

Making a Shelter a Home: Insights From Service Providers, Emergency Shelter Users,
and Supported Housing Residents

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ABSTRACT

Homelessness is a critical and pervasive issue in Canada, with at least 22,000 Canadians estimated to access emergency shelters daily and as many as 300,000 persons a year unsheltered at some time (Statistics Canada, 2019; Strobel et al., 2021). Although previous research has highlighted social and structural factors associated with homelessness (Anderson & Christian, 2003; Liu et al., 2021; Philipps, 2012; Stafford & Wood, 2017), including low income, lack of affordable or subsidized housing, limited housing and support services (Schiff et al., 2015), mental illness, addictions, gender politics and prior experiences of homelessness and poverty (Abramovich & Pang, 2020; Weissman, 2012), considerably less research has examined factors that impact relevant service utilization. The aim of the current dissertation was to build upon research (e.g., Cheng et al., 2007; Kirst et al., 2015; Macnaughton et al., 2017) which generally demonstrates that adequate service use helps individuals enter and retain stable, long-term housing by improving our understanding of how these individuals determine their needs, seek support, and navigate services.

A series of three qualitative interview studies were conducted with: (1) housing and support service providers ($N = 11$), (2) service users of an emergency housing shelter ($N = 15$), and (3) residents of a peer supportive housing unit ($N = 10$). Based on Thematic Analysis (Braun & Clarke, 2006), interviews garnered insights about preferred housing types and service use, substance use, mental health, client/staff interaction, rule enforcement, policing implications, social stigma, political policy, funding, housing acquisition and successful tenancy. Participants from the three study groups highlighted the need for affordable housing, a preference for the supportive housing environment

over emergency shelter and identified numerous practical barriers to service engagement. The current dissertation centered the lived experience of individuals experiencing homelessness and identified tangible targets for change at governmental policy and individual agency levels, with the hope of maximizing service use and successful long-term tenancy.

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CHAPTER 1: DISSERTATION RATIONALE AND GENERAL INTRODUCTION

Homelessness as a Pressing Social Issue

Most people do not choose to experience homelessness, and many feel it is an unsafe, unhealthy, negative, and stressful experience (Gaetz, 2023). Experiences of homelessness have been linked to decreases in quality of life and life expectancy, and increases in the presence of mental, physical, and substance use disorders (Shelton et al., 2009; Stablein et al., 2021, Vickery et al., 2021). Despite the implementation of different governmental policies, homelessness has continued to rise in Canada, with estimates from point-in-time counts raising 20% between 2018 and 2022 (Quayum et al., 2023). The social and economic costs of homelessness (Culhane, 2008; Hoch & Trenamen, 2020), paired with the substantial negative impact it has on individual lives, bolsters the rationale for identifying macro and micro-level solutions to change. Identifying appropriate targets for intervention is predicated upon a proper understanding of what constitutes experiences of homelessness and maximizing input from those with lived experience.

The current dissertation is titled “*Making a Shelter a Home.*” It is acknowledged that emergency shelters are not homes, nor are they intended to be. Further, some individuals may consider their home to represent a spiritual or omnipresent state of being, regardless of their physical residence. However, the term home in the current dissertation is used to represent a physical space that emulates safety and a place that fosters fulfillment of a person’s fundamental needs. Given that emergency shelters continue to be the predominant service available for those experiencing homelessness in

Canada, it is crucial to understand how the shelter environment can be modified to best suit the needs of the users to help them feel at “home.”

Language of Housing Provision – What is Homelessness?

