisfied about the quality of their apartment building and neighbourhood. In the baseline interview, a participant had discussed feeling satisfied with her apartment building. However, her impression of the apartment building changed in the 6-month follow-up interview:

...Now it's really getting cuckoo...A lot of drugs in the building. I'm just not comfortable, and I have to go look for another place...There's a lot of police...A lot of drugs here... Just creating problems for each other...I don't really care to be part of this community in this area because I want to move to another area.

Because of the unstable environment, the apartment did not exhibit qualities of home for the participant. Another participant had considered her apartment to be temporary in the baseline interview, and she continued to have difficulty calling her apartment home in the 6-month follow-up interview. She explained, "I like it a little bit, but I'm still skeptical. Because I still don't call it home." When asked if she would like to take part in her neighbourhood, she explained "No, because I don't plan to call this home. So, when I do plan to call something home, then I'll get to know my neighbors and stuff." Similarly, another participant had also changed her view of her apartment since the baseline interview. The participant had to move from her neighbourhood because of an injury. When she was asked what she will miss about her apartment, the participant explained:

I don't think I'll miss anything about it [Laughs]...I think I had gotten the apartment to get out of the shelter and I've been there almost two years, or a year and half now. Um, so it's

different for me. Um, I just don't like the way the apartment's set up and all the drugs and stuff coming in and out the building...

The participant did not have a sense of community in her neighbourhood because she saw her apartment as an opportunity to transition out of the shelter.

Compared to the baseline interview, more participants described feeling like they were not part of their neighbourhood. Overtime participants were able to see for themselves the challenges of living in their neighbourhoods and did not feel it was worth investing in a neighbourhood that was mostly chaotic and unsafe to live in. Instead, their apartment was seen as a stepping stone towards leaving the shelter and then eventually having a place they can call a home, where they would feel more engaged with investing their time in the neighbourhood.

Community membership in the neighbourhood. Community membership in the neighbourhood remained low since the baseline interview. In the 6-month follow-up interview, only three participants described feeling like they were part of their neighbourhoods. For a participant, being able to see herself as similar to others in the neighbourhood helped her feel closer to her neighbours. She explained:

...I like the fact that it's a mixture [diverse group of people in the neighbourhood] because it's helping me on my road to recovery...I'm not maybe successful. But I'm trying, because I'm not having to be fake. I don't want to be fake...That's why I'm staying alone a lot because I do have to sometimes to be fake and put on airs and that's okay, because people will judge.

In the 6-month follow-up interview, participants also discussed being recognized by neighbours and staff members in neighbourhood businesses. This acknowledgement by

community members occurred over time as participants spent more time in their neighbourhoods. One participant, who had made daily trips to a neighbourhood fast food restaurant explained, "... now some of them say "hi" to me. So, it's like some people say, "hey we're gonna call you the Timmies [fast food restaurant] woman." Similarly, another participant also described staff members in businesses who recognized her. She explained, "Oh, they know who I am now.... Everywhere. They just know me, you know?"

Community membership in the neighbourhood remained just as low as it was in the baseline interview. Three participants however discussed factors that helped them feel more like a community member, which included being able to find similarities related to life challenges with others in the neighbourhood and being acknowledged by neighbours and business owners.

Community involvement. A component of psychological integration is the idea of shared benefits, where while the individual feels like they have a membership, connection to neighbours, and have their needs met, they are also able to influence the community (Aubry & Myner, 1996; McMillan & Chavis, 1986). Similar to the baseline interview, the majority of the participants did not feel like they had much influence in their communities. Two participants did, however, discuss how they have been involved in their neighbourhoods. Involvement in the community was not a priority in the baseline interview for one participant, however, in the 6-month follow-up, the participant described her involvement in maintaining a clean environment around the apartment. The participant explained, "I've cleaned up the yard. Well if I see garbage and shit, I'll pick it up and put in the bins. I sweep my stairwell [stairs that are also connected to other apartments in the building]."

Another participant, who in the baseline interview was interested in being involved with safety in the neighbourhood, described her experience with addressing a disturbance in a building across from her apartment:

It's not the first fight I've gotten into over that building. Like I've literally had to walk in that building, pull the door open, and go and deal with these people because on my apartment I pay market rent, so does everybody else in there and we have to listen to that shit across the street.

Compared to the baseline interview, fewer participants discussed being involved in their communities. The two participants that were involved did so out of frustration with other residents not being responsible for cleaning their space and causing disturbances in the neighbourhood.

Discussion

The present 6-month follow-up qualitative study was designed to examine changes in women's experiences of community integration after living in independent housing for a year. The longitudinal qualitative design of this study, which also included the use of materials produced by the participant and researcher from the baseline study such as photos, maps, and notes strengthened the findings of the study. Of the 13 women participants that took part in this study, different degrees of integration were observed in the 6-months after the baseline interview.

Physical Integration

Although physical integration remained low for participants, participants were spending a little more time in their neighbourhoods compared to the baseline interview. For participants, downtown Ottawa was primarily used as a social outlet and for services in the baseline interview,

however, in the 6-month follow-up participants mainly went to downtown for services. It is possible that participants at the beginning of their transition into housing experienced a “nostalgic” phase where, as Fields (2011) describes it, the person does not ‘trust’ their emotions to their new place, especially with forming attachments, and idealizes the place where they had relationships (i.e., with service providers, friends, and family) and a long history.

A common thread among the participants that impacted their physical integration both in the baseline and 6-month follow-up interview was their health. Although physical health problems remained a significant barrier to physical integration, mental health and substance abuse problems were discussed to a greater extent in the 6-month follow-up interview. It is possible that for some participants living in their own apartments, improvements in physical health occurred a lot quicker after leaving the shelter. However, undiagnosed mental health conditions present during episodes of homelessness may have had lasting effects even after they were housed for some time (McDonald, Donahue, Janes, & Cleghorn, 2009). All of the participants lived in neighbourhoods where drugs were frequently used, and by the 6-month follow-up interview, all participants were aware of how they can access drugs in their neighbourhoods. Participants mainly discussed living with their substance abuse addictions in their neighbourhoods and how they navigated their neighbourhoods to avoid unsafe spaces that would put them at risk of using drugs again. Similar strategies of creating ‘safe’ geographical niches were also found among homeless youth living in in the downtown drug scene in Vancouver (Fast, Shoveller, Shannon, & Kerr, 2010). Nevertheless, participants still described feeling increasingly unsafe in their neighbourhoods, especially during the night. Other researchers have also found similar findings among people with mental illnesses living in

disadvantaged neighbourhoods, where there is a greater risk of crime (Kidd et al., 2016; Manuel et al., 2012).

The amenities participants described using in the neighbourhood included places where they felt safe on a day-to-day basis. Having proximity to amenities continued to be important for participants, however, most participants continued to go to downtown Ottawa for services provided by shelters and community centres. Having access to services in the neighbourhood has been found to be instrumental in community integration, particularly with physical integration and with having a sense of belonging (Coltman et al., 2015; Timko, 1996; Townley et al., 2009). Participants who had amenities, such as grocery stores and fast-food restaurants, close to their home enjoyed having a daily activity routine of going to some of these places. However, for all participants, insufficient income restricted use of amenities, which consequently impacted physical integration. This finding is consistent with other research, which has also found that even after being housed, many formerly homeless people continue to struggle with taking part in activities and meeting their daily essentials such as food (Coltman et al., 2015; De Heer-Wunderink, Visser & Wiersma, 2012; Gaetz, Gulliver, & Richter, 2014; Waldbrook, 2013).

In addition to being restricted financially, participants also discussed the effects of the changing weather on their activity levels in their neighbourhoods. With warmer weather came increased activities in the neighbourhood. A walk in the cold was very different from a walk on a warm summer's day for participants whose primary form of transportation was either using the transit system or walking.

Social Integration

Compared to the baseline interview, more participants described going to downtown Ottawa only for services they could not receive in their neighbourhoods. These findings indicate that overtime participants lost connection with former associates in downtown Ottawa. Furthermore, some participants also discussed the diminishing network of friends and family that they interacted with in the baseline interview. In most cases, participants chose to keep their distance from former associates living both inside and outside their apartment building because they wanted to stay away from heavy drug use and altercations, which would risk them losing their apartment. The finding regarding a diminishing social network is not surprising for individuals with co-occurring disorders, as research shows that their social networks tend to lessen over time, which often leads to social isolation (Aubry et al., 2015a; Aubry et al., 2013; Granerud & Severinsson, 2006; Hawkins & Abrams, 2007). Similar to our participants' explanations for having smaller networks, Hawkins and Abrams (2007) also found that participants' networks tended to shrink because of 1) deaths in participants' social network, 2) participants becoming withdrawn from their social networks due to their addictions and mental health, and 3) participants' social network withdrawing from participant because of their own obstacles such as mental and physical health problems.

Psychological Integration

Compared to the baseline interview, there were not any significant changes to participants' level of psychological integration. Participants continued to view their apartments as a temporary solution to their housing because they intended to move away. Similar to other studies, it is possible that since most of the participants were living in neighbourhoods with high crime rates, low employment, and low income, participants had low psychological sense of community (Brodsky et al., 1999; Martinez, Black, & Starr, 2001; Yanos et al., 2004).

Furthermore, participants continued to go to downtown Ottawa for essential services, which Fields (2011) suggests creates a feeling of living in a neighbourhood that has been forgotten and is unimportant because it is under-resourced.

Summary of Change from Baseline Interview

In summary, the 6-month follow-up study demonstrated that there was not a significant change in community integration for participants since the baseline interview. In general, there was a slight increase in both physical and social integration, however for psychological integration participants did not discuss any meaningful change. It may be possible that with majority of the participants living in the same neighbourhood since the baseline interview, physical and social integration naturally increases over time as participants are being exposed to their environment, however since psychological sense of community is a deeper process that involves belonging and connection to the community (McMillan & Chavis, 1984; Wong & Solomon, 2002) more time in the neighbourhood is necessary. Additionally, it may also be possible that the outcomes of recovery for the Housing First model may be less than expected especially regarding community integration. Furthermore, structural issues such as the criminalization of the drug trade, low income, and health care policies such as long wait times for treatment services can also lead to lower community integration levels.

Policy Implications

Based on our findings, there are a number of policy implications that must be taken into consideration. In the 6-month follow-up interview, all of the participants had remained housed, however, participants discussed a number of challenges they faced, which could consequently impact their levels of community integration and their long-term housing stability.

Over the past two decades, adequate and affordable housing stock has been on the decline in Canada (Gaetz et al., 2014). With social housing that is available, people have often lived in inhabitable conditions before any repairs are made by landlords or provinces and territories (Gaetz, Gulliver, & Richter, 2014). It is clear from our findings that some of the participants were also living in similarly inhabitable housing conditions. Although the social housing stock is limited, landlords need to be held accountable for the apartment's physical quality especially as a number of studies have found that housing quality has been associated with increased housing stability (Rog, 2004; Tsemberis & Eisenberg, 2000). A mandatory minimum habitability standard needs to be implemented to ensure that landlords and provinces and territories are accountable for meeting certain housing standards. Furthermore, participants in the study disclosed a number of neighbourhood characteristics that impacted their level of community integration. Factors such as high crime rate particularly related to violence and drugs and the type and affordability of amenities in the neighbourhood were all concerns that were discussed by participants. Providing a neighbourhood orientation for participants before they move into their apartments would be beneficial, especially if they are shown amenities and services near their apartment. This way participants can consider factors in their residential neighbourhood that are most important to them.

It is evident from our study that an initiative needs to be taken to address trauma, loneliness, and social isolation among women once they have been housed. Participants described being bored and were not aware of social activities occurring in their neighbourhoods. In the initial stage of moving into their neighbourhoods, case managers can be a great source of support to link the participant to their neighbourhoods. However, more opportunities to use support from community organizations such as churches in the community that provide venues to form

relationships and programs that facilitate supported socialization would be beneficial. Previous research using supported socialization programs, which use volunteer partners to engage in social and recreational activities in the neighbourhood have found some improvements in symptom reduction, social functioning, and self-esteem for people with psychiatric disabilities (Davidson, Shahar, & Stayner, 2004; Davidson et al., 2001). Women in the present study were also interested in learning more about how to improve their health through nutrition and yoga and pursuing employment and education. Interventions geared to impact specific outcomes that women are interested in could potentially lead to greater outcome success. However, all too often neighbourhoods where housing programs exist are in low quality neighbourhoods (Newman & Schnare, 1997). A greater investment in providing resources and revitalizing low socioeconomic neighbourhoods, while being sensitive to gentrification should be a priority for policymakers.

Limitations and Future Research

The shortcomings in the present study present opportunities for future research. Generalizability of the study is limited by the small sample size and purposive sampling. With the current study, we cannot be certain that the facilitators and barriers to community integration are generalizable to other women and if the findings are unique to women participants. Similar to Coltman and colleagues' (2015) research, this study also supports the finding that community integration is a process and is often achieved in a non-linear fashion from the time participants move into their neighbourhoods. This study was limited to the scope of a PhD thesis and therefore, was subject to time restriction. Thus, more qualitative longitudinal studies are necessary to fully understand the experiences of "making a home" for participants and the impact this has on levels of community integration. Regarding the photo-producing methods used in the baseline interview, it would be interesting to see the difference in the narrative quality produced

in the follow-up interview if photos were taken by participants. Our prediction is that with having participants more involved in the photo-producing methods, participants would have been more engaged 6-months after in describing the photos and how it relates to their lives in their neighbourhoods.

It is important to note that our overall dropout rate from baseline to the 6-month follow-up was low. Eighty-one percent of the participants took part in both interviews, which perhaps speaks to the rapport we had built with the participants. Given the limited research on women and community integration, it is critical to continue similar research. However, future research that incorporates sex and gender analysis and community integration outcomes would add to the literature. Furthermore, more research using participatory methods, such as neighbourhood walk-along and with participant directed photo-production and photo-elicitation methods would give a deeper understanding of participant's experiences in their communities.

Table 7.

Qualitative Categories and Codes.

Personal
-Past experiences
-Addictions
-Feelings of loneliness
-Family/Partner
-Safety
-Health
-Friends
-Money/Expenses/Poverty
-Crime
-Feelings about herself
-Bad influences surrounding participants
Goals and Choices
-Priorities
-Having a choice
-Things she avoids
-People/Friends/Family
-Rights and responsibilities of being a tenant
-Thoughts on integration
-Exploring neighbourhoods
Housing
-Past housing experiences
-Changes in lifestyle due to housing
-Privacy
-Superintendent/Manager
-Things/Objects
-Description of building
-Transitioning
-Meaning of home to participant
-Future thinking about housing/neighbourhood life
-Description/Feelings about neighbourhood
-Feelings about building
-What would be helpful for woman
Physical Integration
-Outside of neighbourhood
-Things that encourage physical integration
-Things that prevent physical integration
-Regular visit in neighbourhood
-Place wants to go to but haven't yet
-Place she has gone to but doesn't want to go again
-Place she avoids
-Description/feelings about neighbourhoods/Building neighbours/Awareness of what's happening in building
Social Integration
-Store owners and service providers in neighbourhood
-Pets
-Activities
-Social integration outside of neighbourhood
-Superintendent/Manger
-Things that prevent social integration in building
-Things that encourage social integration in building
-Things that prevent social integration in neighbourhood
-Things that encourage social integration in neighbourhood
-Unhealthy social interactions in neighbourhood
-Healthy interactions in neighbourhood
-Social interaction
Psychological Integration

- Fitting in
 - Involvement in community
 - Things that prevent psychological integration
 - Things that encourage psychological integration
-

Change Over 6 Months

- Changes in perception of community
- Changes in physical integration
- Changes in social integration
- Changes in psychological integration
- Changes in lifestyle
- Changes within apartment

Chapter 6: General Discussion

Community integration is a multidimensional concept that includes three elements: physical integration, social integration, and psychological integration (Aubry & Myner, 1996; Wong and Solomon, 2002). The concept has been applied to many populations, including the general population, people with developmental disabilities, people experiencing homelessness, and people with spinal cord injuries (Anderson, Krajci, & Vogel, 2003; Aubry & Myner, 1996; Ecker & Aubry, 2016; Yanos et al., 2011). Community integration among women who have a history of homelessness or may be at risk of homelessness has not previously been sufficiently explored. To address this gap in the literature, this dissertation investigated predictors and the experiences of community integration among vulnerably housed women.

Summary of Findings

Study 1. We examined individual (i.e., age, physical health, mental health, substance use, alcohol use, social support, income, and school enrollment and training program) and environmental (i.e., city, stably housed, and neighbourhood impact) predictors for women who are vulnerably housed at two time points (i.e., follow-up 2 (FU2) and follow-up 3 (FU3)). We were also interested in exploring the individual variables from FU2 that impacted levels of community integration in FU3 while controlling for physical, social, and psychological integration at FU2. Overall, participants reported low levels of physical integration, moderate levels of social integration, and moderate levels of psychological integration at FU2 and FU3.

When all variables were entered into the hierarchical multiple regression model for physical integration, the majority of the variance in the model was explained by 2 individual variables: 1) enrollment in school or training program, and 2) physical health. Participants who took part in activities such as school or training programs reported higher levels of physical

integration. Better physical health also facilitated greater levels of physical integration in our participants.

After including all variables in the last block for FU2 and FU3, the three individual variables that predicted social integration were: 1) social support, 2) substance use, and 3) alcohol use. Participants with greater social support had higher levels of social integration. Surprisingly, participants with problematic substance and alcohol use also had higher levels of social integration.

The variables that predicted a majority of the variance for psychological integration were: 1) mental health functioning, 2) older age, 3) social support, and 4) neighbourhood impact. Specifically, we found that higher mental functioning was associated with greater levels of psychological integration. Participants who were older and had greater social support had higher levels of psychological integration. The only environmental variable that predicted psychological integration was neighbourhood impact. Participants who perceived their neighbourhood as having a positive impact on their lives had higher psychological integration levels.

It is worth noting that stable housing was not a predictor of community integration at FU2 and FU3. It is possible that although participants were stably housed they still continued to feel socially isolated and lonely in their neighbourhoods. Furthermore, participants may have also left their neighbourhoods to spend time with social networks outside of their neighbourhoods.

Study 2. In the second study, we examined how women in the Housing First (HF) program in Ottawa perceived their integration in their neighbourhoods. The participatory approach taken in the study included a mapping activity, a neighbourhood walk-along interview, and the photo-elicitation method. This approach enabled participants to describe, with richer

detail, some of the challenges and opportunities for community integration that their neighbourhoods provided.

Overall, participants described having limited physical integration in their neighbourhoods. Both personal and environmental factors were described as affecting their presence in their neighbourhoods. Personal factors that limited participants' physical integration included: 1) physical and mental health, which restricted their activity level and how often they left their apartments, and 2) not having enough money to spend, which limited their use of goods and services in their neighbourhoods. Reminiscent of findings from Study 1, in this second study participants described their physical health and low incomes as factors that limited their presence in their neighbourhoods. For some participants in Study 2, mental health also limited their physical integration.

Participants also described environmental factors that impacted their level of physical integration in their neighbourhoods such as: 1) being more familiar with businesses and services outside of their neighbourhood, and 2) feeling unsafe because of criminal activities in their apartment and neighbourhood. Day trips to downtown were common among participants since most participants had moved into the outer-suburbs of Ottawa. Having limited income assistance, participants were often left with little choice in the types of neighbourhoods they could afford to live in. Fields (2011) describes this as the reality of marginalized individuals living in disadvantaged neighbourhoods and not experiencing community integration. Either they are expected to integrate into neighbourhoods seen negatively or spend time outside their neighbourhoods by emotionally and physically distancing themselves (Fields, 2011).

Participants described low levels of social integration in their neighbourhoods. The three reasons participants provided for having low social interactions in their neighbourhoods included:

1) lack of interest in social interactions, 2) wishing to maintain their privacy, and 3) protecting their new life from people who were not sober or who might threaten their housing stability.

Interactions that occurred in public were often brief and in business settings. Participants described unstable relationships with people in their apartment buildings and conflicts were common because of disturbances, substance abuse, and neighbours who gossiped about the participant. These results expand previous findings indicating social isolation as being common among formerly homeless people (Aubry et al., 2015a; Hawkins & Abrams, 2007; Polvere et al., 2013). Consistent with our findings, Hawkins and Abrams' (2007) research on formerly homeless people's social networks, found that these individuals isolated themselves not to experience the disappointment that came with interactions and for those who were rebuilding social ties, their networks were often similar to the ones in their past that included people with negative influences.

Participants generally had mixed feelings about psychological integration in their neighbourhoods. Feelings of belonging were not sought after because most participants preferred to keep a private life. Consistent with our findings, Fields (2011) also found that formerly homeless individuals described deeper connections to places where they lived in the past, which then limited their sense of belonging in their current living location. Some participants also described not fitting in their neighbourhoods because of their appearance and the judgment they felt from their neighbours and the businesses in the neighbourhood. It is possible that like Fields' (2011) study, participants in our study found it hard to identify with their disadvantaged neighbourhoods, which led to isolation and distrust and participants wanting to separate themselves from the disorder in their neighbourhoods. Some participants in our study, however,

were hopeful that community involvement would occur naturally after living longer in their neighbourhoods.

Study 3. In the final study, a longitudinal qualitative design was employed in which we examined changes in participants' level of community integration 6-months after the interviews were conducted in Study 2. Materials (i.e., maps, photos, and notes) produced by the participants in Study 2 were used to discuss community integration. Compared to the baseline interview, there was a small increase in participants' level of physical integration. One key change was that participants did not use downtown Ottawa primarily to socialize with old associates. Instead, most participants used downtown Ottawa primarily for services that were not available in their neighbourhoods. Participants continued to struggle with their physical and mental health, as well as substance abuse problems, and these struggles continued to limit their physical integration. Further, participants' financial situations continued to restrict their use of services in their neighbourhoods and participants discussed how winter weather conditions limited the types of activities and the amount of time they spent on activities in their neighbourhoods. Although participants had stable housing, they continued to describe the lingering effects of homelessness, which impacted their level of physical integration.

Regarding social integration, participants described fewer opportunities to interact with neighbours. Compared to the baseline interview, participants discussed having fewer interactions with former associates in downtown Ottawa and with their neighbours. Over time, it is common to find a shrinking social network among people with co-occurring disorders (Aubry et al., 2015a; Aubry et al., 2013; Granerud & Severinsson, 2006; Hawkins & Abrams, 2007). As for psychological integration, participants continued to describe experiences similar to those from their baseline interviews. A majority of the participants viewed their neighbourhoods as being a

temporary place before they moved to their ideal neighbourhood and home. It is possible that as participants spent more time in their neighbourhoods and apartments, they discovered more problems with their surroundings. This coincides with Nemiroff and colleagues (2011) study, which found that formerly homeless women who lived in their housing longer had lower levels of psychological integration.

Discussion

Overall, the finding across the three studies show that both individual and environmental variables have a significant impact on community integration for formerly homeless women. From the quantitative study, we saw that individual predictors had the greatest influence on physical and social integration, while psychological integration was influenced by a mix of individual and an environmental predictor. In the second and third qualitative studies, participants described the impact of both individual (e.g., health) and environmental (e.g., safety) factors that have an influence on community integration. The interplay between individual and environmental context has to be recognized particularly when measuring community integration.

From the three study findings, we have learned that for formerly homeless women, factors that have the greatest impact on community integration are feeling healthy, having social support, partaking in organized activities, receiving greater income support, feeling protected from victimization, and living in good quality apartment and neighbourhood space with close by amenities. The qualitative findings indicate that common citizenship, which is a goal of community integration, was not fully achieved by participants (Wong & Solomon, 2002) and that participants generally saw their apartments as a way to transition out of the shelter system. Engagement with others and with activities in their neighbourhoods were also limited.

Consistent with other studies, our findings also indicate that community integration is a process that is dependent on the phase of transition that participants are experiencing (Coltman et al., 2015; Macnaughton et al., 2016). Macnaughton et al. (2016) support this idea and describe three key transitions in the recovery process of participants with a history of homelessness and mental illness: 1) the transition from being on the street to home, where the participants no longer have the survival and safety concerns they had while living on the streets, 2) transitioning from home to the community involves the participant focusing on themselves and changing their life for the better, and 3) moving forward from the present to the future where the participant thinks about life goals they would like to achieve. The participants in our qualitative study were still experiencing their transition from homelessness to living in their home, which may explain their low levels of community integration. Even though the participants had access to housing and income support, participants continued to experience both personal and systematic challenges that may have contributed to them becoming homeless in the first place. Such challenges included not having their basic needs met such as food and safety, low income, and still being embedded in substance-using social networks. From our studies, we identified how these challenges impacted their level of community integration. Although participants had challenges they were trying to overcome, it is also important to note that themes of self-determination and resiliency were also observable when participants described their future and with living a meaningful life despite challenges they have experienced.

Additionally, our findings also provide more information on the progression of physical, social, and psychological integration. Flynn and Aubry (1999) have pointed out that although physical integration is necessary for social integration, ultimately, it is social integration that is considered to be meaningful for community integration. In our research, it also appears that

social integration played a significant role in participants' community integration levels. Interestingly, the quantitative study findings showed that even with low levels of physical integration, participants had moderate levels of social integration and moderate levels of psychological integration. This may indicate that although participants were not taking part in activities or using goods and services in their communities, they were still engaging in social interactions with community members and feeling part of their community. An explanation for this can be that participants mostly had social interactions with their neighbours inside their apartment building or in settings away from their neighbourhoods. Furthermore, it is possible that participants with a similar history of homelessness were housed close to or within the same apartment building, creating a greater sense of belonging for participants. In contrast, the qualitative 6-month follow-up study showed that although participants were spending a little more time in their neighbourhoods, they still had low levels of interactions with neighbours and low levels of psychological integration. Because each participant experienced community integration on their own terms, which depended on their experience of transitioning from the shelter system to the apartment, past life experiences, and functioning, for most participants the process of community integration only began when participants felt they were ready and had stability in their life after emerging from homelessness.

Limitations and future research. First, the generalizability of the findings is a concern for all the studies. Although the findings for all of the studies were in line with previous research, we cannot be certain that the findings can be generalizable to other formerly homeless women outside of Canada and whether these findings are unique to formerly homeless women. Future research examining formerly homeless women's experiences with community integration should

consider these limitations and should also be inclusive of women from diverse ethnic and cultural backgrounds.

Second, self-reported data can be inherently biased and lead to inaccurate reporting. For Study 1, secondary data was also used, which impacted the quality of the data. For the two qualitative studies, the small sample size was a limitation; however, the collected data was robust in its quality because of the longitudinal design, the contextual data we collected through the walk-along and photo-elicitation methods, and the rapport and trust we built with the participants. Because of the non-linear process of change in community integration, future qualitative research should have a longer time gap between follow-up interviews to capture change (Coltman et al., 2015).

Third, community integration questionnaires should be developed by first consulting with formerly homeless individuals. This would validate the items in the questionnaire making it more relevant to the lives of formerly homeless people. Data from a study that primarily focused on community integration would have produced richer data if more information about participants' use of amenities in their community (i.e., mapping exercise) and the amount of time participants spent socializing with residents within their apartment building versus people they socialize within their neighbourhoods was collected. Further, for the qualitative study, giving participants the opportunity to practice with their cameras, would have given participants more confidence in taking photos during the walk-along interview. The participants taking photos would have produced a richer contextual understanding of participants' life in their neighbourhoods. Future research in community integration should also compare the experiences of men and women and explore community integration outside the boundaries of a neighbourhood, such as downtown where participants spent a significant amount of time.

Lastly, as researchers and policy advisors, we also have to be cognisant of how research findings can be interpreted. When looking at the quantitative findings alone, there is a risk of blaming the participants for having certain individual characteristics such as low mental and physical health functioning that could have impacted their level of community integration in their neighbourhoods. However, the qualitative findings show that although participants had certain individual characteristics (i.e., substance abuse and mental health problems) that would impact community integration, environmental variables such as disorganized and unsafe neighbourhoods also play an important role in participants' community integration levels. Future research should consider the environment as an important factor for offering and denying opportunities to people. Furthermore, triangulating results using mixed methods to have a better understanding of the findings is also important for future research.

Implications and conclusion. The findings from the three studies have specific implications for service providers and policy advisors. It is clear that after receiving housing, formerly homeless women are more receptive to addressing their health problems, however, consumers are often tackling confusing and fragmented systems of care (Bond et al., 2004; Drury, 2003; Osher & Drake, 1996; Padgett, Tiderington, Smith, Derejko & Henwood, 2016). Service providers should take advantage of this window of opportunity to intervene and provide services specific to women's needs. Access to services should be made easier for formerly homeless consumers, so that participants do not have to travel great distances to receive essential services, such as addictions and mental health services. Having more community outreach services, where services are brought to the person, especially in the beginning stages of transition would be beneficial.

Our findings also highlighted the importance of collective support services in the form of social opportunities for participants. Participants' involvement in mediating structures such as consumer-run organizations (CROs) can play an important role in empowering consumers of mental health services through their active participation in activities such as community planning and advocacy (Brown & Rogers, 2014; Janzen, Nelson, Trainor, & Ochocka, 2006; Shinn, 2015). Participants often turned to prostitution, selling drugs, and panhandling to supplement their financial security, putting them at risk of becoming homeless again. A supported employment and education program can also be beneficial in connecting consumers with the job market and in helping participants meet their goals (Bond et al., 2004; Gumber & Stein, 2017; Nuechterlein, Subotnik, Turner, & Ventura, Becker, & Drake, 2008). However, as Klodawsky (2009) points out, service providers need to keep in mind that employability can not outweigh the process of healing and making a "home" for participants. Continued advocacy for services that provide necessities such as food, clothing, health services, and importantly higher social assistance would go a long way in preventing the cycle of homelessness. Furthermore, service providers can help foster connections with informal support systems and people who act as natural support in the community, such as family and friends.

The transition from being homeless to being housed can be a long nonlinear journey for formerly homeless women who have experienced a number of challenges such as trauma and substance abuse. From our qualitative study, we learned that for many of the participants their main priority after receiving housing was to focus on their recovery and to over time leave behind relationships they formed while homeless. Although community integration has long been seen as a primary desired outcome from housing programs, this may not fit with the actual goals that women have for themselves. Instead greater emphasis from service providers may be placed on

helping women create a home, which includes elements of safety and security, stability, familiarity and consistency. All of these may eventually contribute to successful community integration.

Living space that would be most conducive to community integration for formerly homeless women would include good quality apartments and neighbourhoods where participants would feel safe, have close by amenities, and not experience temptations for drugs or other behaviours that they were trying to leave behind. It was challenging for participants to live in disorganized neighbourhoods with neighbours experiencing similar life challenges, however, participants also spoke about not fitting into high-income neighbourhoods or highly organized neighbourhoods. These findings have important implications for the types of neighbourhoods best fitted for formerly homeless women in a Housing First program as placing participants in neighbourhoods that have high social cohesion could potentially isolate participants, while areas of high neighbourhood disorganization may be too chaotic and threatening for social interactions (Trute & Segal, 1976). An ideal environment would be one where participants can interact with people and not stand out as an “outsider”, but live in an environment where they are not largely surrounded by community members with a problematic past (Trute & Segal, 1976). Having these qualities in a neighbourhood would set the stage for creating an ideal environment where participants can first address their immediate priorities like their health and addictions and then ultimately their level of community integration in their neighbourhoods.

The decline in adequate and affordable housing in Canada (Gaetz et al., 2014), has limited participants’ choice in the types of apartments and neighbourhoods they can live in. Participants often live in subsidized apartment buildings, where “vertical poverty” is common (Kidd et al., 2016), and they end up having little choice about who they can interact with other than people

with similar life experiences. As researchers and policy advisors, we have to pay attention to the impact the Housing First program has in the recovery process when housing is located in neighbourhoods with low income, high unemployment and poverty rates, and poor housing stock. From our findings, we see that for formerly homeless people to physically integrate, socialize, and feel part of their community, apartment and neighbourhood quality is vital. It should also be made mandatory that landlords meet certain housing standards and that although housing choices are limited, participants are given a neighbourhood orientation before they move into their apartments, which would include service providers showing the participant the different amenities and services available in the neighbourhood. This would be beneficial because consumer choice has been associated with positive outcomes in community integration (Gulcur et al., 2007; Yanos et al., 2004). Beyond the quality of apartment and neighbourhood space, consumers of affordable housing also need to be informed about their citizenship rights especially regarding their rights to living in their homes (Sylvestre et al., 2007).

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Appendix A

Health and Housing in Transition Study (HHiT) FU2 & FU3 Survey Instrument

March 8, 2011 & December 19, 2011

HEALTH AND HOUSING IN TRANSITION STUDY

Follow-UP 3 Survey Instrument
December 19, 2011

Survey Number* <table border="1" style="width: 100%; height: 30px; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table> <div style="display: flex; justify-content: space-around; font-size: 8px;"> 123456 </div>							Date of Survey <div style="text-align: center; margin-top: 10px;"> ____ / ____ / ____ <small>d d m m y y</small> </div>	Interviewer's Initials <table border="1" style="width: 100%; height: 30px; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%;"></td> </tr> </table> <div style="display: flex; justify-content: space-around; font-size: 8px;"> First NameLast Name </div>									
City: <input type="checkbox"/> Ottawa <input type="checkbox"/> Toronto <input type="checkbox"/> Vancouver																	
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		:															
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				Mins													

To be completed by Research Coordinator	
Forms returned	<input type="checkbox"/> Consent form <input type="checkbox"/> Reimbursement signature
Data entered	<input type="checkbox"/> Quantitative data <input type="checkbox"/> Qualitative data <input type="checkbox"/> Identifying data
Scanned	<input type="checkbox"/> Yes
Baseline Survey Number	
Health Card # Obtained	<input type="checkbox"/> Yes <input type="checkbox"/> No, need to obtain in Section 14

INSTRUCTIONS FOR INTERVIEWERS

- A. Every time you see **[REFER TO SCALE]** you should turn to the appropriate page of the scales booklet and present the new scale to the participant.
- B. Any text inside parenthesis and/or in italic is a note for the interviewer; you should NOT read it to the participant.
Example: *(Ask these questions even if the participant is sleeping anywhere outside).*
- C. Bolded text has the objective of drawing the interviewer’s attention to part of a sentence or an entire sentence.
Example: I want you to think about where you have been living **in the past 12 months**.
- D. Skip patterns are properly indicated throughout the survey (see example below). If no skip pattern is indicated go to the following question.

6.1	Do you have a regular medical doctor?	1. Yes 2. No → (go to 6.3)	996. Not applicable 997. Refused 998. Don’t know	}	go to 7
------------	---------------------------------------	--------------------------------------	--	---	---------

E. To select an answer circle corresponding code number. See examples below:

A	In general, compared to other people your age, how would you rate your health?	1 Excellent	2 Very good	3 Good	4 Fair	5 Poor	996. N/A 997. Refused 998. Don’t know
---	--	----------------	----------------	-----------	-----------	-----------	---

C	How would you rate the place where you currently live in terms of spaciousness* ?	1	2	3	4	5	6	7	996	997	998
---	--	---	---	---	---	---	---	---	-----	-----	-----

4.1	Have you needed mental health care in the past 12 months but were not able to get help?	1. Yes 2. No → go to 4.3	996. Not applicable 997. Refused 998. Don’t know	}	go to 4.3
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- F. There are NOT APPLICABLE (996), REFUSED (997) and DON’T KNOW (998) options available in every question. Do not present these as options for respondents. It is important not to overuse these options. NOT APPLICABLE answers should be extremely rare, since the survey has a planned skip pattern built in. Both the DON’T KNOW option and the NOT APPLICABLE option should only be selected after proper probing. The refused option should be selected when necessary. Refusal to answer a question should also be rare, but, if it happens, the interviewer should respect the participant’s desire and not probe again.
- G. When writing qualitative open-ended answers record verbatim and make sure your printing is clear. If the answer is too long to record fully, record key points using the participant’s own language and read back to the participant to validate.

BEFORE BEGINNING SURVEY, ASK PARTICIPANT FOR CONTACT INFORMATION AND ENTER ON PAGE 41 OF SURVEY

SECTION 1 - HOUSING

1.1 Housing History (Dartmouth Follow-Back Calendar)

The first question I'll be asking has to do with where you have been living for the last while... *(Ask these questions even if the participant is sleeping anywhere outside.)*

I want you to think about where you have been living **since our last interview**. Let's look at this calendar together [**REFER TO CALENDAR**], and I'll make notes as you talk. This is (current date), so the time we'll be talking about is between (date of last interview) and today. We will start with where you are living now and work backwards from there, month by month.

(Prompts for type of residence - only read if necessary: Own house, apartment, temporary stay with friends and/or relatives, homeless shelter, homeless (on the streets, in the park/ravine, in a car or other vehicle, abandoned buildings, public places such as bus/train stations), rooming house, boarding home, group home, single room occupancy unit, medical hospital, psychiatric hospital, substance abuse treatment facility, halfway house, nursing home, motel or hotel, jail or prison.)

1.1.1 Current Location		N/A	Refused	DK
A	Location <i>(If participant doesn't know the address ask for major intersection or neighbourhood)</i>	996	997	998
B	Type of residence	996	997	998
C	Date moved in (dd/mm/yyyy) ___ ___ / ___ ___ / _____	996	997	998
<i>(If type of residence is a shelter, street, treatment facility, hospital or jail go to G)</i>				
D	Is this ...	996	997	998
1. Your own place 2. A place belonging to friends or family → Do you pay rent? 1. Yes 2. No → go to G				
E	How much do YOU pay for rent? <i>(participants share of rent - monthly amount)</i>	996	997	998
F	Is this subsidized housing? **	996	997	998
1. Yes 2. No				
G	Why did you move to this place? <i>(If participant hasn't moved in the past 12 months, skip to 1.2)</i>	996	997	998
_____ _____ _____ _____				

** If participant does not know whether their housing is **subsidized**, ask: "Is part or all of your rent being paid by the government, a community agency, or another organization? In other words, you are receiving support to pay your rent above and beyond any income you have."

1.1.1 If the participant indicates he/she is currently staying in a place classified as vulnerably housed (i.e., rooming house; SRO; motel or hotel), ask the following questions. If not, skip to the next housing location.