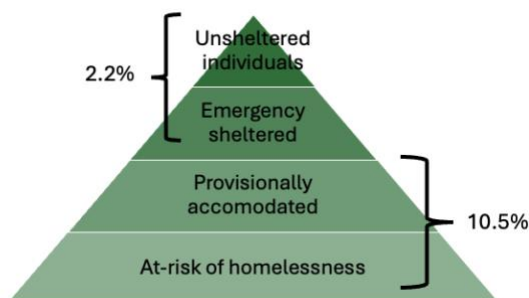
The term homelessness defines a range of experiences from having no access to housing to living in precarious housing (Gaetz et al., 2012). Although important terms related to the experience of homelessness have been outlined in full (see Table 7), it is important to note Gaetz and colleagues’ (2012) typology concerning the range of accommodations to which individuals experiencing homelessness are using:

1. **Unsheltered:** people who lack permanent housing; not utilizing emergency shelters or accommodation; often live in spaces without consent or contract (e.g., vacant buildings, public spaces like parks) or in places not intended or designed for permanent human habitation (e.g., cars or vehicles, tents, shacks).
2. **Emergency Sheltered:** people who cannot secure permanent housing and are accessing diverse forms of emergency shelters, some targeting specific sub-sections of the population (e.g., victims of intimate partner violence).
3. **Provisionally Accommodated:** despite no access to permanent housing, can access provisional accommodation; live with others (e.g., couch surfing); visit accommodation centers for immigrants and refugees; or live in halfway homes or other interim institutional care.
4. **At Risk of Homelessness:** individuals whose current housing situations are unpredictable and lack stability, who are at imminent risk of homelessness (e.g., experiencing precarious employment, facing eviction) or have precarious housing (e.g., inadequate or unaffordable).

As many as 400,000 Canadians fall within categories of homelessness as outlined by the Canadian Observatory on Homelessness (Argintaru et al., 2013). Although Statistics Canada provides data on hidden homelessness and on shelter capacity, it does not provide annual data on the total number of individuals experiencing homelessness (Echenberg & Munn-Rivard, 2020). In fact, Statistics Canada does not investigate the exhaustive set of individuals who experience the four types of homelessness, making it difficult to evaluate trends by typology (Dionne et al., 2023). Nevertheless, the Canadian Housing Survey ascertains experiences of visible homelessness (defined as unsheltered or emergency sheltered) compared to hidden homelessness (e.g., provisionally accommodated and at-risk of homelessness). In line with this conceptualization, 2021 data from the Canadian Housing Survey indicates that 2.2% of the Canadian population has experienced homelessness while 10.5% has experienced hidden homelessness (Dionne et al., 2023; See Figure 1). These data are consistent with research suggesting that being provisionally accommodated is about five times more prevalent than experiencing unsheltered homelessness in Canada (Uppal, 2022). For the purposes of the current dissertation, the term homelessness is used to focus on individuals who are unsheltered, or emergency sheltered.

Figure 1

Visual Representation of Housing Typology



Systemic issues and societal structures rooted in Galtung and Hoivik's notions of structural violence (1971) are the predominant explanation for homelessness (Addoriso et al., 2021; Calsyn & Rodes, 1994; Galtung & Höivik, 1971; Gilderbloom et al., 2013; Weissman, 2017b). Structural violence refers to harm engendered by societal structures that create conditions of unequal power, agency, and unequal life choices (Galtung, 1969). This inequality manifests as differential morbidity and mortality rates, less access to resources and greater restriction on personal decision making. Galtung (1969) describes structural violence as "silent" because it is "hidden" and stable in comparison to personal violence. Although the social structures that perpetuate structural violence are changeable, they are robust to change, as they benefit and are protected by those in power. Major structural factors contributing to the recent increase in those experiencing homelessness include a shrinking affordable housing market, more individuals living in poverty, and a retraction of supports in line with political regimes of power (Aubry et al., 2013; Foucault, 2008; Rose, 1999).