A. Do you always stay here (e.g., at the SRO; rooming house; motel or hotel) or are there times when you don't stay here and you choose to sleep elsewhere – like in a shelter or on the streets or with a friend? (If the person stays here, then skip to next housing location; if not, ask remaining questions)

- 1. Yes → skip to 1.1.2
- 2. No

B. Where do you stay? (Note: list all places the participant stays)

C. How often are you away from here (e.g., the SRO; rooming house; motel or hotel) in a typical week? (Record an alternate response if this time frame is not appropriate)

On average, _____ nights per week

Alternate response:

D. What are the reasons that you don't stay here (e.g., the SRO; rooming house; motel or hotel)?

E. What are the reasons that you keep this place (e.g., the SRO; rooming house; motel or hotel)?

1.1.2			N/A	Refused	DK
A	Location		996	997	998
B	Type of residence		996	997	998
C	Date moved in (dd/mm/yyyy)	___ ___ / ___ ___ / _____	996	997	998
D	Date moved out (dd/mm/yyyy)	___ ___ / ___ ___ / _____	996	997	998
<i>(If type of residence is a shelter, street, treatment facility, hospital or jail go to G)</i>					
E	Was this ...	1. Your own place 2. A place belonging to friends or family → Did you pay rent? 1. Yes 2. No	996	997	998
F	Was this subsidized housing? **	1. Yes 2. No	996	997	998
G	Do you remember why you moved to this place?	_____ _____ _____ _____	996	997	998

1.1.3			N/A	Refused	DK
A	Location		996	997	998
B	Type of residence		996	997	998
C	Date moved in (dd/mm/yyyy)	___ ___ / ___ ___ / _____	996	997	998
D	Date moved out (dd/mm/yyyy)	___ ___ / ___ ___ / _____	996	997	998
<i>(If type of residence is a shelter, street, treatment facility, hospital or jail go to G)</i>					
E	Was this ...	1. Your own place 2. A place belonging to friends or family → Did you pay rent? 1. Yes 2. No	996	997	998
F	Was this subsidized housing? **	1. Yes 2. No	996	997	998
G	Do you remember why you moved to this place?	_____ _____ _____ _____	996	997	998

** If participant does not know whether their housing is **subsidized**, ask: "Is part or all of your rent being paid by the government, a community agency, or another organization? In other words, you are receiving support to pay your rent above and beyond any income you have."

1.1.4			N/A	Refused	DK
A	Location		996	997	998
B	Type of residence		996	997	998
C	Date moved in (dd/mm/yyyy)	___ ___ / ___ ___ / _____	996	997	998
D	Date moved out (dd/mm/yyyy)	___ ___ / ___ ___ / _____	996	997	998
<i>(If type of residence is a shelter, street, treatment facility, hospital or jail go to G)</i>					
E	Was this ...	1. Your own place 2. A place belonging to friends or family → Did you pay rent? 1. Yes 2. No	996	997	998
F	Was this subsidized housing? **	1. Yes 2. No	996	997	998
G	Do you remember why you moved to this place?	_____ _____ _____ _____	996	997	998

1.1.5			N/A	Refused	DK
A	Location		996	997	998
B	Type of residence		996	997	998
C	Date moved in (dd/mm/yyyy)	___ ___ / ___ ___ / _____	996	997	998
D	Date moved out (dd/mm/yyyy)	___ ___ / ___ ___ / _____	996	997	998
<i>(If type of residence is a shelter, street, treatment facility, hospital or jail go to G)</i>					
E	Was this ...	1. Your own place 2. A place belonging to friends or family → Did you pay rent? 1. Yes 2. No	996	997	998
F	Was this subsidized housing? **	1. Yes 2. No	996	997	998
G	Do you remember why you moved to this place?	_____ _____ _____ _____	996	997	998

** If participant does not know whether their housing is **subsidized**, ask: "Is part or all of your rent being paid by the government, a community agency, or another organization? In other words, you are receiving support to pay your rent above and beyond any income you have."

Thank you for sharing your housing history, now I will ask you some questions about your current housing situation.

1.2	Do you have the kind of housing that you want? A. (If Yes) What makes this the kind of housing that you want? B. (If No) What is keeping you from getting the kind of housing that you want? <hr/> <hr/> <hr/> <hr/>	1. Yes 2. No 996. N/A 997. Refused 998. Don't know
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(If participant is a shelter resident, skip to 1.4. If participant is homeless, in a hospital or rehab facility, or in jail, skip to 1.12)

1.3	How did you get this housing? <hr/> <hr/> <hr/>	996	997	998
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1.4	How many people do you share your apartment/room with? What is your relationship with these people?	996	997	998
------------	---	-----	-----	-----

(If participant is a shelter resident, skip to 1.12)

1.5	Is this building in need of any repairs? <i>(If yes, prompt for minor or major repairs)</i>	1. Yes (minor repairs are needed - missing or loose floor tiles, bricks or shingles, defective steps, etc.) 2. Yes (major repairs are needed - defective plumbing or electrical wiring, structural repairs, etc.) 3. No (only regular maintenance is needed - painting, furnace cleaning, etc.)	996	997	998
------------	--	---	-----	-----	-----

1.6	Do you have your own bathroom?	1. Yes → go to 1.8 2. No	996	997	998
------------	--------------------------------	-----------------------------	-----	-----	-----

1.7	With how many people do you share a bathroom?		996	997	998
------------	---	--	-----	-----	-----

1.8	Do you have your own cooking facilities?	1. Yes → go to 1.10 and then 1.12 2. No	996	997	998
------------	--	--	-----	-----	-----

1.9	Are there cooking facilities in your building that you have access to?	1. Yes 2. No → go to 1.12	996	997	998
1.10	Do they work?	1. Yes 2. No	996	997	998
1.11	With how many people do you share these facilities? skip to 1.12, if Y or N to question 1.8.		996	997	998
1.12	Does your room/building have bed bugs, mice, cockroaches, rats, etc.?	1. Yes 2. No	996	997	998

1.13 Housing Quality (Toro’s Instrument)

(Ask these questions even if the participant is sleeping anywhere outside, in a car or other vehicle, abandoned building, bus station or other public place, or place of business.) [REFER TO SCALE]

		Very bad	Bad	Somewhat bad	Neither good or bad	Somewhat good	Good	Very good	N/A	Refused	DK
A	How would you rate the place where you currently live in terms of comfort ?	1	2	3	4	5	6	7	996	997	998
B	How would you rate the place where you currently live in terms of safety ?	1	2	3	4	5	6	7	996	997	998
C	How would you rate the place where you currently live in terms of spaciousness *?	1	2	3	4	5	6	7	996	997	998
D	How would you rate the place where you currently live in terms of privacy **?	1	2	3	4	5	6	7	996	997	998
E	How would rate the place where you currently live in terms of friendliness ***?	1	2	3	4	5	6	7	996	997	998
F	How would you rate the place where you currently live in terms of overall quality ?	1	2	3	4	5	6	7	996	997	998

* Spaciousness: Feeling like you have enough space to live comfortably.
 ** Privacy: Feeling like you have your own space where you will not be disturbed by other people.
 ***Friendliness: Feeling like you are in a pleasant and welcoming atmosphere and you are comfortable in these surroundings.

1.14

How does your current housing situation affect your physical and emotional health? *(If required give prompts: location or neighbourhood, type of housing, supports or services, structural characteristics. Prompt for positive and or negative effects.)*

996. N/A
 997. Refused
 998. Don't know

1.15 Housing Impact (QoLHHI Impact: Living Conditions)

I'm going to ask you about the impact or the effect that different aspects of your living conditions have on your quality of life.

1.15.1 Let's start with some questions about the place where you currently live or stay . (Note: Yes/No = sometimes, depends, or any other mixed response. Use the description section to expand on any responses.)									
		Yes	No	Yes/No	Description	N/A	Refused	DK	
A	Do you feel that the place where you live or stay is affordable?	1	2	3		996	997	998	
B	Does the place where you live or stay have the amenities that are important to you (like a fridge, stove, own bathroom, elevator)?	1	2	3		996	997	998	
C	Do you have access to bathing facilities (such as a shower)?	1	2	3		996	997	998	
D	IF YES: Do you feel that these bathing facilities are clean enough to use?	1	2	3		996	997	998	
E	IF YES: Do you feel safe using these bathing facilities?	1	2	3		996	997	998	
F	Overall, do you feel that the place where you live or stay is clean enough?	1	2	3		996	997	998	
G	Do you feel like you have control over your own space?	1	2	3		996	997	998	
H	Are the other people living or staying there too disruptive?	1	2	3		996	997	998	
I	Do you have enough privacy there?	1	2	3		996	997	998	
J	Do you feel there are too many restrictions placed on you there?	1	2	3		996	997	998	

		Yes	No	Yes/ No	Description	N/A	Refused	DK
K	Are you always worrying that you'll catch some illness from other people living there?	1	2	3		996	997	998
L	Do you feel your stuff is safe there?	1	2	3		996	997	998
M	Do you feel that you're treated well there (for example: by landlord, shelter staff, other residents)?	1	2	3		996	997	998
N	Does it feel like a home to you?	1	2	3		996	997	998
O	What is the worst thing about the place where you currently live or stay?					996	997	998
P	What is the best thing about the place where you currently live or stay?					996	997	998
Q	Anything else you want to tell me about the place where you live or stay:					996	997	998
R	<p>You've talked about some things that describe the place where you currently live or stay. Now I want to know what kind of impact/effect that the place where you live or stay has on you. You could tell me that the place where you live or stay has no impact/effect on you at all. Or you could say that it has a positive impact/effect and makes things better for you. Or, maybe it has a negative impact/effect and makes things worse for you. I'd like you to rate the kind of impact/effect that the place where you currently live or stay has on you. [REFER TO SCALE]</p> <p style="text-align: center;"> 1 Large negative impact/effect 2 Moderate negative impact/effect 3 Small negative impact/effect 4 No impact/effect 5 Small positive impact/effect 6 Moderate positive impact/effect 7 Large positive impact/effect </p>					996. N/A 997. Refused 998. Don't know		

1.15.2 Now I have some questions about your **neighbourhood**. By ‘neighbourhood’, we mean the neighbourhood of the place where you are currently living or staying - even if you haven’t been there very long. (**Exception:** *if person is usually in one shelter but happens to be in a different one today only, rate neighbourhood of usual shelter.*)

		Yes	No	Yes/ No	Description	N/A	Refused	DK
A	Do you feel safe in your neighbourhood?	1	2	3		996	997	998
B	Why is that?					996	997	998
C	Do you feel the same or different about safety in your neighbourhood during the day and at night? <i>If different, say: “Please explain what is different”</i>					996	997	998
D	Do you feel that you’re part of the community in your neighbourhood?	1	2	3		996	997	998
E	Do you feel stuck in your neighbourhood?	1	2	3		996	997	998
F	Do you feel that there are a lot of bad influences there for you (for example: too many drugs, too much crime)?	1	2	3		996	997	998
G	Do you think that there are enough resources there? (for example: food bank, health care, support workers)	1	2	3		996	997	998
H	What is the worst thing about your neighbourhood?					996	997	998
I	What is the best thing about your neighbourhood?					996	997	998
J	Anything else you want to tell me about your neighbourhood?					996	997	998

K	You've talked about some things that describe your neighbourhood. Now I'd like you to rate the kind of <u>impact/effect</u> that your neighbourhood has on you. [REFER TO SCALE]							996. N/A 997. Refused 998. Don't know
	1 Large negative impact/effect	2 Moderate negative impact/effect	3 Small negative impact/effect	4 No impact/effect	5 Small positive impact/effect	6 Moderate positive impact/effect	7 Large positive impact/effect	

1.15.3 Next, I have some questions about the **food** you eat.

		Yes	No	Yes/ No	Description	N/A	Refused	DK
A	Are you usually able to get food that you like?	1	2	3		996	997	998
B	Would you say that the food you eat is nutritious?	1	2	3		996	997	998
C	Are you usually able to get good quality food?	1	2	3		996	997	998
D	Do you find that you get stuck eating the same thing almost every day?	1	2	3		996	997	998
E	Do you have trouble getting enough to eat?	1	2	3		996	997	998
F	What is the worst thing about the food you eat?					996	997	998
G	What is the best thing about the food you eat?					996	997	998
H	Anything else you want to tell me about the food you eat?					996	997	998
I	You've talked about some things that describe the food you eat. Now I'd like you to rate the kind of <u>impact/effect</u> that the food you eat has on you. [REFER TO SCALE]							996. N/A 997. Refused 998. Don't know
	1 Large negative impact/effect	2 Moderate negative impact/effect	3 Small negative impact/effect	4 No impact/effect	5 Small positive impact/effect	6 Moderate positive impact/effect	7 Large positive impact/effect	

J	In a typical week, which of the following places do you access to get food? Check all that apply. [REFER TO SCALE]								
1	2	3	4	5	6	7	8	9	
Buy your own groceries	Buy food at a restaurant	Buy food at food cart	Ask for food that is leftover from a restaurant	Meal Program	Food program in your housing	Foodbank	Family or Friends' Place	Other Please Specify	_____ _____ _____
									996. N/A 997. Refused 998. Don't know
Also, please indicate the one that is your most frequent source of food. Record the number (1-9) _____									

SECTION 2 – HEALTH STATUS

<p>2.1 (SF-12)</p> <p>These next questions are about your health status. Please try to answer every question as accurately as you can. [REFER TO SCALE]</p>		
A	<p>In general, would you say your health is...</p> <p style="text-align: center;"> 1 2 3 4 5 Excellent Very good Good Fair Poor </p>	<p>996. N/A 997. Refused 998. Don't know</p>
<p>The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? [REFER TO SCALE]</p>		
B	<p>...moderate activities such as moving a table. Does your health now limit you a lot, limit you a little, or not limit you at all?<i>(If participant says s/he does not do activity, probe: Is that because of your health?)</i></p> <p style="text-align: center;"> 1 2 3 Yes, limited a lot Yes, limited a little No, not limited at all </p>	<p>996. N/A 997. Refused 998. Don't know</p>
C	<p>...climbing several flights of stairs. Does your health now limit you a lot, limit you a little, or not limit you at all? <i>(If participant says s/he does not do activity, probe: Is that because of your health?)</i></p> <p style="text-align: center;"> 1 2 3 Yes, limited a lot Yes, limited a little No, not limited at all </p>	<p>996. N/A 997. Refused 998. Don't know</p>
<p>The following questions that I will ask you are about your physical health and your daily activities during the past 4 weeks.</p>		
D	<p>During the past 4 weeks, have you accomplished less than you would like as a result of your physical health?</p> <p style="text-align: center;"> 1 2 Yes No </p>	<p>996. N/A 997. Refused 998. Don't know</p>
E	<p>During the past 4 weeks, were you limited in the kind of work or other regular daily activities you do as a result of your physical health?</p> <p style="text-align: center;"> 1 2 Yes No </p>	<p>996. N/A 997. Refused 998. Don't know</p>
<p>The following questions that I ask you are about your emotions and your daily activities during the past 4 weeks.</p>		
F	<p>During the past 4 weeks, have you accomplished less than you would like as a result of any emotional problems, such as feeling depressed or anxious?</p> <p style="text-align: center;"> 1 2 Yes No </p>	<p>996. N/A 997. Refused 998. Don't know</p>

G	<p>During the past 4 weeks, did you not do work or other regular daily activities as carefully as usual as a result of any emotional problems, such as feeling depressed or anxious?</p> <p style="text-align: center;">1 Yes</p> <p style="text-align: center;">2 No</p>	<p>996. N/A 997. Refused 998. Don't know</p>
<p>The next questions are also about your physical and emotional health during the past 4 weeks. [REFER TO SCALE]</p>		
H	<p>During the past 4 weeks, how much did pain interfere with your normal work, including both outside and inside the home? Did it interfere. ... (<i>Pain refers to physical pain only</i>)</p> <p style="text-align: center;">1 Not at all</p> <p style="text-align: center;">2 Slightly</p> <p style="text-align: center;">3 Moderately</p> <p style="text-align: center;">4 Quite a bit</p> <p style="text-align: center;">5 Extremely</p>	<p>996. N/A 997. Refused 998. Don't know</p>
<p>The next questions are about how you feel and how things have been with you during the past 4 weeks. As I read each statement, please give me the answer that comes closest to the way you have been feeling: Is it all of the time, most of the time, a good bit of the time, some of the time, a little of the time, or none of the time? [REFER TO SCALE]</p>		
I	<p>How much of the time during the past 4 weeks...have you felt calm and peaceful?</p> <p style="text-align: center;">1 All of the time</p> <p style="text-align: center;">2 Most of the time</p> <p style="text-align: center;">3 A good bit of the time</p> <p style="text-align: center;">4 Some of the time</p> <p style="text-align: center;">5 A little of the time</p> <p style="text-align: center;">6 None of the time</p>	<p>996. N/A 997. Refused 998. Don't know</p>
J	<p>How much of the time during the past 4 weeks...did you have a lot of energy?</p> <p style="text-align: center;">1 All of the time</p> <p style="text-align: center;">2 Most of the time</p> <p style="text-align: center;">3 A good bit of the time</p> <p style="text-align: center;">4 Some of the time</p> <p style="text-align: center;">5 A little of the time</p> <p style="text-align: center;">6 None of the time</p>	<p>996. N/A 997. Refused 998. Don't know</p>
K	<p>How much of the time during the past 4 weeks...have you felt down?</p> <p style="text-align: center;">1 All of the time</p> <p style="text-align: center;">2 Most of the time</p> <p style="text-align: center;">3 A good bit of the time</p> <p style="text-align: center;">4 Some of the time</p> <p style="text-align: center;">5 A little of the time</p> <p style="text-align: center;">6 None of the time</p>	<p>996. N/A 997. Refused 998. Don't know</p>
L	<p>During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities like visiting with friends or relatives? [REFER TO SCALE]</p> <p style="text-align: center;">1 All of the time</p> <p style="text-align: center;">2 Most of the time</p> <p style="text-align: center;">3 Some of the time</p> <p style="text-align: center;">4 A little of the time</p> <p style="text-align: center;">5 None of the time</p>	<p>996. N/A 997. Refused 998. Don't know</p>

SECTION 3 – HEALTH CONDITIONS

The next section is about health conditions that you may or may not have had in the last year.

3.1 In the past 12 months, have you had any of the following medical conditions?						
		Yes	No	N/A	Refused	DK
A	Bed bug bites	1	2	996	997	998
B	Head lice, body lice, scabies, or other similar problems	1	2	996	997	998
C	Skin infection, skin sores or ulcers	1	2	996	997	998
D	Problems with your feet	1	2	996	997	998
E	Pneumonia	1	2	996	997	998
F	TB/Tuberculosis – active disease, NOT only positive skin test	1	2	996	997	998
G	Any STDs (chlamydia, genital warts, gonorrhea, herpes, syphilis, other STD other than HIV/AIDS)	1	2	996	997	998
H	HIV/AIDS	1	2	996	997	998
I	Hep B	1	2	996	997	998
J	Hep C	1	2	996	997	998
K	Injury to the head which knocked you out or at least left you dazed, confused, or disoriented	1	2	996	997	998
L	(For females only) Pregnancy	1	2	996	997	998
M	(For females only – skip if response to ‘Pregnancy’ is ‘No’) Have you given birth?	1	2	996	997	998
N	Other physical or mental health condition specify _____	1	2	996	997	998

SECTION 4 – MENTAL HEALTH

Now I'd like to ask you about your mental health.