Various societal narratives explain how people end up without stable housing (Anderson, 1923; O'Sullivan et al., 2021; Wagner, 1993; Weissman, 2017b). Some researchers conceptualize homelessness as the loss of basic material necessities (Barile et al., 2018; Toolis & Hammack, 2015), whereas others consider homelessness as evidence of moral ineptitude or failure on the part of the individual (Giannini, 2017; Yarbrough, 2021). Thus, the perceptions of individuals' experiences of homelessness are polarized, framed as victimhood of failed fiscal and social policies of the State or understood as a personal failure wherein a flawed individual has made the wrong choices (Caton, 1990; DePastino, 2003; Hoch, 2000; Weissman, 2013; Wright, 1997). Many

service organizations simultaneously emphasize these contradictory narratives of political inaction and personal responsibility (Yarbrough, 2021). Both views propagate the stereotype that individuals who are homeless are not competent to participate as equals in the decision-making process and development of interventions geared towards eradicating homelessness. Therefore, the valuable perspective of those experiencing homelessness has been lost, and pre-emptively dismissed by other stakeholders, including those with decisional power (Levac et al., 2019; Lived Experience Advisory Council, 2016). The limited focus on lived experience has existed since homelessness research and social policy boomed in the 1980's (Hulchanski, 1983).

Esping-Anderson (1990) explains that the welfare state is a system of stratification promoting dualism between individuals who are on social assistance, conceptualized as weak or dependent, and those who are not, conceptualized as capable and independent. The strong liberalist welfare state that characterizes Canada directly impacts and propagates experiences of homelessness, due to a significant adherence to traditional work ethic norms, making eligibility for social assistance restrictive and associated with stigma (Esping-Andersen, 1990). In liberal regimes like Canada, individuals who find themselves in marginalized states, such as living in poverty, are often framed as being unable to market themselves appropriately (Bambra, 2007; Farrugia et al., 2016). Performing responsibility (e.g., actively engaging in the capitalist market system) is imperative within this liberal ideology and capitalist regime, leading to the construction of moral hierarchies that rationalize systemic inequalities (Farrugia et al., 2016). Foucault defined this neoliberal measure of worth as the emergence of homo economicus, the modern human condition wherein worth is determined by economic and

political viability (Foucault, 2008). For example, city-level policies describe experiences of homelessness using words like “dirty” (Toolis & Hammack, 2015), and homeless individuals are depicted as “immoral” or “disgusting,” providing a collective reaffirmation that middle-class standards are those to be sought after (Skeggs, 2005).

Mass homelessness in Canada began in the 1980s and boomed in the mid 1990s following macro-level changes in the Canadian socio-political context (e.g., disinvestment in affordable housing; reduced federal and provincial spending on social supports; Baral et al., 2021). The primary societal response at the time was the development of many emergency shelters (Gaetz et al., 2016), now understood to be a less effective policy to lessen homelessness compared to Housing First initiatives (Fleury et al., 2021; Gilderbloom et al., 2013; Quirouette et al., 2016). Prior to 2015, provincial governments were afforded significant discretion in how they chose to fund interventions targeting homelessness, resulting in a wide variety of programs and shelter types being implemented. However, despite changes in federal funding allocation, the number of emergency shelter beds across Canada has continued to rise, from 15,409 in 2016 to 16,009 in 2020 (Statistics Canada, 2022). In 2022, 18,467 beds were documented across 518 shelters across Canada (Statistics Canada, 2024). The number of shelters in the province of New Brunswick has grown from 8 in 2020 to 11 in 2022 (Statistics Canada, 2024).

More recently, following the publication of research endorsing the effectiveness of the Housing First model (e.g., Latimer et al., 2017; Macnaughton et al., 2017; Tsemberis, 2010; Worton et al., 2019), national government policy had mandated that 65% of federal funding allocated to homelessness be invested in Housing First initiatives

(Macnaughton et al., 2017). Housing First is an approach to homelessness service provision that focuses on providing individuals with independent and permanent housing alongside additional supports as needed, without any pre-requisites. Despite increased spending on Housing First programs across North America, there is little research evaluating the impact of the diverse iterations of the program, making it difficult to identify which resources are most pertinent to improving client functioning and quality of life (Oudshoorn et al., 2023). Housing First programs may include access to any combination of services and resources (i.e., health care, substance use treatment, peer support, employment counselling, occupational, physiotherapy; Jacob et al., 2022), which makes it difficult to compare program effectiveness among sites.

Current Research and Understanding of Homelessness

An estimated 22,000 Canadians access emergency shelters daily, and countless others lack appropriate or stable housing (Statistics Canada, 2019; Strobel et al., 2021). The most recent Canadian point-in-time count, conducted between 2020 and 2022 found that over 40,000 people across 72 communities in the country were experiencing homelessness (Quayum et al., 2023). Moreover, when compared to the 2018 point-in-time count, rates of homelessness had increased by 20 percent (Quayum et al., 2023). Low income, lack of affordable and subsidized housing and a lack of appropriate services are cited consistently as significant factors leading to homelessness (Woodhall-Melnik et al., 2018). Factors associated with increased risk for homelessness include early adverse childhood experiences (Thistle, 2019), sexual exploitation, poor mental health (e.g., depression), substance use, educational difficulties, poverty (Weissman, 2012, 2013, 2018), and a history of criminal or antisocial behaviour (e.g., aggression,

criminality; Gonzalez et al., 2018; Liu et al., 2021; Nyamathi et al., 2010; Thompson et al., 2010). Other research also has highlighted relationships between early childhood trauma, poverty, and later experiences of homelessness (Davies & Allen, 2017; Hamilton et al., 2011; Koh & Montgomery, 2021).

Each encounter with homelessness is rarely uniform, as people with lived experience of homelessness can go through repetitive periods of being housed and losing housing for many characterological or situational reasons. These include recurring and poorly managed psychiatric symptoms, unsuccessful results from current services, or dissatisfaction with available accommodation, such as being placed in poor housing stock, or residing in neighborhoods perceived as less favorable or safe (Jost et al., 2011; Stonehouse et al., 2021).

Among individuals experiencing chronic homelessness (i.e., each episode lasting over one year), first episodes are often triggered by significant unplanned life events such as major illness, loss of government benefits, eviction, major trauma or external factors (e.g., loss of local housing stock; Paat et al., 2019; Woodhall-Melnik & Weissman, 2021). These primary incidents may trigger issues that lead to recurrent episodes of homelessness (e.g., problematic substance use, difficulty maintaining employment, lack of an address for obtaining benefits, deep and enduring depression). For example, illicit substances may be used as a stress-management technique and may lead to a loss of housing due to an inability to cover expenses or eviction (Paquette & Pannella-Winn, 2016). Furthermore, if the person is criminalized for self-medicating and receives a criminal conviction, getting placed on subsequent housing lists is even more difficult.

Even when individuals experiencing homelessness manage to find housing, they are often not well equipped to maintain it. For example, a study of housing unit takeovers (HUTs) showed that housing predators (e.g., drug gangs, hostile acquaintances) play a role in displacing individuals in supportive housing (Weissman, 2017a). However, research shows that access to appropriate services and support can help individuals obtain and maintain housing long term despite vulnerabilities, as per the HUTs study, the National at Home/Chez Soi Project on Housing First, and other sources (Culhane et al., 2002; Goering et al., 2014; Kidd et al., 2013; Pauley et al., 2016; Weissman, 2017a).

The pathways in and out of homelessness are neither clear nor linear and are often related to the confluence of issues, including economic means, housing availability, interpersonal issues, and personal factors (Stafford & Wood, 2017). The Pathways Model of homelessness highlights the relationship between individuals' housing status and wider societal processes (e.g., poverty, unemployment, the local housing market) that influence individuals' pathways in and out of acute homelessness (Anderson, 2001; Clapham, 2002, 2003; Stonehouse et al., 2021). Individuals may experience homelessness driven by multiple structural factors including poor housing affordability, limited job opportunities and insufficient government assistance (Kneebone & Wilkins, 2016). Individuals' vulnerabilities can be compounding, with those facing unemployment concurrent with a housing crisis being more at risk of experiencing prolonged homelessness than those facing only housing instability (Anderson & Christian, 2003). Furthermore, it often takes numerous cycles of individuals moving in

and out of short-term shelter before they are ready to contemplate long-term housing options (Meschede, 2011, Weissman, 2017b).