4.1	Have you needed mental health care in the past 12 months and were not able to get help?	1. Yes 2. No → go to 4.3	996. Not applicable 997. Refused 998. Don't know	} go to 5
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4.2	What were the reasons that you were not able to access mental health care? <i>(Do not read list. Check all that apply.)</i> If >1 reason mentioned, ask: "What is the most important reason that you were not able to access mental health care?" <i>(Circle the letter corresponding to the most important reason.)</i>			
	Reason	<input type="checkbox"/>	Reason	<input type="checkbox"/>
	A. Recently moved to (Ottawa, Toronto, Vancouver)		L. Inconvenient clinic hours	
	B. Moved around a lot within (Ottawa, Toronto, Vancouver)		M. Couldn't get child care	
	C. Didn't have a health card		N. Was too nervous or afraid	
	D. Didn't have a phone number		O. Was too depressed/not up for going	
	E. Was too busy finding food, shelter, or other necessities		P. Was refused services	
	F. Didn't know where to go to get care		Q. Could not afford it	
	G. Couldn't get time off work		R. Other, specify _____	
	H. Looking for work		996. Not applicable	
	I. Had no transportation		997. Refused	
	J. Mental health care too far away		998. Don't know	
	K. The wait for an appointment was too long			

4.3	What helps you get through the rough times? What are some of the things you do to cope? <hr/> <hr/> <hr/> <hr/> <hr/>	996. N/A 997. Refused 998. Don't know
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SECTION 5 – QUALITY OF LIFE

<p>5.1 Health Quality (QoLHHI Impact: Health)</p> <p>Now I want to know about the kind of impact/effect that different aspects of your health have on you. You could tell me, for example, that your physical health has no impact/effect on you at all. Or you could say that it has a positive impact/effect and makes things better for you. Or, maybe it has a negative impact/effect and makes things worse for you. [REFER TO SCALE]</p>											
		Large negative impact/effect	Moderate negative impact/effect	Small negative impact/effect	No impact/effect	Small positive impact/effect	Moderate positive impact/effect	Large positive impact/effect	N/A	Refused	DK
A	I'd like you to rate the kind of impact/effect that your current level of physical health has on you	1	2	3	4	5	6	7	996	997	998
B	I'd like you to rate the kind of impact/effect that your current level of mental or emotional health has on you	1	2	3	4	5	6	7	996	997	998
C	I'd like you to rate the kind of impact/effect that your current level of physical activity or exercise has on you	1	2	3	4	5	6	7	996	997	998
D	I'd like you to rate the kind of impact/effect that the quality of sleep that you've been getting lately has on you	1	2	3	4	5	6	7	996	997	998
E	Would you describe your current level of stress as low, medium, or high?	<ol style="list-style-type: none"> 1. Low 2. Medium 3. High 							996	997	998
F	Given your (low/medium/high) stress level, I'd like you to rate the kind of impact/effect that this has on you	1	2	3	4	5	6	7	996	997	998
G	Have you been experiencing physical pain lately?	<ol style="list-style-type: none"> 1. Yes 2. No, not anymore 3. No, pain has never really been an issue for you (go to I) 							996	997	998
H	I'd like you to rate the kind of impact/effect that (having/ no longer having) physical pain has on you	1	2	3	4	5	6	7	996	997	998

		Large negative impact/ effect	Moderate negative impact/ effect	Small negative impact/ effect	No impact/ effect	Small positive impact/ effect	Moderate positive impact/ effect	Large positive impact/ effect	N/A	Refused	DK
I	Have you been experiencing emotional pain lately?	1. Yes 2. No, not anymore 3. No, pain has never really been an issue for you (go to K)							996	997	998
J	I'd like you to rate the kind of impact/effect that (having/no longer having) emotional pain has on you	1	2	3	4	5	6	7	996	997	998
K	Do you currently drink alcohol?	1. Yes 2. No, you've stopped 3. No, you never did (go to M)							996	997	998
L	I'd like you to rate the kind of impact/effect that (drinking/no longer drinking) has on you	1	2	3	4	5	6	7	996	997	998
M	Do you currently use pot?	1. Yes 2. No, you've stopped 3. No, you never did (go to O)							996	997	998
N	I'd like you to rate the kind of impact/effect that (using/no longer using) pot has on you	1	2	3	4	5	6	7	996	997	998
O	Do you currently use other street drugs - such as cocaine, heroin, or crystal meth for example?	1. Yes 2. No, you've stopped 3. No, you never did (go to Q)							996	997	998
P	I'd like you to rate the kind of impact/effect that (using/no longer using) street drugs has on you	1	2	3	4	5	6	7	996	997	998
Q	Do you have one or more chronic illnesses or conditions (for example: HIV, hepatitis, diabetes, disability)?	1. Yes 2. No (go to S)							996	997	998
R	I'd like you to rate the kind of impact/effect that this has on you	1	2	3	4	5	6	7	996	997	998
S	Are you supposed to follow a special diet because of a health condition?	1. Yes 2. No (go to X)							996	997	998
T	Are you following this special diet?	1. Yes (go to U and then X) 2. No (go to V) 3. Partially							996	997	998

		Large negative impact/effect	Moderate negative impact/effect	Small negative impact/effect	No impact/effect	Small positive impact/effect	Moderate positive impact/effect	Large positive impact/effect	N/A	Refused	DK
U	I'd like you to rate the kind of impact/effect that following this diet has on you	1	2	3	4	5	6	7	996	997	998
V	I'd like you to rate the kind of impact/effect that not following this diet has on you	1	2	3	4	5	6	7	996	997	998
W	If you are NOT following or only partially following this special diet, why not?	Is it... 1 ... because the food you need for this diet is too expensive? 2 ... because it's too difficult for you to get the food you need for this diet? 3 ... you don't have any way to prepare or store the food you need for this diet? 4 ... because you are not willing to give up certain foods as part of this diet (for example: salt, red meat, sweets)? 5 Other _____							996	997	998
X	Are you currently supposed to be taking medication that was prescribed by a doctor?	1. Yes 2. No (go to 5.2)							996	997	998
Y	Are you taking this medication?	1. Yes (go to Z but skip AA and BB) 2. No (go to AA) 3. Some							996	997	998
Z	I'd like you to rate the kind of impact/effect that taking this medication has on you	1	2	3	4	5	6	7	996	997	998
AA	I'd like you to rate the kind of impact/effect that not taking this medication has on you	1	2	3	4	5	6	7	996	997	998
BB	If you are NOT taking the medication prescribed to you, why not?	Is it... 1 ... because the medication is too expensive? 2 ... because it's too difficult for you to store the medication? 3 ... you're not able to take the medication as recommended (for example: with food, 3 times a day)? 4 ... because you don't like the side effects? 5 ... because you don't believe in taking medication? 6 Other _____							996	997	998

5.2 Quality of life overall part A (QOLHHI Overall Satisfaction Scale: Short Version 1)

Now I am going to ask you some questions about how satisfied or dissatisfied you feel about different areas of your life right now. This is the response scale we will be using. **[REFER TO SCALE]** (*Read scale to the participant*)

		Very dissatisfied	Quite dissatisfied	Slightly dissatisfied	Neither dissatisfied nor satisfied	Slightly satisfied	Quite satisfied	Very satisfied	N/A	Refused	DK
A	On the whole, how do you feel about your life currently?	1	2	3	4	5	6	7	996	997	998
B	On the whole, how do you feel about your current health?	1	2	3	4	5	6	7	996	997	998
C	On the whole, how do you feel about your current experiences with the health care system?	1	2	3	4	5	6	7	996	997	998
D	On the whole, how do you feel about the place where you currently live or stay?	1	2	3	4	5	6	7	996	997	998
E	On the whole, how do you feel about the food that you eat?	1	2	3	4	5	6	7	996	997	998
F	On the whole, how do you feel about your current financial situation?	1	2	3	4	5	6	7	996	997	998
G	On the whole, how do you feel about your current employment situation? This could also include the situation of being unemployed.	1	2	3	4	5	6	7	996	997	998
H	On the whole, how do you feel about your current experiences with the social and support services that you use? This includes things like types of services available, access to services, and treatment by and your relationship with social workers, housing support workers, or agency staff.	1	2	3	4	5	6	7	996	997	998
I	On the whole, how do you feel about your current recreational and leisure activities? This includes things like watching movies, reading, sports, creating art, and other things you do for fun.	1	2	3	4	5	6	7	996	997	998
J	On the whole, how do you feel about your spiritual life right now? This can also include <i>not</i> having a spiritual life.	1	2	3	4	5	6	7	996	997	998
L	RS1. Next I want to ask about your romantic situation. This could include your relationship with a spouse, boyfriends or girlfriends, or sexual partners. It could also include <i>not</i> having such a relationship, or a recent change in a relationship, such as living apart, divorce, or death of a partner. On the whole, how do you feel about your current romantic situation?	1	2	3	4	5	6	7	996	997	998
M	Next I want to ask about your family. This includes everyone, from kids, to parents, to anyone you would consider as family, but not solely your current partner (because we've already asked about that) and not your friends (because we'll ask about them in a minute). On the whole, how do you feel about your relationships with your family right now?	1	2	3	4	5	6	7	996	997	998
N	On the whole, how do you feel about your relationships with your friends right now? This also includes the situation if you <i>don't</i> feel like you have any friends right now.	1	2	3	4	5	6	7	996	997	998

SECTION 6 - SOURCE OF HEALTH CARE

Now I am going to ask you some questions about your usual source of health care.

6.1	Do you have a regular medical doctor?	1. Yes → Did your family doctor change in the past 12 months? 1. Yes	996. Not applicable 997. Refused 998. Don't know } go to 7
		2. No → go to 6.3	

6.2	Where do you usually visit this person? (<i>Do not read list. Check all that apply and go to 7.1</i>)		
	Reason	<input checked="" type="checkbox"/>	996. N/A 997. Refused 998. Don't know
	A. Emergency department	<input type="checkbox"/>	
	B. Doctors' office or outpatient clinic (not a walk-in clinic)	<input type="checkbox"/>	
	C. Shelter, meal program, bus or other program	<input type="checkbox"/>	
	D. Community health centre	<input type="checkbox"/>	
	E. Walk-in clinic	<input type="checkbox"/>	
F. Other, specify _____	<input type="checkbox"/>		

6.3	What are the reasons you do not have a regular medical doctor? (<i>Do not read list. Check all that apply</i>)			
	<i>If >1 reason mentioned, ask: "What is the most important reason that you do not have a regular medical doctor?" (Circle the letter corresponding to the most important reason.)</i>			
	Reason	<input checked="" type="checkbox"/>	Reason	<input checked="" type="checkbox"/>
	A. Recently moved to (Ottawa, Toronto, Vancouver)	<input type="checkbox"/>	L. Have had a negative experience in the past	<input type="checkbox"/>
	B. Moved around a lot within (Ottawa, Toronto, Vancouver)	<input type="checkbox"/>	M. Too busy finding food, shelter, or other necessities	<input type="checkbox"/>
	C. No medical doctors available in the area	<input type="checkbox"/>	N. Have no transportation	<input type="checkbox"/>
	D. Medical doctors in the area are not taking new patients	<input type="checkbox"/>	O. The wait for an appointment was too long	<input type="checkbox"/>
	E. Have not tried to contact a medical doctor	<input type="checkbox"/>	P. Clinic hours are inconvenient	<input type="checkbox"/>
	F. Had a medical doctor who left or retired	<input type="checkbox"/>	Q. Usual source of health care in area no longer available	<input type="checkbox"/>
	G. Seldom or never get sick	<input type="checkbox"/>	R. Other, specify _____	<input type="checkbox"/>
	H. Don't know where to go for care	<input type="checkbox"/>		<input type="checkbox"/>
	I. Don't use doctors/treat myself	<input type="checkbox"/>	996. Not applicable	<input type="checkbox"/>
	J. Don't have a health card	<input type="checkbox"/>	997. Refused	<input type="checkbox"/>
	K. Don't have a telephone number	<input type="checkbox"/>	998. Don't know	<input type="checkbox"/>

SECTION 7 – HEALTH CARE UTILIZATION

The next few questions are about your use of health care services.

7.1 In the past 12 months, have you gotten health care from...
Read categories, If answer is "Yes" ask: "How many times/nights in the past 12 months?"

		Yes	No	If yes, # of times	If yes, # of nights	N/A	Refused	DK
A	A hospital emergency room?	1	2			996	997	998
B	A hospital, nursing home or convalescent home where you stayed at least 1 night, not counting staying overnight in the Emergency Department?	1	2			996	997	998

7.2 In the past 12 months, not counting when you were an overnight patient, have you seen...
Read categories, If answer is "Yes" ask: "How many times in the past 12 months?"

		Yes	No	# of times	N/A	Refused	DK
A	A family doctor/ general practitioner?	1	2		996	997	998
B	A psychiatrist?	1	2		996	997	998
C	Any other medical doctor (such as a surgeon, allergist, orthopedist, gynecologist/urologist)?	1	2		996	997	998
D	An eye specialist such as an ophthalmologist or optometrist?	1	2		996	997	998
E	A nurse for care and advice about your physical, emotional or mental health?	1	2		996	997	998
F	A dentist, orthodontist or dental hygienist?	1	2		996	997	998

7.3	<p>In the past 12 months, was there ever a time when you felt that you needed health care but you didn't receive it?</p>	<p>1. Yes 2. No → go to 8</p> <p>996. Not applicable 997. Refused 998. Don't know</p> <p>} go to 8</p>
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7.4 What were the **main reasons** that you were not able to get health care? *(Do not read list. Check all that apply.)*
If >1 reason mentioned, ask: "What is the most important reason that you were not able to access health care?"
(Circle the letter corresponding to the most important reason.)

Reason	<input type="checkbox"/>	Reason	<input type="checkbox"/>
A. Recently moved to (Ottawa, Toronto, Vancouver)		L. Inconvenient clinic hours	
B. Moved around a lot within (Ottawa, Toronto, Vancouver)		M. Couldn't get child care	
C. Didn't have a health card		N. Was too nervous or afraid	
D. Didn't have a phone number		O. Was too depressed/not up for going	
E. Were too busy finding food, shelter, or other necessities		P. Was refused services	
F. Didn't know where to go to get care		Q. Could not afford	
G. Couldn't get time off work		R. Other _____	
H. Looking for work			
I. Had no transportation		996. Not applicable	
J. Health care too far away		997. Refused	
K. The wait for an appointment was too long		998. Don't know	

SECTION 8 – HEALTH-RELATED QUALITY OF LIFE

8.1 EQ5D		
Please let me know which of the statements I read to you best describes your own health state today . [REFER TO SCALE]		
A Let's first look at mobility		
I have no problems walking about	1	996. Not applicable 997. Refused 998. Don't know
I have some problems in walking about	2	
I am confined to bed	3	
B Now let's look at self-care		
I have no problems with self-care	1	996. Not applicable 997. Refused 998. Don't know
I have some problems washing or dressing myself	2	
I am unable to wash or dress myself	3	
C Next, let's go to usual activities (e.g. going for a walk)		
I have no problems with performing my usual activities	1	996. Not applicable 997. Refused 998. Don't know
I have some problems with performing my usual activities	2	
I am unable to perform my usual activities	3	
D Okay, now tell me about your pain/discomfort		
I have no pain or discomfort	1	996. Not applicable 997. Refused 998. Don't know
I have moderate pain or discomfort	2	
I have extreme pain or discomfort	3	
E Finally, let's look at anxiety/depression		
I am not anxious or depressed	1	996. Not applicable 997. Refused 998. Don't know
I am moderately anxious or depressed	2	
I am extremely anxious or depressed	3	

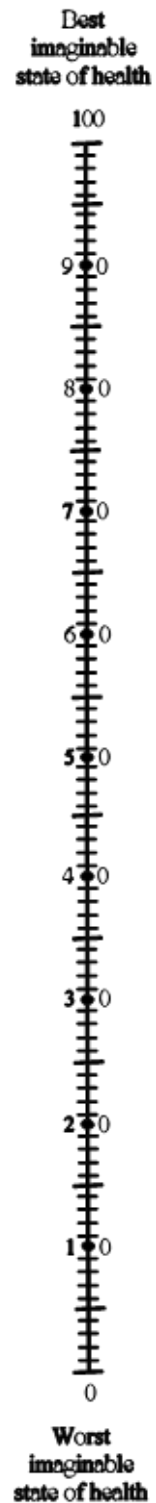
8.2 Vas Scale

To help people say how good or bad their state of health is, we have drawn a scale (rather like a thermometer) in which the best state you can imagine is marked 100 and worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is **today**, in your opinion. Please do this by drawing a line from the box below to whichever point in the scale indicates how good or bad your state of health is **today** (*Ask participant to say the number and record it next to the scale*).

- 996. Not applicable
- 997. Refused
- 998. Don't know

Your own
state of health
today



SECTION 9 – SUBSTANCE USE

<p>9.1 DAST The following questions concern information about your potential involvement with drugs NOT including alcoholic beverages during the past 12 months. When the words “drug use” are utilized, they refer to the use of prescribed or over-the-counter drugs in excess of the directions, and any nonmedical use of drugs. The various classes of drugs may include cannabis (marijuana, hashish), solvents (paint thinner), tranquilizers (Valium), barbiturates, cocaine, stimulants (speed), hallucinogens (LSD), or narcotics (heroin). Remember that the questions do not include alcoholic beverages.</p>						
		Yes	No	N/A	Refused	DK
A	In the past 12 months , have you used drugs other than those required for medical reasons?	1	2 (go to 9.3)	996	997	998
B	In the past 12 months , did you use more than one drug at a time?	1	2	996	997	998
C	In the past 12 months , were you always able to stop using drugs when you wanted to?	1	2	996	997	998
D	In the past 12 months , have you had ‘blackouts’ or ‘flashbacks’ as a result of drug use?	1	2	996	997	998
E	In the past 12 months , did you ever feel bad or guilty about your drug use?	1	2	996	997	998
F	In the past 12 months , have you had any contact with your partner (or spouse or parents)?	1	2 (go to H)	996	997	998
G	If YES , did your partner (or spouse or parents) ever complain about your involvement with drugs?	1	2	996	997	998
H	In the past 12 months , have you neglected your family because of your use of drugs?	1	2	996	997	998
I	In the past 12 months , have you engaged in illegal activities - other than buying the drugs - in order to obtain drugs?	1	2	996	997	998
J	In the past 12 months , have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	1	2	996	997	998
K	In the past 12 months , have you had medical problems as a result of your drug use (e.g., memory loss, convulsions, bleeding)?	1	2	996	997	998

9.2 In the past 12 months, which drugs have you used other than those required for medical reasons?
 (Do not read options. For each drug: check appropriate box in column 'A'; ask frequency in the past month and check appropriate box in column 'B'; and if appropriate, ask whether injected in the last three months and check appropriate box in column 'C')

		A) In the past 12 months?		B) Frequency of use in past month? [REFER TO SCALE]					C) Injected in past 3 months?	
		Yes	No	Never	≥1 time, but <1 day/week	1-2 days/wk	3-6 days/wk, not every day	Everyday	Yes	No
996. Not applicable 997. Refused 998. Don't know										
A	Marijuana, hash, pot	1	2	1	2	3	4	5	-	-
B	Solvents, glue	1	2	1	2	3	4	5	-	-
C	Mushrooms	1	2	1	2	3	4	5	-	-
D	Acid, mescaline, PCP	1	2	1	2	3	4	5	1	2
E	Amphetamines, speed, uppers, Ritalin	1	2	1	2	3	4	5	1	2
F	Ecstasy	1	2	1	2	3	4	5	1	2
G	Methamphetamine, ice, crystal	1	2	1	2	3	4	5	1	2
H	Benzodiazepines, Clonazepam, Ativan, Valium	1	2	1	2	3	4	5	1	2
I	Ketamine	1	2	1	2	3	4	5	1	2
J	GHB	1	2	1	2	3	4	5	1	2
K	Cocaine	1	2	1	2	3	4	5	1	2
L	Crack	1	2	1	2	3	4	5	1	2
M	Heroin alone	1	2	1	2	3	4	5	1	2
N	Heroin mixed with cocaine (Speedball)	1	2	1	2	3	4	5	1	2
O	Methadone	1	2	1	2	3	4	5	1	2
P	Morphine, percocet, oxycontin, Tylenol #3, codeine	1	2	1	2	3	4	5	1	2
Q	Other drugs, specify: _____	1	2	1	2	3	4	5	1	2