Individuals experiencing homelessness at different ages have been shown to experience distinct pathways to homelessness (Clapham, 2003; Stonehouse et al., 2021). For example, youth homelessness has been linked to being in foster care, experiencing violence or abuse, and moving frequently as a child or having academic and social difficulties (Anderson, 2001; Tyler & Schmitz, 2013). Many Canadian youth report family conflict as a key factor leading to their experiences of homelessness (Abramovich & Pang, 2020). A national survey conducted by the Canadian Observatory on Homelessness to evaluate youth homelessness during the COVID-19 pandemic found that the public health response created additional difficulties for young people at risk of or experiencing homelessness, including challenges with isolation, physical distancing, and maintaining hygiene (Buchnea & McKitterick, 2020). Adult pathways to homelessness have been linked to five typical routes: housing crisis, family breakdown, substance use problems, mental health, and a rocky transition from adolescence to adulthood (Chamberlain & Johnson, 2011). The authors explain that adults who experience housing dissolution because of a housing crisis or family breakdown tend to experience shorter bouts of homelessness than those in the problematic substance use, mental health, or transition-related pathways. Individuals who experience homelessness for the first time in late middle age, understood as over age 50, are more likely to have had a spouse and full-time employment in young adulthood (Brown et al., 2016). Single adults tend to be at higher risk of enduring chronic homelessness, perhaps due to lower levels of embedded social support (Paat et al., 2019).

Importance of Lived Experience in the Study of Homelessness

The lived experience of individuals facing homelessness is a crucial component of determining the appropriate levels of services needed. Lived experience refers to a person's knowledge, awareness, and understanding of their encounters with the world around them. It also encompasses individuals' identities and histories, all which shape their perceptions of the world they live in. This dissertation examines the lived experience of staff members working in the emergency shelter system and individuals experiencing homeless who use emergency shelters or reside in supportive housing. In line with Geertz' (2008) approach of thick description, analyzing individuals' lived experience allows researchers to capture in detail the way an issue is embodied in their lives. The use of qualitative interviews enabled examination of thick description, an approach deemed successful elsewhere (Denzin & Lincoln, 2005; Magnusson & Marecek, 2015; Martins, 2008; Polkinghorne, 2005; Weissman, 2018).

Staff members at the shelter and individuals experiencing homelessness are best positioned to offer insights into the components of current systems (e.g., community services, the emergency shelter environment, supported housing) that are working well and the factors that should be changed to maximize the potential benefits provided by the relevant services. Developing policy or recommendations for change without embedding their perspectives could lead to organizational changes that do not best serve their needs. If organizations and governmental agencies do not incorporate the perspectives of those with lived experience, they run the risk of creating mismatches between their needs and the policies they implement (Smith et al., 2021). For example, policies developed without their input could be counterproductive in helping people experiencing

homelessness access resources. Without the input of relevant lived experience, broader policy implementation can become irrelevant to local circumstance (Malik et al., 2024).

Housing and Homelessness

The theoretical connection between homelessness and housing affordability is clear. For example, even when an individual or family can afford the minimum quality of housing available, their remaining income may not cover other necessities (e.g., food, clothing; Kneebone & Wilkins, 2016). When the cost of minimum-quality housing consumes too large a proportion of their income, individuals risk losing their housing (Lee et al., 2021). Furthermore, the provincial population continues to grow, mostly due to international immigration and migration from other provinces (Hansen, 2021), which leads to decreased availability of housing and higher rental costs.