9.3 Now I am going to ask you some questions about use of alcoholic beverages such as beer, wine, vodka, during the **past 12 months**. Please remember that one drink is: ½ pint average strength beer OR one glass of wine OR one single measure of spirits. *Record how they spent the majority of the last 12 months. If they spent 7 months drinking, and 5 months not drinking at all, then ask about the 7 months when they were drinking. If they spent 6 months heavily drinking and 6 months sober ask them what they would identify as the majority of their time in the last 12 months, and then record those responses.*

A	<p>During the past 12 months, how often did you have a drink containing alcohol? [REFER TO SCALE]</p> <p style="text-align: center;"> 1 Never (Go to 9.3K) 2 Monthly/less than monthly 3 2-4 times per month 4 2-3 times per week 5 4 or more times per week </p>	<p>996. Not applicable 997. Refused 998. Don't know</p>
B	<p>During the past 12 months, how many drinks containing alcohol did you have on a typical day when you were drinking? [REFER TO SCALE]</p> <p style="text-align: center;"> 1 1-2 2 3 or 4 3 5 or 6 4 7-9 5 10 or more </p>	<p>996. Not applicable 997. Refused 998. Don't know</p>
C	<p>During the past 12 months, how often did you have six or more drinks on one occasion?[REFER TO SCALE]</p> <p style="text-align: center;"> 1 Never 2 Less than monthly 3 Monthly 4 Weekly 5 Daily or almost daily </p>	<p>996. Not applicable 997. Refused 998. Don't know</p>
D	<p>How often during the past 12 months have you found that you were unable to stop drinking once you started?</p> <p style="text-align: center;"> 1 Never 2 Less than monthly 3 Monthly 4 Weekly 5 Daily or almost daily </p>	<p>996. Not applicable 997. Refused 998. Don't know</p>
E	<p>How often during the past 12 months have you failed to do what was normally expected of you because of drinking?</p> <p style="text-align: center;"> 1 Never 2 Less than monthly 3 Monthly 4 Weekly 5 Daily or almost daily </p>	<p>996. Not applicable 997. Refused 998. Don't know</p>
F	<p>How often during the past 12 months have you needed a first drink in the morning to get yourself going after a heavy drinking session?</p> <p style="text-align: center;"> 1 Never 2 Less than monthly 3 Monthly 4 Weekly 5 Daily or almost daily </p>	<p>996. Not applicable 997. Refused 998. Don't know</p>
G	<p>How often during the past 12 month have you felt guilt or remorse after drinking?</p> <p style="text-align: center;"> 1 Never 2 Less than monthly 3 Monthly 4 Weekly 5 Daily or almost daily </p>	<p>996. Not applicable 997. Refused 998. Don't know</p>
H	<p>How often during the past 12 months have you been unable to remember what happened the night before because of drinking?</p> <p style="text-align: center;"> 1 Never 2 Less than 3 Monthly 4 Weekly 5 Daily or </p>	<p>996. Not applicable 997. Refused 998. Don't know</p>

	monthly	almost daily	
I	Have you or someone else been injured as a result of your drinking? [REFER TO SCALE]		996. Not applicable 997. Refused 998. Don't know
	1 No	2 Yes, but not in the past 12 months	
J	Has a friend, or relative, or doctor or other health worker been concerned about your drinking or suggested you cut down? (go to 9.4)		996. Not applicable 997. Refused 998. Don't know
	1 No	2 Yes, but not in the past 12 months	
K	Looking back before the past 12 months , have you or someone else been injured as a result of your drinking? [REFER TO SCALE]		996. Not applicable 997. Refused 998. Don't know
	1 No	2 Yes, but not in the past 12 months	
L	Has a friend, or relative, or doctor or other health worker been concerned about your drinking or suggested you cut down?		996. Not applicable 997. Refused 998. Don't know
	1 No	2 Yes, but not in the past 12 months	

9.4	In the past 12 months , have you followed a program, been in therapy, or taken part in self-help groups for alcohol use problems?	1. Yes	996. Not applicable 997. Refused 998. Don't know	} go to 9.6
		2. No → go to 9.6		

9.5 What type(s) of resources did you use for your alcohol use problems?
(Do not read list but if participant is unsure give examples. Check all that apply. Follow-up by asking): How often have you been using these resources **in the past 12 months**? AND For how long have you been using these resources **in the past 12 months**?

		Yes	No		
A	Outpatient or day treatment/therapy/counseling	1	2	996. N/A 997. Refused 998. Don't know	
B	Self-help group like AA	1	2		
C	Other, specify _____	1	2		
<i>If Yes for resources listed below, ask number of days used</i>					
		Yes	No		Total number of days
D	Residential treatment	1	2		
E	Detox	1	2		
F	Recovery House	1	2		

9.6	<p>In the past 12 months, have you followed a program, been in therapy, or taken part in self-help groups for drug use problems?</p>	<p>1. Yes 2. No → go to 9.8</p>	<p>996. Not applicable 997. Refused 998. Don't know</p>	<p>} go to 9.8</p>
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<p>9.7 What type(s) of resources did you use for your drug use problems? This would include Methadone treatment and counseling for example. <i>(Do not read list but if participant is unsure give examples. Check all that apply. Follow-up by asking):</i> How often have you been using these resources in the past 12 months? AND For how long have you been using these resources in the past 12 months?</p>					
		Yes	No		<p>996. N/A 997. Refused 998. Don't know</p>
A	Outpatient or day treatment/therapy/counseling	1	2		
B	Self-help group like NA	1	2		
C	Other, specify _____	1	2		
<i>If Yes for resources listed below, ask number of days used</i>					
		Yes	No	Total number of days	
D	Residential treatment	1	2		
E	Detox	1	2		
F	Methadone maintenance	1	2		
G	Recovery House	1	2		

9.8	<p>At the present time, do you smoke cigarettes daily, occasionally or not at all</p>	<p>1. Daily 2. Occasionally 3. Not at all</p>	<p>996. Not applicable 997. Refused 998. Don't know</p>
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SECTION 10 – COMMUNITY INTEGRATION

I am now going to ask you how often you have been involved in different kinds of community activities during the **past month**. Please give me the word that best describes how frequently you have participated in the following community activities. **[REFER TO SCALE]**

If the person is in a hospital or jail for >=1 month, SKIP 10.1 If the person is in a hospital or jail for <1 month, ASK 10.1 ASK 10.1 of all other participants.

10.1 Physical Integration Scale. In the past month, how many times have you:									
		Never	Rarely	Sometimes	Often	Very Often	N/A	Refused	DK
A	Attended a movie or concert?	1	2	3	4	5	996	997	998
B	Participated in outside sports or recreation?	1	2	3	4	5	996	997	998
C	Gone to meet people at a restaurant or coffee shop?	1	2	3	4	5	996	997	998
D	Participated in a community event?	1	2	3	4	5	996	997	998
E	Gone to a place of worship or participated in a spiritual ceremony?	1	2	3	4	5	996	997	998
F	Participated in a volunteer activity?	1	2	3	4	5	996	997	998
G	Gone to a library?	1	2	3	4	5	996	997	998
H	Gone to a bar, pub, lounge?	1	2	3	4	5	996	997	998
I	Is there anything else you do to socialize?						996	997	998

If the person is in a hospital or jail AND has given up their previous place of residence, SKIP 10.2 and 10.3 If the person is in a hospital or jail AND still maintains their previous place of residence, ASK 10.2 and 10.3, but specify that they should base their answers on the place where they were living prior to entering hospital or jail.

10.2 Psychological Integration Scale. Next I want to ask you about your beliefs about the people who live in the neighbourhood and about the neighbourhood itself. By neighbourhood, we mean the surrounding area within normal walking distance of where you are currently living. These next questions I'm interested in knowing how much you agree or disagree with the following statements when it comes to your neighbourhood. **[REFER TO SCALE]**

		Strongly disagree	Disagree	Neither	Agree	Strongly agree	N/A	Refused	DK
A	Compared to other neighbourhoods, I view this neighbourhood as a safe place	1	2	3	4	5	996	997	998
B	I like to think of myself as similar to the people who live in this neighbourhood.	1	2	3	4	5	996	997	998
C	If I had an emergency, even people I do not know in this neighbourhood would be willing to help.	1	2	3	4	5	996	997	998
D	I plan to remain a resident of this neighbourhood for a number of years.	1	2	3	4	5	996	997	998
E	There are people in this neighbourhood who really care about me.	1	2	3	4	5	996	997	998
F	People in this neighbourhood don't get too friendly with each other	1	2	3	4	5	996	997	998

10.3 Contact with neighbours. An important aspect of neighbourhood life involves the contact that goes on between residents of a neighbourhood. In this next set of questions, I would like to find out how often you have had the following kinds of contact with your present neighbours. By neighbours, we mean people who live near where you are presently living but not with you. Neighbour does NOT include other shelter residents or other residents in residential treatment, but it does include anyone they share an apartment building with (non-roomies), an SRO or rooming house with and everyone else in their neighbourhood. Please indicate the frequency of your contact with neighbours according to the following scale. Please tell me the word that best describes how much you have of each kind of contact with your neighbours. **[REFER TO SCALE]**

		Never	Rarely	Occasionally	Fairly Often	Frequently	N/A	Refused	DK
A	How often have you said hello or waved to a neighbour when seeing them on the street ?	1	2	3	4	5	996	997	998
B	How often have you gone with a neighbour on a social outing such as shopping, to a movie, eating or other similar kind of event?	1	2	3	4	5	996	997	998
C	How often have you discussed neighbourhood issues and problems with a neighbour?	1	2	3	4	5	996	997	998
D	How often has a neighbour invited you into their home for coffee, drink, or other kind of socializing?	1	2	3	4	5	996	997	998
E	How often have you assisted a neighbour with a household task such as minor house repair, shoveling snow, or moving heavy items?	1	2	3	4	5	996	997	998

F	How often have you talked with a neighbour about personal issues such as housing concerns or health?	1	2	3	4	5	996	997	998
G	How often have you had a conversation with a neighbour when seeing them on the street?	1	2	3	4	5	996	997	998

SECTION 11 – SOCIAL SUPPORT

11.1 Social Provisions Scale									
I'm going to read you some statements about your relationships with others. For each, could you please tell me whether you strongly disagree, disagree, agree, or strongly agree? [REFER TO SCALE]									
		Strongly agree	Agree	Disagree	Strongly disagree	N/A	Refused	DK	
A	If something went wrong, no one would help me.	1	2	3	4	996	997	998	
B	I have family and friends who help me feel safe, secure and happy.	1	2	3	4	996	997	998	
C	There is someone I trust whom I could turn to for advice if I were having problems.	1	2	3	4	996	997	998	
D	There is no one I feel comfortable talking about problems with.	1	2	3	4	996	997	998	
E	I lack a feeling of intimacy with another person.	1	2	3	4	996	997	998	
F	There are people I can count on in an emergency.	1	2	3	4	996	997	998	
G	I provide support to my friends and/ or my family.	1	2	3	4	996	997	998	
H	I have a lot of serious disagreements and arguments with my family.	1	2	3	4	996	997	998	

11.2 Social Support Network Instrument			
Now, I'm going to ask you some questions about the people you are close to.			
A	Are there any people with whom you feel at ease and can talk to about personal issues?	1. Yes 2. No → go to 11.3	996. Not applicable 997. Refused 998. Don't know } go to 11.3
B	Among these people, how many are: Family members (including spouse) Care providers Friends Boyfriend, girlfriend or partner Spiritual leaders Other (specify): _____		996. Not applicable 997. Refused 998. Don't know
C	Do you use Facebook or other social networking sites to talk about personal issues?	1. Yes 2. No	996. Not applicable 997. Refused 998. Don't know

11.3 SOCIAL SERVICES UTILIZATION

Now I'm going to ask you about social and community services you might use. [REFER TO THE EXAMPLE CARD]

In the **past month** which social services agencies did you use? (List the agency name and follow-up by asking the type of service utilized and number of times each service was utilized. Mark the number of times in the box between the appropriate agency name and service category Note: If participant is a shelter resident, don't ask if they've used the shelter for showers.)

		Use the phone	Legal aid	Financial (management/trustee)	Employment services (job finding)	Education and training	Social groups or workshops	Art/creative groups or workshops	AA/NA/ other self help groups	Mental health counseling (individual or group)	Health care (provided by physician, psychiatrist or nurse)	Laundry, shower or clothing	Housing placement	Meal program	Food bank	996. Not applicable 997. Refused 998. Don't know	
																(* If 'other' service category is mentioned, specify in the agencies box)	
Agencies																	

SECTION 12 – LEGAL AND OTHER EXPERIENCE

These next questions are about your legal issues and other events that may have taken place.

12.1 In the past 12 months, were you...		
A	<p>Arrested by the police?</p>	<p>1. Yes → If YES, how many times? _____</p> <p>2. No</p> <p>996. Not applicable 997. Refused 998. Don't know</p>
B	<p>Incarcerated, whether in preventive detention, prison or a penitentiary?</p> <p><i>(If time incarcerated is ≥ 14 days, confirm that this is recorded in housing history)</i></p>	<p>1. Yes → If YES, how many times? _____ → If you add up all the times, how long have you been incarcerated? _____ days _____ wks _____ mths</p> <p>2. No</p> <p>996. Not applicable 997. Refused 998. Don't know</p>
12.2	<p>In the past 12 months, were you physically attacked?</p>	<p>1. Yes → If YES, how many times? _____</p> <p>2. No</p> <p>996. Not applicable 997. Refused 998. Don't know</p>
12.3	<p>In the past 12 months, did anyone force you or attempt to force you into any unwanted sexual activity?</p>	<p>1. Yes → If YES, how many times? _____ → If YES, Did you receive any support for this?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>2. No</p> <p>996. Not applicable 997. Refused 998. Don't know</p>

SECTION 13 – EMPLOYMENT AND INCOME

These next few questions concern your employment history and sources of income.

13.1 Employment			
A	In the past 12 months, did you work at a paid job?	1. Yes 2. No → go to 13.2	996. Not applicable 997. Refused 998. Don't know } go to 13.2
B	Are you currently working?	1. Yes 2. No → go to E	996. Not applicable 997. Refused 998. Don't know } go to E
C	How many hours did you work last week?		996. Not applicable 997. Refused 998. Don't know
D	What type(s) of work are you doing?		996. Not applicable 997. Refused 998. Don't know
E	How many different paid jobs did you have in the past 12 months?		996. Not applicable 997. Refused 998. Don't know
F	In the past 12 months, how many months did you work at a paid job?		996. Not applicable 997. Refused 998. Don't know

13.2 Income							
In the past 12 months, what were your sources of income? What did you do to get money? (Read list. Check response and amount of monthly income for each source that is reported. Record all that apply)							
		Yes	No	If Yes: Income/month	N/A	Refused	DK
A	Governmental (welfare; disability income, pension, GST credit or rebate, shelter stipend)	1	2		996	997	998
B	Employment (part-time work; full-time work)	1	2		996	997	998
C	Employment Insurance or Workers Compensation	1	2		996	997	998
D	Support from your family, friend(s) or alimony	1	2		996	997	998
E	Any of these: fraud, selling stolen goods, prostitution, pimping, robbery, selling drugs	1	2		996	997	998
F	Panhandling, squeegee	1	2		996	997	998
G	Selling personal items (pawn shop, etc.)	1	2		996	997	998
H	Artistic activities on the streets (playing music, painting, etc)	1	2		996	997	998
I	Other, specify _____	1	2		996	997	998

SECTION 14 – DEMOGRAPHICS

Now I will ask for your demographic information.

14.3	Do you have a partner?	<ol style="list-style-type: none"> 1. Yes 2. No 	996. Not applicable 997. Refused 998. Don't know
14.4	What is your marital status? <i>(Read list, mark one only)</i>	<ol style="list-style-type: none"> 1. Single/never married 2. Divorced/separated 3. Widowed 4. Married, including common-law 	996. Not applicable 997. Refused 998. Don't know
14.5	Do you have any children?	<ol style="list-style-type: none"> 1 Yes 2 No 	996. Not applicable 997. Refused 998. Don't know
14.6	In the past 12 months, have you been enrolled in a school or a training program?	<ol style="list-style-type: none"> 1. Yes 2. No → go to 14.1 P. 40 	996. Not applicable 997. Refused 998. Don't know
14.6B	What type of training was/is it?	<ol style="list-style-type: none"> 1. GED 2. Vocational 3. English as a Second Language 4. College 5. Other, please specify _____ 	996. Not applicable 997. Refused 998. Don't know
14.7	Did you complete the program?	<ol style="list-style-type: none"> 1 Yes → go to 14.1 P. 40 2 No 	996. Not applicable 997. Refused 998. Don't know
14.8	Are you still enrolled?	<ol style="list-style-type: none"> 1 Yes 2 No 	996. Not applicable 997. Refused 998. Don't know

*******SKIP TO SECTION 14 (DEMOGRAPHICS CONTINUED) PAGE 40,
AND RETURN TO THIS QUESTION AFTER CONTACT INFORMATION
HAS BEEN ACQUIRED*******

SECTION 16 – FINAL QUESTION

16.1 Thank you for participating in the study. Just before we end, we’re wondering if there is anything else you would like to add about your housing or health experiences that we haven’t covered yet? I want to also give you another chance to tell us **your** ideas about your housing situation and what could help people who are in a similar situation. Is there one thing that you want to tell us?

Nothing to add

996. N/A
997. Refused
998. Don’t know

END OF THE SURVEY - PLEASE REMEMBER TO:

- Double check that you have the signed consent form
- Provide reimbursement
- Obtain signature for reimbursement

After participant leaves:

- Fill in Section 17
- Fill in the survey number on each page of the questionnaire
- Fill in start, finish, and total time on the first page of the questionnaire

SECTION 17 – INTERVIEWER’S COMMENTS

17.1 Was the participant interested and co-operative

1	2	3	4	5
Not at all interested or cooperative	Not very interested or cooperative	Reasonably interested and cooperative	Very interested and cooperative	Extremely interested and cooperative

17.2 How much difficulty did the participant have answering the questions?

1	2	3	4	5
Extreme difficulty	More than average difficulty	Average difficulty	Less than average difficulty	No difficulty at all

17.3 Use this space to make a note of any relevant information/issues provided by the participant during the interview process that was not written down anywhere else in the questionnaire.

14.1	What is your name?	First _____ Middle _____ Last _____
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14.2	<p>Do you have a provincial health card number?</p> <p><i>(Check response on the cover page of the survey. If 'no', ask for health card number. If 'yes', go to 14.3)</i></p>	<p>1. Yes, in possession → _ _ _ - _ - _ - _</p> <p>2. No</p> <p>3. Yes, not here</p> <p>Is there a doctor's office, clinic, or hospital you've been to recently that we might be able to contact to get your health card number?</p> <p>_____</p> <p>_____</p>	<p>996. Not applicable</p> <p>997. Refused</p> <p>998. Don't know</p>
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SECTION 15 – CONTACTS

To help us keep in contact with you, I will now ask you to give me your contact information including the names and telephone numbers of friends, family members, acquaintances, services providers, case workers, hospitals, homeless shelters, drop-in centres, prisons, probation offices, drug treatment centres, and other agencies or organizations whom we could contact if we are unable to contact you directly.

15.1 Participant information

Address: _____ Telephone 1: _____

Email: _____ Telephone 2: _____

15.2 Contact information				
Full Name of Contact	Relationship	Phone Number(s)	Email Address	Street Address

15.3 Is there a place where we can usually find you?

Appendix B

Table 1a.

Correlation Matrix for FU2 Physical Integration

	FU2-PI	Age	PCS	MCS	DAST	AUDIT	Inc.	S.P.	Edu.	Van.	Tor.	SH	NI
FU2-PI	1.00	-.068	.319***	.235***	-.044	-.040	.104	.199**	.316***	.053	.023	.009	.177**
Age		1.00	-.285***	-.005	-.226***	-.121	-.110	.027	-.143*	-.015	.154*	.103	.068
Phys.			1.00	.139*	-.019	-.064	-.015	.131	.145*	-.165*	.143*	.034	.106
Ment.				1.00	-.150*	-.111	.083	.246***	.096	.006	.023	-.095	.354***
DAST					1.00	.246***	.183**	-.152*	-.035	.217***	-.146*	-.036	-.009
AUDIT						1.00	.065	-.064	-.022	.062	-.002	-.090	-.120
Inc.							1.00	-.010	.093	.291***	-.080	-.202**	-.009
Soci.Prov.								1.00	.190**	-.106	.021	.082	.145*
Edu/Train.									1.00	-.003	-.050	.136	.110
Van										1.00	-.424***	-.078	.075
Tor											1.00	.160*	.115
Stab.Hous												1.00	.006
Neigh. Imp													1.00

*p<.05; **p<.01; ***p<.001

Legend: FU2-PI: Follow-up 2 Physical Integration; Phys: Physical Health; Ment: Mental Health; DAST: Substance Use; AUDIT: Alcohol Use; Inc: Income; Soci. Prov: Social Provision; Edu/Train: Enrollment in School or Training; Van: Vancouver vs Ottawa; Tor: Toronto vs Ottawa; Stab.Hous: Stably Housed; Neigh. Imp: Neighbourhood Impact

Appendix C

Table 2a.

Correlation Matrix for FU-2 Social Integration.

	FU2-SI	Age	PCS	MCS	DAST	AUDIT	Inc	SP	Edu	Van	Tor	SH	NI
FU2-SI	1.00	-.007	.106	.114	.147*	.052	-.017	.272***	-.058	.026	-.068	.110	.141*
Age		1.00	-.285***	-.005	-.226***	-.121	-.110	.027	-.143*	-.015	.154*	.103	.068
Phys.			1.00	.139*	-.019	-.064	-.015	.131	.145*	-.165	.143*	.034	.106
Ment.				1.00	.150*	-.111	.083	.246***	.096	.006	.023	-.095	.354**
DAST					1.00	.246***	.183**	-.152*	-.035	.217***	-.146*	-.036	-.009
AUDIT						1.00	.065	-.064	-.022	.062	-.002	-.090	-.120
Inc.							1.00	-.010	.093	.291***	-.080	-.202**	-.009
Soci.Prov.								1.00	.190**	-.106	-.021	.082	.145*
Edu/Train.									1.00	-.003	.050	.136	.110
Van										1.00	-.424***	-.078	.075
Tor											1.00	.160*	.115
Stab.Hous												1.00	.006
Neigh.Imp													1.00

*p<.05; **p<.01; ***p<.001

Legend: FU2-SI: Follow-up 2 Social Integration; Phys: Physical Health; Ment: Mental Health; DAST: Substance Use; AUDIT: Alcohol Use; Inc: Income; Soci. Prov: Social Provision; Edu/Train: Enrollment in School or Training; Van: Vancouver vs Ottawa; Tor: Toronto vs Ottawa; Stab.Hous: Stably Housed; Neigh. Imp: Neighbourhood Impact

Appendix D

Table 3a.

Correlation Matrix for FU-2 Psychological Integration.

	FU2-Psy	Age	PCS	MCS	DAST	AUDIT	Inc	SP	Edu	Van	Tor	SH	NI
FU2-PsyI	1.00	.096	.168*	.336***	.039	-.114	-.016	.240***	-.010	.048	.104	.072	.666***
Age		1.00	-.285***	-.005	-.226***	-.121	-.110	.027	-.143*	-.015	.154*	.103	.068
Phys.			1.00	.139*	-.019	-.064	-.015	.131	.145*	-.165*	.143*	.034	.106
Ment.				1.00	-.150*	-.111	.083	.246***	.096	.006	.023	-.095	.354***
DAST					1.00	.246***	.183**	-.152*	-.035	.217***	-.146*	-.036	-.009
AUDIT						1.00	.065	-.064	-.022	.062	-.002	-.090	-.120
Inc.							1.00	-.020	.093	.291***	-.080	-.202*	-.009
Soci.Prov.								1.00	.190**	-.106	.021	.082	.145*
Edu/Train.									1.00	-.003	.050	.136	.110
Van										1.00	-.424***	-.078	.075
Tor											1.00	.160*	.115
Stab.Hous												1.00	.006
Neigh.Imp													1.00

*p<.05; **p<.01; ***p<.001

Legend: FU2-Psy: Follow-up 2 Psychological Integration; Phys: Physical Health; Ment: Mental Health; DAST: Substance Use; AUDIT: Alcohol Use; Inc: Income; Soci.Supp:

Social Support; Edu/Train: Enrollment in School or Training; Van: Vancouver vs Ottawa; Tor: Toronto vs Ottawa; Stab.Hous: Stably Housed; Neigh. Imp: Neighbourhood Impact

Appendix E

Table 4a.

Correlation Matrix for FU3 Physical Integration.

	FU3-PI	Age	PCS	MCS	DAST	AUDIT	Inc	SP	Edu	Van	Tor	SH	NI
FU3-PI	1.00	-.028	.165*	.210**	-.047	-.032	.146	.211**	.186**	.055	.031	-.085	.149*
Age		1.00	-.211**	.017	-.175*	-.034	-.045	-.030	-.169*	-.019	.152*	.048	.078
Phys.			1.00	.064	-.056	-.193**	.034	.102	.131	-.103	.050	-.007	.051
Ment.				1.00	-.129	-.107	.002	.289***	.058	.090	.007	-.119	.269***
DAST					1.00	.240***	.125	-.146*	-.038	.115	-.223***	.066	-.115
AUDIT						1.00	.018	-.008	.005	.173*	-.073	.016	-.123
Inc.							1.00	-.020	.009	.168	-.092	.023	-.103
Soci.Prov								1.00	.124	-.014	-.120	.011	.202**
Edu/Train									1.00	.028	.086	-.062	.063
Van										1.00	-.460***	-.187**	.046
Tor											1.00	-.072	.185**
Stab.Hous												1.00	-.089
Neigh.Imp													1.00

*p<.05; **p<.01; ***p<.001

Legend: FU3-PI: Follow-up 3 Physical Integration; Phys: Physical Health; Ment: Mental Health; DAST: Substance Use; AUDIT: Alcohol Use; Inc: Income; Soci. Prov: Social Provision; Edu/Train: Enrollment in School or Training; Van: Vancouver vs Ottawa; Tor: Toronto vs Ottawa; Stab.Hous: Stably Housed; Neigh. Imp: Neighbourhood Impact

Appendix F

Table 5a.

Correlation Matrix for FU3 Social Integration.

	FU3-SI	Age	PCS	MCS	DAST	AUDIT	Income	SP	Edu	Van	Tor	SH	NI
FU3-SI	1.00	-.027	-.051	.104	.127	.179**	.238***	.053	.002	.102	-.080	.061	.131
Age		1.00	-.211**	.017	-.175**	-.034	-.045	.030	-.169*	-.019	.152*	.048	.078
Phys.			1.00	.064	-.056	-.193**	.034	.102	.131	-.103	.050	-.007	.051
Ment.				1.00	-.129	-.107	.002	.289***	.058	.090	.007	-.119	.269***
DAST					1.00	.240***	.125	-.146*	-.038	.115	-.223***	.066	-.115
AUDIT						1.00	.018	-.008	.005	.173*	-.073	.016	-.123
Inc.							1.00	-.020	.009	.168*	-.092	.023	.103
Soci.Prov.								1.00	.124	-.014	-.120	.011	.202**
Edu/Train									1.00	.028	.086	-.062	.063
Van										1.00	-.460***	-.187**	.046
Tor											1.00	-.072	.185**
Stab.Hous												1.00	-.089
Neigh.Imp													1.00

*p<.05; **p<.01; ***p<.001

Legend: FU3-SI: Follow-up 3 Social Integration; Phys: Physical Health; Ment: Mental Health; DAST: Substance Use; AUDIT: Alcohol Use; Inc: Income; Soci. Prov: Social Provision; Edu/Train: Enrollment in School or Training; Van: Vancouver vs Ottawa; Tor: Toronto vs Ottawa; Stab.Hous: Stably Housed; Neigh. Imp: Neighbourhood Impact

Appendix G

Table 6a.

Correlation Matrix for FU3 Psychological Integration.

	FU3-Psy	Age	PCS	MCS	DAST	AUDIT	Inc	SP	Edu	Van	Tor	SH	NI
FU3-PI	1.00	.037	.088	.222**	-.034	-.032	.082	.206**	.120	.114	.128	-.096	.395***
Age		1.00	-.211**	.017	-.175	-.034	-.045	.030	-.169*	-.019	.152*	.048	-.078
Phys.			1.00	.064	-.056	-.193**	.034	.102	.131	-.103	.050	-.007	.051
Ment.				1.00	-.129	-.107	.002	.289***	.058	.090	.007	-.119	.269***
DAST					1.00	.240***	.125	-.146*	-.038	.115	-.223***	.066	-.115
AUDIT						1.00	.018	-.008	.005	.173*	-.073	.016	-.123
Inc.							1.00	-.020	.009	.168*	-.092	.023	.103
Soc.Sup								1.00	.124	-.014	-.120	.011	.202**
Edu/Train									1.00	.028	.086	-.062	.063
Van										1.00	-.460***	-.187**	.046
Tor											1.00	-.072	.185**
Stab.Hous												1.00	-.089
Neigh.Imp													1.00

*p<.05; **p<.01; ***p<.001

Legend: FU3-Psy: Follow-up 3 Psychological Integration; Phys: Physical Health; Ment: Mental Health; DAST: Substance Use; AUDIT: Alcohol Use; Inc: Income; Soci.Sup:

Social Support; Edu/Train: Enrollment in School or Training; Van: Vancouver vs Ottawa; Tor: Toronto vs Ottawa; Stab.Hous: Stably Housed; Neigh. Imp: Neighbourhood Impact

Appendix H*Table 7a.**Correlation Matrix for FU2 Physical, Social, and Psychological Integration*

	Physical	Social	Psychological
Physical	1.00	.311**	.280**
Social	.311**	1.00	.376**
Psychological	.280**	.376**	1.00

*p<.05; **p<.01; ***p<.001

Appendix I*Table 8a.**Correlation Matrix for FU3 Physical, Social, and Psychological Integration*

	Physical	Social	Psychological
Physical	1.00	.247**	.209**
Social	.247**	1.00	.294**
Psychological	.209**	.294**	1.00

*p<.05; **p<.01; ***p<.001

Appendix J

Neighbourhood Walking Tour Interview Consent Form

PROJECT DESCRIPTION

Researchers from the University of Ottawa are conducting a study with women participants from the SHARPE Project to better understand their experiences in supported housing and how they perceive and participate in their local communities.

You are invited to participate in three interviews to share your experiences about living in your neighbourhood.

Your Participation in this Project

As a participant in this research, you play an important role. You will be asked to attend 3 meetings (the Neighbourhood Walking Tour, Photo-Interviewing and Changes Over Time meeting). These meetings will last from 1 to 2 hours each.

At the first meeting, you will be asked to map out different locations in your neighbourhood. Then you will be asked to go on a neighbourhood walking tour with the interviewer to talk more about your experiences and to take photos of your neighbourhood. For the walking tour, the meeting will be held in a public place in your neighbourhood. The walking tour will remain outdoors and will be rescheduled in case of bad weather.

At the second meeting, we will discuss the map and photographs from the walking tour meeting and your experiences and perceptions of your neighbourhood. In the third meeting, we will talk about changes in your perceptions of your neighbourhood. The last two meetings will occur at the research offices at the University of Ottawa or in a private area of a community agency.

The interview will be held with a student researcher. The researcher will audio-record and take notes during the meeting. This information will be used to better understand your experiences within the neighbourhood.

You will receive an honorarium of \$20 for participating in each meeting.

Potential Harms

Some questions may make you feel uncomfortable. However, the researcher will do her best to make sure you feel comfortable during the interview. You can skip any question you do not want to answer. There is potential risk to you if the confidentiality of the information you give us were to be lost. To protect your confidentiality, personal information will be kept on a numbered form that does not have your name or other identifying information. We will keep your name and other identifying information on a separate numbered form. All information you give us will be kept in a secure research office, and only authorized research staff will have access to the information. The electronic and paper data will be de-identified and kept in strict confidence. All of the paper data will be stored in locked filing cabinets that only the study team has access to and all of the electronic data will be kept on a secure institutional network.

These interviews will take place Monday to Friday during working hours and a counselor from the CMHA will be available to speak with you after the interview if you think this would be helpful.

During the neighbourhood walking tour, you will only be going to places where both you and the researcher feel comfortable.

Benefits from Participating in this Study

Your participation in this interview will help researchers better understand women's perspectives on their communities while living in supported housing. During this interview you will be able share your experiences and thoughts, which you may find rewarding and validating.

Anonymity and Confidentiality

Confidentiality will be respected and no information that discloses your identity will be released or published without consent unless required by law, such as disclosing abuse or acute risk of harm to yourself or others. If there is perceived risk, privacy will be breached and you will be asked/made to seek care.

No comments you make will be personally attributed to you in any report associated with this research. Please also note that all photographs taken must be submitted to the researchers at the University of Ottawa, as ownership of these photographs belongs to the University of Ottawa.

Voluntary Participation

Participating in this interview is voluntary. You can end the interview at any time. This also means that you do not have to attend the interview if you do not wish to attend. If you choose not to participate in the interview, your housing and the services you currently receive will not be affected in any way.

WHO TO CONTACT

If you are interested in participating in this interview, or wish to learn more, please contact:

Dr. John Sylvestre, at the School of Psychology

Vanier Hall, 136 Jean Jacques Lussier, Room 3001, Ottawa ON K1N 6N5

Tel: .

Email: .

Aman Bassi, at the University of Ottawa

416A Montpetit Hall, Ottawa ON Canada K1N 6N5

Tel: .

Email: .

Project Contacts

If you have any questions or require further information about the interview you can contact:

Dr. John Sylvestre, at the School of Psychology

Vanier Hall, 136 Jean Jacques Lussier, Room 3001, Ottawa ON K1N 6N5

Tel: .

Email: .

OR you can contact:

Aman Bassi, at the University of Ottawa

416A Montpetit Hall, Ottawa ON Canada K1N 6N5

Tel: .

Email: .

Introduction

Before you agree to participate in this research study, it is important that you read and understand the following explanation of the study. It describes the purpose, procedures, benefits, and risks associated with the study. If you have questions after you read through this form, ask your interviewer. You should not sign this form until you are sure you understand everything on this form.

Description of the Research

You are invited to participate in an interview to share your experiences and views about your neighbourhood. The goal of this research is to study how women from supported housing perceive and participate in their local communities.

If you choose to participate in the interview today, you will be asked to share about your perceptions and experiences in your neighbourhood. The different locations within your neighbourhood that you visit and do not visit will be mapped. You will also be asked to go on a neighbourhood walking tour. This tour will lead to further discussions about your community involvement and the places you like/dislike to visit. Photos of your neighbourhood will also be taken along the way. The interview will last for approximately 1 to 2 hours and will be completely voluntary. Participation in this interview will give you the opportunity to share your experiences about your neighbourhood.

We will keep in contact with you so that we can do 2 more interviews with you. After today's interview, one interview will occur in about a week and the last interview will occur in about 6 months. To help us keep in contact with you, we will ask you to give us the names and phone numbers of friends, family members, acquaintances, health centers, organizations and agencies you would like for us to contact if we are unable to contact you directly. We are also asking for your permission to obtain your up-to-date contact information from the Supportive Housing for People with Problematic Substance Use Evaluation Project.

The interviews will be conducted by a student researcher. The researcher will audio-record and take notes during the meeting. This information will be used to better understand your experiences in your neighbourhood.

Study Funding

The study has received funding from the Canadian Mental Health Association.

Safety

The following rules apply when photographing other people:

If people are depicted in your photograph, they must be approached before the photograph is taken. The interviewer will help explain the project to each person, ask their permission to be photographed, ask them to sign a release form and given them the contact information of the researchers at the University of Ottawa should they need any further information on the project.

During the neighbourhood walking tour, you will only be going to places where both you and the researcher feel safe.

Use of Photographs

All photographs taken must be submitted to the researchers at the University of Ottawa, as ownership of these photographs belongs to the University of Ottawa.

Potential Harms

Some questions may make you feel uncomfortable. You can skip any question you do not want to answer. There is potential risk to you if the confidentiality of the information you give us were to be lost. To protect your confidentiality, personal information will be kept on a numbered form that does not have your name or other identifying information. We will keep your name and other identifying information on a separate numbered form. All information you give us will be kept in a secure research office, and only authorized research staff will have access to the information. The electronic and paper data will be de-identified and kept in strict confidence. All of the paper data will be stored in locked filing cabinets that only the study team has access to and all of the electronic data will be kept on a secure institutional network.

These interviews will take place Monday to Friday during working hours and a counselor from the CMHA will be available to speak with you after the interview if you think this would be helpful.

Potential Benefits

During this interview you will be able share your experiences and thoughts, which you may find rewarding and validating. The information collected during the study will be used to help us understand the effectiveness of the program in which you are involved and potentially improve it which would be of benefit to you and to others entering the program.

Anonymity and Confidentiality

Confidentiality will be respected and no information that discloses your identity will be released or published without consent unless required by law, such as disclosing abuse or acute

risk of harm to yourself or others. If there is perceived risk, privacy will be breached and you will be asked/made to seek care

The Research Ethics Board at the University of Ottawa may need to review records for monitoring purposes. As part of this review, someone may contact you from the Research Ethics Board to discuss your experience in the research study.

No comments you make will be personally attributed to you in any report associated with this research. Please also note that all photographs taken must be submitted to the researchers at the University of Ottawa, as ownership of these photographs belongs to the University of Ottawa.

Publication of Results

In the event that the results of this study are published or presented at conferences, seminars or other public forums, no individual information or information that could identify you will be released. Note that the investigators may choose to not publish or make use of the results of the study.

Reimbursement

You will receive an honorarium of \$20 for participating in this interview. If you decide to stop before finishing the interview, you will still receive \$20.

Participation and Withdrawal

Participation in any research study is voluntary. If you choose not to participate, you will continue to have access to any services that you have now. If you decide to participate in this study you can change your mind without giving a reason, and you may withdraw from the study at any time without any effect on the care or services that you will receive. Also, if you decide to withdraw from the study, we will not try to contact you again.

Contact Information If you have any questions about this research study, you may contact John Sylvestre or the research assistant Aman Bassi. The contact information is given at the top of this form.

Research Ethics Board Contact For more information on your rights as a participant in this study: You may contact the research ethics board at the University of Ottawa. The protocol officer for ethics in research can be reached at the following address: Research Grants and Ethics

550 Cumberland, Room 154

University of Ottawa

Ottawa, ON, Canada, K1N 6N5

Tel: (613) 562-5387

Fax: (613) 562-5387

Email: ethics@uottawa.ca

Consent

I understand that the interview will involve:

- Meeting with a research student for an interview lasting approximately 1 to 2 hours.
- Discussing my experiences and perceptions of my neighbourhood.
- Going on a neighbourhood walking tour to have further discussions about my community involvement and the places I like/dislike to visit. We will also be taking photos of my neighbourhood along the way.

I acknowledge that the research study described above has been explained to me and that any questions that I have asked have been answered to my satisfaction. I have been informed of my right to choose to not participate in the study. As well, the potential risks, harms and discomforts have been explained to me and I also understand the benefits of participating in the research study. I understand that I have not waived my legal rights nor released the investigators, sponsors, or involved institutions from their legal and professional duties. I know that I may ask now or in the future any questions I have about the study or the research procedures. I have been assured that information relating to me and my health care will be kept confidential and that no information will be released or printed that would disclose my personal identity without my permission unless required by law. I understand that the researchers will have access to my information from the baseline survey collected in the Supported Housing for People with Problematic Substance Use Evaluation Project.

I have been given sufficient time to read and understand the above information.

I freely consent to participate in this interview. I will be given a signed copy of the entire consent form, including this signature page.

Name (please print) _____

Signature _____

Date _____

Signature of Interviewer _____

Date _____

CONSENT TO THE RELEASE OF INFORMATION BY CONTACT PERSONS

____ (Initial) I consent to the research team contacting my friends, family members, acquaintances, health centres, organizations and agencies when attempting to contact me for the purpose of conducting follow-up interviews. I authorize these people to release information regarding my up-to-date mailing address and phone number to the research team.

Please complete if assistance was given to study participant

I was assisted during the consent process by having the consent form read to me.

Yes No ____ (initial)

If Yes, please check the relevant box and complete the signature space below.

The consent form was read to me, and the person signing below attests that the study was accurately explained to me and I have understood what was said.

Name of Person Assisting in the Consent Discussion

Signature of Person Assisting in the Consent Discussion

Date and Time

Photo-Release Form

This project examines the experiences, both positive and negative, of women living in Ottawa. Participants are using digital cameras to capture images related to their neighbourhood experiences.

I understand that the photographer has taken my (our) picture because he/she thinks that it shows something positive about this neighbourhood. I give my permission for the project leaders at the University of Ottawa to use this photograph for any other reproduction of the photograph in whatever way is appropriate. The University of Ottawa will own these pictures and may use my picture or other reproduction without mention of my name.

These pictures will only be used for research and educational purposes. My (our) pictures will not be used in endorsement of product advertising. I am aware that, in the future, I will not be able to ask the University of Ottawa to remove my picture and/or reproduction from displays or from any editorial or educational document that has already been developed and/or distributed. However, I will be able to ask that my appearance, likeness, photograph, or other reproduction, not be used in any future documents that have not been developed and/or distributed.

As long as my name is not connected with my picture I agree not to make any claims or demands to the photographer or to the University of Ottawa with regard to the use of my image. I agree that I will also not institute any proceedings against the photographer or the University of Ottawa, and that the photographer and the University are not liable for any damages caused by my appearance.

Dated: _____

Signed: _____

Name (please print): _____

Address: _____

If you have any questions or require any further information about the project, or if you would like to have your photograph withdrawn, you can contact:

Dr. John Sylvestre, at the School of Psychology

Vanier Hall, 136 Jean Jacques Lussier, Room 3001, Ottawa ON K1N 6N5

Tel: .

Email: .

OR you can contact:

Aman Bassi, at the University of Ottawa
416A Montpetit Hall, Ottawa ON Canada K1N 6N5

Tel: .

Email: .

You may also contact the research ethics board at the University of Ottawa. The protocol officer for ethics in research can be reached at the following address:

Research Grants and Ethics

550 Cumberland, Room 159A

University of Ottawa

Ottawa, ON Canada K1N 6N5

(613) 562-5841

Fax/Telecopieur: (613) 562-5318

Email: ethics@uottawa.ca

By signing this photo release form, you understand and agree to the above information. You will be asked to sign two copies; one will be kept by the research team and the other will be yours to keep.

Appendix K

Neighbourhood Walking Tour Interview Protocol

Introduction

The purpose of the meeting today is to learn more about your neighbourhood. There will be two parts to our meeting today. I want to spend some time asking you questions about your thoughts on what you think about this neighbourhood and learn more about the places you go to or don't go to. Then I would like to visit some of these places and take some pictures.

There are no right or wrong answers to any of these questions. Although we have some questions prepared to help guide the discussion, we invite you to share any thoughts or experiences you may have about this topic. Some of these topics can be difficult things to talk about. If at any time you do not feel comfortable with what we are talking about or do not feel comfortable answering any questions we ask, just let me know and we can move onto the next question. Also, if you need a break at any point or want to end the interview, let me know and we can stop.

Everything you say during the interview will be recorded and I will take some notes throughout the interview. Remember that everything you say today will be held in the strictest confidence and your name will not be associated with anything you say. All information will be identified by code numbers only and all information will be stored in locked filing cabinets.

Do you have any questions about your participant today?

If you have any questions at any time throughout this interview, please do not hesitate to ask.

Can we begin?

Interviewer: At the beginning of the recording state:

- 1) Name of Interviewer
- 2) Participant #
- 3) Date
- 4) Confirm that ethics consent signed
- 5) Honorarium
- 6) Read the introduction

A) Neighbourhood Impression

Okay let's start with some general questions about your experience in this neighbourhood.

- 1) Tell me about your impressions of this neighbourhood.
 - a. Do you like it here?
 - b. Is this the kind of place you see yourself becoming involved in more or less over time?
 - c. Do you like the people?

B) Use of Places Within the Neighbourhood

Let's talk more about places you go to regularly. I'd like to ask you a few questions about these places. These could be places you have been to over the past few weeks. You might go to them for things like groceries, places you go to enjoy yourself or to be with friends (park, café, library), places you go to work, or places you might go for services.

- 1) Have you had the chance to explore and visit different places in your neighbourhood?
- 2) Can you list some of these places that you go to regularly?

Interviewer takes note of places participant goes to regularly

- 3) Of these places how many are in your local neighbourhood? By neighbourhood I mean places that are a walking distance from home or within your local community near your home.

Interviewer takes note of places participant goes to regularly

- 4) Are there **any other** places in your local neighbourhood that you go to regularly (e.g. Shopping centers, cafes etc.)?

Interviewer takes note of places participant goes to regularly

- 5) Thinking about our local neighbourhood, are there places you think you might want to go to but haven't yet? These could be places you don't think you could go to, would not feel welcomed in, feel comfortable in, or feel safe in.

Interviewer takes note of places participant would like to go to but haven't yet

- 6) What about place you have gone to, but don't want to go to again? Can you list these places?

Interviewer takes note of places participant has gone to, but doesn't want to go to again.

- 7) Are there places you have never gone to? These could be places you don't think you could go to, would not feel welcomed in, feel comfortable in, or feel safe in.

Interviewer takes note of places participant has never gone to.

C) Mapping and Route Plan

Now that you have identified all these places for me, let's see where they are on this map of your neighbourhood and the route you usually take to get to these places.

As part of the meeting today, you will have the option of taking me to some of these places within your local community.

As we mark these places on the map, please let me know about the safe and unsafe areas in this neighbourhood. And also let me know if there are any places you want to avoid going to today.

Interviewer and participant map out the different locations and the route taken to these locations. **Interviewer: keep in mind location, accessibility and diversity of the locations pointed out

Now that you have marked these places on the map, you have the option of coming along with me to a few of these places and take photos of your neighbourhood. Would you like to come along for a walk?

If No: Okay, that's not a problem. I'll go ahead and take photos of some of these places. Then when we meet again, we can talk about the photos I've taken.

Will you have time to meet again next week? What day/time works best for you?

Is there a number I can reach you at to remind you of our meeting?

Interviewer: schedule Photo-Interview meeting

If Yes: That's great! On the way, it would be good for me to get a better sense of what it is like living in this neighbourhood. We will be taking photos, as we go along.

D) Neighbourhood Walking Tour

We will visit some of the places you pointed out on the map and try to follow the route here, but we don't have to follow the map strictly. If you remember places along the way or have a different route, we can change things around. It's very flexible.

During the walking tour, it's very important that we keep in mind our safety. We will avoid all areas in which either one of us feels uncomfortable, and if at any time you feel like not going a particular path, we can change our route.

Interviewer: remember to take note of these changes on the map

As we take photos today, we have to respect other people's rights and privacy. We will not take photos of places and people that may put us in danger. We cannot take photographs of people who don't want to be photographed. Before taking a photo of someone, we need to make sure they have signed the photo release form and for children under the age of 18 we will need to get approval from a parent or guardian. We also can't take photos of places and people involved in illegal activities. Making sure of your personal safety is of highest priority here and no photo is worth personal danger.

We can only take photographs of public spaces. We can't go onto private property. If you are unsure about taking a photo at anytime you can always ask me.

As we are walking to these places let's think about:

- What you think about the neighbourhood quality? For example, do you think your neighbourhood is in a good area, is it a safe area? What do you think should change about this neighbourhood or should remain the same? **(Physical)**.
- Think about places you would like to go to but don't feel welcomed to go or places you've gone to and feel welcomed; things that make you feel part of this neighbourhood **(Psychological)**.
- Think about the neighbours with whom you've had interactions and where these interactions were in this neighbourhood **(Social)**.
- When we are done with the walk today, we will use the photos we have taken today for our discussion next time we meet.

Camera:

If you feel comfortable, you can take the pictures on your own. Or if you like, I can take the pictures and you can have a look at the viewfinder to see if I'm taking the picture at a right angle.

Photo Release:

If you would like to include people in the photos we take today, we have to get a photo release form signed by these individuals.

Okay let's have a look at the map. The closest place to this location would be **X**. Would you like to start off our walking tour there? So as we walk to this location and other locations throughout our tour, I'll ask you about the different places we come across.

Interviewer: Using the map with route indicated, walk with participant or by yourself (if participant isn't joining you) to the first location.

Walking Tour Photo Pointers:

Physical

- 1) Do you usually take this path when going to X?
 - a. Why do you like this route?
 - b. How do you feel walking here at night?
 - i. Do you feel safe?
- 2) What do you think about the buildings around here?
- 3) Point out traffic, garbage, vandalism, green space etc.

Psychological

- 1) What are some of the areas that make you feel welcomed and not welcomed?
- Social
- 1) Where do you usually see a lot of neighbours?
 - 2) Are there any other areas in this neighbourhood, where you like to or would like to hang out with people?
 - 3) What areas in this neighbourhood do you like to avoid?

End of Meeting:

2nd Meeting

We will talk more about the photos we took today in our next meeting. Will you have time to meet again next week?

What day/time works best for you?

Is there a number I can reach you at to remind you of our meeting?

Places in the Neighbourhood

List of Places Participant Visits Regularly

List of Places Participant Would Like to Go to But Haven't Yet

List of Places Participant Has Gone to and Doesn't Want to Go to Again

List of Places Participant Has Never Gone to

Appendix L

Photo-Elicitation Interview Consent Form

Photo-Interviewing Consent Form

Project Contacts

If you have any questions or require further information about the interview you can contact:

Dr. John Sylvestre, at the School of Psychology
Vanier Hall, 136 Jean Jacques Lussier, Room 3001, Ottawa ON K1N 6N5
Tel: .
Email: .

OR you can contact:

Aman Bassi, at the University of Ottawa
416A Montpetit Hall, Ottawa ON Canada K1N 6N5
Tel: .
Email: .

Introduction

Before you agree to participate in this research study, it is important that you read and understand the following explanation of the study. It describes the purpose, procedures, benefits, and risks associated with the study. If you have questions after you read through this form, ask your interviewer. You should not sign this form until you are sure you understand everything on this form.

Description of the Research

You are invited to participate in an interview to share your experiences and views about your neighbourhood. The goal of this research is to study how women from supported housing perceive and participate in their local communities.

If you choose to participate in the interview today, we will review the map and photographs taken from the neighbourhood walking tour. The map and photos will be used to guide discussions about the places you use and how you identify with your neighbourhood.

We will keep in contact with you so that we can do 1 more interview with you in about 6 months. To help us keep in contact with you, we will ask you to give us the names and phone numbers of friends, family members, acquaintances, health centres, organizations and agencies you would like for us to contact if we are unable to contact you directly. We are also asking for your permission to obtain your up-to-date contact information from the Supported Housing for People with Problematic Substance Use Evaluation Project.

The interviews will be held with a student researcher. The researcher will audio-record and take notes during the meeting. This information will be used to better understand your experiences within the neighbourhood.

Study Funding

The study has received funding from the Canadian Mental Health Association.

Use of Photographs

All photographs taken in the first interview must be submitted to the researchers at the University of Ottawa, as ownership of these photographs belongs to the University of Ottawa.

Potential Harms (Injury, Discomforts or Inconvenience)

Some questions may make you feel uncomfortable. You can skip any question you don't want to answer. There is potential risk to you if the confidentiality of the information you give us were to be lost. To protect your confidentiality, personal information (such as your health conditions) will be kept on a numbered form that does not have your name or other identifying information. We will keep your name and other identifying information on a separate numbered form. All information you give us will be kept in a secure research office, and only authorized research staff will have access to the information. The electronic and paper data will be de-identified and kept in strict confidence. All of the paper data will be stored in locked filing cabinets that only the study team has access to and all of the electronic data will be kept on a secure institutional network.

These interviews will take place Monday to Friday during working hours and a counselor from the CMHA will be available to speak with you after the interview if you think this would be helpful.

Potential Benefits

During this interview, you will be able share your experiences and thoughts, which you may find rewarding and validating. The information collected during the study will be used to help us understand the effectiveness of the program in which you are involved and potentially improve it which would be of benefit to you and to others entering the program.

Anonymity and Confidentiality

Confidentiality will be respected and no information that discloses your identity will be released or published without consent unless required by law, such as disclosing abuse or acute risk of harm to yourself or others. If there is perceived risk, privacy will be breached and you will be asked/made to seek care.

The Research Ethics Board at the University of Ottawa may need to review records for monitoring purposes. As part of this review, someone may contact you from the Research Ethics Board to discuss your experience in the research study.

No comments you make will be personally attributed to you in any report associated with this research. Please also note that all photographs taken must be submitted to the researchers at the University of Ottawa, as ownership of these photographs belongs to the University of Ottawa.

Publication of Results

In the event that the results of this study are published or presented at conferences, seminars or other public forums, no individual information or information that could identify you

will be released. Note that the investigators may choose to not publish or make use of the results of the study.

Reimbursement

You will receive an honorarium of \$20 for participating in this interview. If you decide to stop before finishing the interview, you will still receive \$20.

Participation and Withdrawal

Participation in any research study is voluntary. If you choose not to participate, you will continue to have access to any services that you have now. If you decide to participate in this study you can change your mind without giving a reason, and you may withdraw from the study at any time without any effect on the care or services that you will receive. Also, if you decide to withdraw from the study, we will not try to contact you again.

Contact Information

If you have any questions about this research study, you may contact John Sylvestre or the research assistant Aman Bassi. The contact information is given at the top of this form.

Research Ethics Board Contact

For more information on your rights as a participant in this study:

You may contact the research ethics board at the University of Ottawa. The protocol officer for ethics in research can be reached at the following address:

Research Grants and Ethics
550 Cumberland, Room 154
University of Ottawa
Ottawa, ON, Canada, K1N 6N5
Tel: (613) 562-5387
Fax: (613) 562-5387
Email: ethics@uottawa.ca

Consent

I understand that the interview will involve:

- Meeting with a research student for an interview lasting approximately 1 to 2 hours.
- Reviewing photographs and map from the neighbourhood walking tour
- Discussing my experiences and perceptions of my neighbourhood.

I acknowledge that the research study described above has been explained to me and that any questions that I have asked have been answered to my satisfaction. I have been informed of my right to choose to not participate in the study. As well, the potential risks, harms and discomforts have been explained to me and I also understand the benefits of participating in the research study. I understand that I have not waived my legal rights nor released the investigators, sponsors, or involved institutions from their legal and professional duties. I know that I may ask now or in the future any questions I have about the study or the research procedures. I have been assured that

information relating to me and my health care will be kept confidential and that no information will be released or printed that would disclose my personal identity without my permission unless required by law. I understand that the researchers will have access to my information from the baseline survey collected in the Supported Housing for People with Problematic Substance Use: Evaluation Plan for the Ottawa Project.

I have been given sufficient time to read and understand the above information.

I freely consent to participate in this interview. I will be given a signed copy of the entire consent form, including this signature page.

Name (please print) _____

Signature _____

Date _____

Photo-Interviewing Consent Form

Signature of Interviewer _____

Date _____

CONSENT TO THE RELEASE OF INFORMATION BY CONTACT PERSONS

____ (Initial) I consent to the research team contacting my friends, family members, acquaintances, health centres, organizations and agencies when attempting to contact me for the purpose of conducting follow-up interviews. I authorize these people to release information regarding my up-to-date mailing address and phone number to the research team.

Please complete if assistance was given to study participant

I was assisted during the consent process by having the consent form read to me.

Yes No _____ (initial)

If Yes, please check the relevant box and complete the signature space below.

The consent form was read to me, and the person signing below attests that the study was accurately explained to me and I have understood what was said.

Name of Person Assisting in the Consent Discussion

Signature of Person Assisting in the Consent Discussion

Date and Time

Appendix M

Photo-Elicitation Interview Protocol

Introduction

The purpose of the meeting today is to learn more about your neighbourhood. We are interested in your views and what your experiences have been so far in this neighbourhood. We will use the photos and the map from our last meeting to talk more about your experiences in your neighbourhood.

There are no right or wrong answers to any of these questions. Although we have some questions prepared to help guide the discussion, we invite you to share any thoughts or experiences you may have about this topic and we are hoping the pictures we took during our last meeting will help with the discussion.

Some of these topics can be difficult things to talk about. If at any time you do not feel comfortable with what we are talking about or do not feel comfortable answering any questions we ask, just let me know and we can move onto the next question. Also, if you need a break at any point or want to end the interview, let me know and we can stop.

Everything you say during the interview will be recorded and I will take some notes throughout the interview. Remember that everything you say today will be held in the strictest confidence and your name will not be associated with anything you say. All information will be identified by code numbers only and all information will be stored in locked filing cabinets.

Do you have any questions about your participation today?

If you have any questions at any time throughout this interview, please do not hesitate to ask.

Can we begin?

Interviewer: At the beginning of the recording state:

- 7) Name of Interviewer
- 8) Participant #
- 9) Date
- 10) Confirm that ethics is signed
- 11) Confirm that honorarium is given
- 12) Confirm that the introduction has been read

A) Transition to Neighbourhood

Let's begin by first looking at how the move to this new apartment has been so far for you and generally how you feel about this place.

- 1) How has the transition to your apartment been so far?
 - a. Was the move to the apartment pretty smooth? Or did you find it stressful?

- 2) Do you feel like you have settled in?

- 3) Do you like your apartment?
 - a. Do you think the buildings/apartments in this area are as nice other areas?
 - i. Are there any problems with your apartment?

- 4) How do you feel about living in this neighbourhood?
 - a. Do you like the area you live in?
 - i. Would you say this is a neighbourhood you enjoy living in?
 - ii. Is there a sense of pride in having this neighbourhood as your address?
 - iii. Do you feel like you belong here?

- 5) How would you describe the area where you live?
 - a. What stands out the most in this neighbourhood?
 - i. The people?
 - ii. Places you could go for fun or for errands?

- 6) Is it for important you to be part of this community?
 - a. Why or why not?

B) Photo Ranking

Let's have a look at some of the photos we took during our walking tour last time. Please have a look at all the photos we took together, and then we will look at them individually.

To make this easier, you can select the top 5 photos that you think closely represents your neighbourhood. Then I will ask questions for each photo. We can have a look at each photo and you can tell me why we took this photo and what you see. And then if we have some extra time we can have a look at some of the remaining photos.

Interviewer:

Give participant a few minutes to look over the photos. Once the participant has chosen her five photos, label them from 1 to 5.

** Labeling will be important for referring back to the photos for meeting 3.

Looking at the photos you took during our last meeting, were there any places or people missing in the photos that you wish you had captured?

Let's have a look at the photos you have selected.

Interviewer: For the selected photos, begin by first asking the participant questions related to the photos (see Photo Questions below). Then depending on the photo content and discussion, use the Community Integration Questions (psychological, physical and social integration) as a framework to elicit additional information or to re-focus the interview around the research questions regarding perceptions and community involvement.

C) Photo Questions

Why (Interpretation) & Purpose of creation (Who, When, How)

- 1) How does this picture represent your neighbourhood?
- 2) Why did you take this photo of this place/object/person?
- 3) Can you describe why you chose this photo for our meeting today?

What (Focused on Content)

- 1) What do you think of when you see this photo?
- 2) Tell me more about this place/object/person? What's important about this place/object/person?
- 3) What's missing from this photo?
 - a. Are there other places that are important to you that weren't shown in the photos we took?
 - b. Are there people in this neighbourhood that are important and not shown in the photos?

D) Community Integration Questions

Psychological Integration: Respondents sense of belonging, availability of help, feelings of influence, and emotional investment in relation to neighbours and the neighbourhood. Also includes acceptance or discrimination.

- 1) Looking at this photo, does it say anything about how attached you feel to this neighbourhood or the people who live in it?

- 2) Thinking about this photo and the places you go to regularly, does it reflect anything about how involved you feel with other people living in this neighbourhood?
 - a. **Do you think you can rely on your neighbours if you ever need help or in an emergency?

- 3) Does this photo say anything about how much influence you feel you have on this neighbourhood?

Physical Integration: Involvement in different activities outside their household, such as eating in a restaurant, visiting library, and walking in a park. Also includes perceptions of safety.

- 1) Looking at this photo, does it say anything about how much or little you take part in community activities?
 - a. **How have taking part in community activities changed from your previous place?

- 2) Thinking about this photo, does it say anything about how safe you feel in your neighbourhood or your apartment?
 - a. **How safe do you feel walking alone in this neighbourhood after dark?
 - b. **How much of a problem is vandalism, damage to property, theft in your neighbourhood?

Interviewer: For questions 3-6 ask participant whether she feels welcomed, comfortable and safe in these locations.

- 3) Looking at the photos and this map of all the different places you go to regularly.

Interviewer: if map isn't clear enough, list places to participant

- a. What do you like about these places?
- b. What don't you like about these places?

- 4) Looking at the photos and this map, you mentioned places you would like to visit, but haven't yet.

Interviewer: if map isn't clear enough, list places to participant

- a. What do you like about these places?
- b. What don't you like about these places?
- c. Why do you think you haven't gone to these places yet?

5) Thinking about the photos and looking at this map, you mentioned places you have gone to, but don't want to visit again.

Interviewer: if map isn't clear enough, list places to participant

- a. Why do you think you don't want to go to these places again?

6) We also talked about places you have never gone to.

Interviewer: if map isn't clear enough, list places to participant

Thinking about the photos you've taken and this map, what is it about these places that you try to avoid?

Social Integration: Looks at social contact with neighbours. Also includes welcoming neighbourhood social climate, relationship with landlord/property manager/ neighbours.

- 1) Looking at this photo and thinking about places you go to regularly, does it say anything about how important is it for you to be part of this neighbourhood?
 - a. **How important is it for you to connect or take part in the community or have friendships and associations in the neighbourhood?
 - b. **Do you bring your friends or family here?
- 2) Looking at these photos, how you feel about belonging in this neighbourhood?
 - a. **If there were an event happening in this neighbourhood, would you feel that its something "we" are doing rather than "they" were doing?
- 3) Thinking about these photos and places you go to regularly, do you feel comfortable interacting with people living in this area?
 - a. **Are the people around here pretty welcoming?
 - b. **Can you make friends easily here?
- 4) Thinking about the places you go to or don't go to regularly, have there been times when you felt community members didn't want to mingle with you?

Physical Environment: Housing quality (conditions of walls, plumbing & heat), neighbourhood quality (access to stores, condition of neighbouring building, availability of transportation, crime rate).

- 1) Thinking about the location of your home. How easy is it for you to get to places like the grocery store, doctors, convenient store, etc?

Concluding Questions

- 1) Thinking about the photos you've taken and through your own experiences within this neighbourhood, what are the 3 things you dislike/like most about living in this neighbourhood?
- 2) **If you had free choice, which neighbourhood would you choose to live?
 - a. Would you want to move out of this neighbourhood?
- 3) **How does this area compare with the one that you were living in previously?
- 4) **How do you think this neighbourhood/area will change in the next two years?
 - a. **Do you think it will get better, worse, or remain the same?
 - b. **How do you think they can improve this neighbourhood?
 - c. **What do you think should stay the same in this neighbourhood?

Okay, this concludes our meeting today. Thank you so much for your time, we really appreciate your help. Do you have any questions or comments?

I hope to see you again in 6 months, so that will be in **X (Interviewer: mention the month for next meeting)**. As we get closer to **X (month)**, I will be getting in touch with you to see when you are available to meet. Is your contact information still the same?

Interviewer: Make sure you have updated contact information.
--

Appendix N

Change Over Time Interview Consent Form

Project Contacts

If you have any questions or require further information about the interview you can contact:

Dr. John Sylvestre, at the School of Psychology
Vanier Hall, 136 Jean Jacques Lussier, Room 3001, Ottawa ON K1N 6N5
Tel: .
Email: .

OR you can contact:

Aman Bassi, at the University of Ottawa
416A Montpetit Hall, Ottawa ON Canada K1N 6N5
Tel: .
Email: .

Introduction

Before you agree to participate in this research study, it is important that you read and understand the following explanation of the study. It describes the purpose, procedures, benefits, and risks associated with the study. If you have questions after you read through this form, ask your interviewer. You should not sign this form until you are sure you understand everything on this form.

Description of the Research

You are invited to participate in an interview to share your experiences and views about your neighbourhood. The goal of this research is to study how women from supported housing perceive and participate in their local communities.

If you choose to participate in the interview today, we talk about the changes in patterns of use of different services in your neighbourhood and your perceptions of your local community. The map and photographs from the neighbourhood walking tour will be reviewed to understand your neighbourhood better.

The interviews will be held with a student researcher. The researcher will audio-record and take notes during the meeting. This information will be used to better understand your experiences within the neighbourhood.

Study Funding

The study has received funding from the Canadian Mental Health Association.

Use of Photographs

All photographs taken in the first interview must be submitted to the researchers at the University of Ottawa, as ownership of these photographs belongs to the University of Ottawa.

Potential Harms (Injury, Discomforts or Inconvenience)

Some questions may make you feel uncomfortable. You can skip any question you don't want to answer. There is potential risk to you if the confidentiality of the information you give us were to be lost. To protect your confidentiality, personal information (such as your health conditions) will be kept on a numbered form that does not have your name or other identifying information. We will keep your name and other identifying information on a separate numbered form. All information you give us will be kept in a secure research office, and only authorized research staff will have access to the information. The electronic and paper data will be de-identified and kept in strict confidence. All of the paper data will be stored in locked filing cabinets that only the study team has access to and all of the electronic data will be kept on a secure institutional network.

These interviews will take place Monday to Friday during working hours and a counselor from the CMHA will be available to speak with you after the interview if you think this would be helpful.

Potential Benefits

During this interview you will be able share your experiences and thoughts, which you may find rewarding and validating. The information collected during the study will be used to help us understand the effectiveness of the program in which you are involved and potentially improve it which would be of benefit to you and to others entering the program.

Anonymity and Confidentiality

Confidentiality will be respected and no information that discloses your identity will be released or published without consent unless required by law, such as disclosing abuse or acute risk of harm to yourself or others. If there is perceived risk, privacy will be breached and you will be asked/made to seek care.

The Research Ethics Board at the University of Ottawa may need to review records for monitoring purposes. As part of this review, someone may contact you from the Research Ethics Board to discuss your experience in the research study.

No comments you make will be personally attributed to you in any report associated with this research. Please also note that all photographs taken must be submitted to the researchers at the University of Ottawa, as ownership of these photographs belongs to the University of Ottawa.

Publication of Results

In the event that the results of this study are published or presented at conferences, seminars or other public forums, no individual information or information that could identify you will be released. Note that the investigators may choose to not publish or make use of the results of the study.

Reimbursement

You will receive an honorarium of \$20 for participating in this interview. If you decide to stop before finishing the interview, you will still receive \$20.

Participation and Withdrawal

Participation in any research study is voluntary. If you choose not to participate, you will continue to have access to any services that you have now. If you decide to participate in this study you can change your mind without giving a reason, and you may withdraw from the study at any time without any effect on the care or services that you will receive. Also, if you decide to withdraw from the study, we will not try to contact you again.

Contact Information

If you have any questions about this research study, you may contact John Sylvestre or the research assistant Aman Bassi. The contact information is given at the top of this form.

Research Ethics Board Contact

For more information on your rights as a participant in this study:

You may contact the research ethics board at the University of Ottawa. The protocol officer for ethics in research can be reached at the following address:

Research Grants and Ethics
550 Cumberland, Room 154
University of Ottawa
Ottawa, ON, Canada, K1N 6N5
Tel: (613) 562-5387
Fax: (613) 562-5387
Email: ethics@uottawa.ca

Change Over Time Consent Form

Consent

I understand that the interview will involve:

- Meeting with a research student for an interview lasting approximately 1 to 2 hours.
- Reviewing the map and photographs from the neighbourhood walking tour meeting.
- Discussing the change in patterns of use of different services in my neighbourhood.

I acknowledge that the research study described above has been explained to me and that any questions that I have asked have been answered to my satisfaction. I have been informed of my right to choose to not participate in the study. As well, the potential risks, harms and discomforts have been explained to me and I also understand the benefits of participating in the research study. I understand that I have not waived my legal rights nor released the investigators, sponsors, or involved institutions from their legal and professional duties. I know that I may ask now or in the future any questions I have about the study or the research procedures. I have been assured that information relating to me and my health care will be kept confidential and that no information will be released or printed that would disclose my personal identity without

my permission unless required by law. I understand that the researchers will have access to my information from the baseline survey collected in the Supported Housing for People with Problematic Substance Use Evaluation Project.

I have been given sufficient time to read and understand the above information.

I freely consent to participate in this interview. I will be given a signed copy of the entire consent form, including this signature page.

Change Over Time Consent Form

Name (please print) _____

Signature _____

Date _____

Signature of Interviewer _____

Date _____

CONSENT TO THE RELEASE OF INFORMATION BY CONTACT PERSONS

____ (Initial) I consent to the research team contacting my friends, family members, acquaintances, health centres, organizations and agencies when attempting to contact me for the purpose of conducting follow-up interviews. I authorize these people to release information regarding my up-to-date mailing address and phone number to the research team.

Please complete if assistance was given to study participant

I was assisted during the consent process by having the consent form read to me.

Yes No ____ (initial)

If Yes, please check the relevant box and complete the signature space below.

The consent form was read to me, and the person signing below attests that the study was accurately explained to me and I have understood what was said.

Name of Person Assisting in the Consent Discussion

Signature of Person Assisting in the Consent Discussion

Date and Time

Appendix O

Change Over-Time Interview Protocol

Interviewer:

Ensuring Personal Safety: You should always provide the investigators of this research with the address of the meeting place and how long you expect to be for the meeting.

Leave your cell phone on at all times.

Introduction

The purpose of the meeting today is to talk about your experiences in your neighbourhood. It has been 6 months since we had our last meeting. We are interested in learning about what has happened to you during this time period in terms of your interaction within your neighbourhood. We will use the photos and the map from our first meeting to talk more about your experiences in your neighbourhood. We want to know about things that have changed and remained the same for you and how this has affected your experiences in your neighbourhood.

There are no right or wrong answers to any of these questions. Although we have some questions prepared to help guide the discussion, we invite you to share any thoughts or experiences you may have about this topic and we are hoping the pictures we took during our first meeting will help with the discussion.

Some of these topics can be difficult things to talk about. If at any time you do not feel comfortable with what we are talking about or do not feel comfortable answering any questions we ask, just let me know and we can move onto the next question. Also, if you need a break at any point or want to end the interview, let me know and we can stop.

Everything you say during the interview will be recorded and I will take some notes throughout the interview. Remember that everything you say today will be held in the strictest confidence and your name will not be associated with anything you say. All information will be identified by code numbers only and all information will be stored in locked filing cabinets.

Do you have any questions about your participation today?

If you have any questions at any time throughout this interview, please do not hesitate to ask.

Can we begin?

Interviewer: At the beginning of the recording state:

- 13) Name of Interviewer
- 14) Participant #
- 15) Date
- 16) Confirm that ethics is signed
- 17) Confirm that honorarium is given
- 18) Confirm that the introduction has been read

A) General Questions

- 1) Now that you've been living in this neighbourhood for a while, how do you feel about living here?
 - a. How has it been living in the apartment over the last 6 months?
 - b. Are you settling in?
- 2) Has anything changed with living here since the last time we met or over the last 6 months?

B) Map and Photo Review

Let's have a look at the map and the path we had taken during our first meeting in the neighbourhood walking tour.

During our tour, we had taken this path to these different locations in your neighbourhood and had taken pictures of some of these places.

(Interviewer: point out path taken during tour on the map).

Then during our second meeting, you chose five photos that you felt best represented your neighbourhood. These are the five we talked about.

(Interviewer lays out the five photos on the table or shows the photos on a laptop).

Today we will talk a little bit more about these different locations and the photos we had taken and what has changed and remained the same for you over the last six months.

Interviewer: For this meeting, look at the five photos the participant had selected from the second meeting and discuss elements of integration from Community Integration Questions below (physical, psychological and social). Keep in mind that for this meeting, the objective is to capture changes in the pattern of use of different community settings and changes in perceptions of the local community.

The questions in the Integration section refer back to the photos or map.

Questions marked with a star (**) are also included to elicit additional information or to re-focus the interview. For each question ask the participant whether any changes have occurred after reviewing with them their previous response from meetings 1 & 2.

C) Community Integration Questions

Physical Integration/Environment:

Physical Integration: Involvement in different activities outside their household, such as eating in a restaurant, visiting library, and walking in a park. Also includes perceptions of safety.

Physical Environment: Housing quality (conditions of walls, plumbing & heat), neighbourhood quality (access to stores, condition of neighbouring building, availability of transportation, crime rate).

- 1) Looking at the map, in our first meeting you had said that in this neighbourhood you like going to regularly:

Interviewer: list places mentioned from interview 1 & 2

- a. Has this changed since the last time we met? Do you still like going to these places?

Yes:

Looking at these 5 photos as a reminder of some of the places in your neighbourhood

- i. What do you like about these places?
- ii. Are there things you don't like about these places?

No:

- i. Why don't you like going to X?

For both Yes & No responses:

- I. **Are people welcoming there? Do you feel comfortable going to these places?
- II. **Do you feel safe there?

- b. Are there any other places you like going to regularly?

Interviewer: list places participant no longer goes to and any new places she goes to regularly.

- 2) You had also given me a list of places within this neighbourhood that you wanted to go to but didn't at that time.

Interviewer: list places mentioned from interview 1 & 2

- a. Has this changed since the last time we met? Have you had the chance to explore and visit these places in your neighbourhood?

Yes:

- i. What made you try these new places?
- ii. How do you feel about this change in going to these places now?
- iii. How has this affected your experiences in this neighbourhood?

For both Yes & No responses:

- i. Why do you think you haven't gone to these places?
- ii. **Are people welcoming there? Do you feel comfortable going to these places?
- iii. **Do you feel safe there?

- b. Are there any other places within this neighbourhood that you want to go to but haven't yet?

Interviewer: list places participant now goes to and any other places she avoids going to.

- 3) During our meeting you had given me a list of places you have gone to, but don't want to go to again.

Interviewer: list places mentioned from interview 1 & 2

- a. Has this changed since the last time we met? Do you go to any of these places now?

Yes:

- i. What led to this change?
- ii. How do you feel about this change of going to these places now?
- iii. How has this affected your experiences in this neighbourhood?

For both Yes & No responses:

- i. Why do you want to avoid going to these places?
- ii. **Are people welcoming there? Do you feel comfortable going to these places?
- iii. **Do you feel safe there?

b. Are there any other places within this neighbourhood that you have gone to, but don't want to go to again?

Interviewer: list places participant now goes to but had avoided in the past and any other places she avoids going to.

4) You had also told me about some of the places you have never gone to.

Interviewer: list places mentioned from interview 1 & 2

- a. Has this changed since the last time we met? Do you go to any of these places now?

Yes:

- i. What led to this change in going to these places?
- ii. How do you feel about this change?
- iii. How has this affected your experiences in this neighbourhood?

For both Yes & No responses:

- i. Why do you avoid going to these places?
- i. **Are people welcoming there? Do you feel comfortable going to these places?
- ii. **Do you feel safe there?

b. Are there any other places you never go to?

Interviewer: list places participant now goes to but had avoided in the past and any other places she avoids going to.

- 5) Looking at this photo and the map of all the places you like to go to, what does it say about how much or how little you take part in community activities?
- a. Has this changed since the last time we met?
 - i. What led to this change?
 - ii. How do you feel about this change?
 - iii. How has this affected your experiences in this neighbourhood?
- 6) Looking at this photo, what does it say about the physical quality of your neighbourhood? How have things been in terms of safety?
- a. Does it say something about safety, about where you go, about how the neighbourhood is laid out?
 - b. Has this view of yours changed at all since the last time we spoke?
 - i. What led to this change?
 - ii. How do you feel about this change?
 - iii. How has this affected your experiences in this neighbourhood?

Interviewer: mention any major themes from interview 1&2 about safety ask if this still remains the same or has changed

Psychological Integration: Respondents sense of belonging, availability of help, feelings of influence, and emotional investment in relation to neighbours and the neighbourhood. Also includes acceptance or discrimination.

- 1) Looking at this photo, how have your experiences been with your neighbours?
- a. Do you feel close to your neighbours?
 - i. **Do you feel like you can ask them for favors during an emergency?
 - ii. **Has there been a time when you were able to voice your opinion about issues in this neighbourhood? Do you think you have influence?
 - b. Has this changed since the last time we spoke?
 - i. What led to this change?
 - ii. How do you feel about this change?
 - iii. How has this affected your experiences in this neighbourhood?

Interviewer: mention any major themes from interview 1&2 about psychological integration belonging and ask if this still remains the same or has changed.

Social Integration: Looks at social contact with neighbours. Also includes welcoming neighbourhood social climate, relationship with landlord/property manager/ neighbours.

1) Let's talk a little about being part of the community. Looking at the photos and remembering the map with all the places you like to visit. How important is it for you to connect or take part in the community and have friendships and associations in this neighbourhood?

- a. ****Do you bring your friends or family here?**
- b. Over the last six months, do you feel like this has changed for you?
 - i. What led to this change?
 - ii. How do you feel about this change?
 - iii. How has this affected your experiences in this neighbourhood?

Interviewer: review with participant any major themes from interview 1 & 2 for being part of the community and ask if this still remains the same or has changed.

E) Conclusion

Interviewer: Review with participant any other major themes from physical, psychological, or social integration that weren't mentioned throughout the meeting. Refer back to the photos and/or map.

If any changes have occurred since the last meeting regarding these themes:

- a. What led to this change?
- b. How do you feel about this change?
- c. How has this affected your experiences in this neighbourhood?

Okay, this concludes our meeting today. Thank you so much for your time. This has been a great learning experience for me and I hope you enjoyed it too. Do you have any questions or comments?