As of March 2018, the waiting list for subsidized rental housing included more than 5,000 families, with 994 in the Fredericton region (Government of New Brunswick, 2019). As of February 1st 2024, there were 10,733 households on the waitlist for a subsidized unit in the province (Silberman, 2024). The average time spent on the provincial wait list varies by household type, as families, seniors, and non-elderly, single individuals spend on average 15.1 months, 25.2 months, and 18.9 months, respectively (Government of New Brunswick, 2019). The average 2020 rental cost in Fredericton was \$986 per month for a 2-bedroom apartment, an increase of fifty dollars over the previous year (Government of New Brunswick, 2021). In the fall of 2023, the CBC news stated that average rent for a 2-bedroom apartment in Fredericton rose to 1,268\$ a month (Silberman, 2024). Despite these increasing costs, most individuals on social assistance in New Brunswick receive only \$637 per month effective April 2023, and a single

individual with extended benefits receives only \$886 per month as of December 2023 (Gregorski, 2024).

There is a significant gap between demand for rental units and availability of low-cost housing, especially low-cost rentals (Bryant, 2003). Affordable units tend to be in older buildings, and the costs associated with maintaining these units (e.g., heating because of poorer insulation, repair costs) are higher (Hansen, 2021). Moreover, even when individuals who are currently unsheltered can find housing, they often report it is of poor quality (e.g., infested with pests, poor plumbing; Sylvestre et al., 2018). In a 2021 survey, 47% of approximately 5,000 tenants in New Brunswick reported their rentals were in poor condition (Government of New Brunswick, 2021). The National Occupancy Standard was created by the Canadian government in the 1980's to provide a point of reference in determining suitable housing. Its recommendations include: a maximum of two people should live in one bedroom, and single parents should have a bedroom separate from their children's (Canada Mortgage and Housing Corporation, 2022). In 2019, the Canadian government passed the National Housing Strategy Act, which recognizes housing as a human right, and states that adequate housing should be available to all persons (Canadian Human Rights Commission, 2022). Despite these national guidelines and policies, many Canadians, especially those in vulnerable social positions, report living in conditions that do not meet these standards (Canadian Center for Housing Rights, 2024).

The quality of housing is as important as its availability because, without a clean and safe living environment, the provision of (minimal) housing does little to improve their quality of life. Further, as noted above, the high cost of housing leaves little

disposable income for other necessities (e.g., clothing, food; Sylvestre et al., 2018). Due to these significant discrepancies in personal income and subsidies, and the cost and availability of housing, emergency shelters have become a place of permanent housing for many individuals (Schmidt et al., 2015).

Considering the transition from shelter use to stable housing, research suggests that personal characteristics such as race, gender, and age play less of a role in predicting housing status than specific policies that target prerequisites for access to shelter, such as clean criminal records, marital status, or where supportive funding might come from; Weinreb et al., 2010). The fact that shelter-stay length is more closely related to available resources than to individuals' constellation of needs makes a compelling argument for exploring which services are available and how they can best be tailored to facilitate access to stable housing. Poverty and social exclusion, an inability to find and maintain housing, unresolved mental and physical health issues, and ineffective services certainly interact in a vicious cycle to undermine individuals' capacities to maintain adequate housing (Schmidt et al., 2015).

Experiences of Homelessness in Fredericton

A 2023 point-in-time count conducted on April 17th and 18th, 2023 found that 119 adults were experiencing homelessness in Fredericton (Human Development Council, 2023). Seventy-four percent of those individuals endorsed experiencing chronic homelessness (i.e., over 180 days of homelessness in the last year). Sixty percent of the sample reported staying at a homeless shelter, 35% remained unsheltered in public space, and 5% reported staying in encampments (Human Development Council, 2023).

Data from the 2022 Canadian Shelter Capacity report indicated an available 254 shelter beds across the province (Infrastructure Canada, 2024).

Adults in Fredericton can access one of three homeless shelters, and as of 2024—after the current dissertation data were collected and analyzed—are all open 24 hours a day (Social Supports New Brunswick, 2024). In December 2023, the John Howard Society also opened a 24/7 housing-focused resource center aimed at helping individuals obtain documents they may need for housing and information about other services they may need (Urquhart, 2024).

What Constitutes Traditional Emergency Shelters

Emergency shelters are facilities usually intended to provide short-term stays for individuals who become homeless and can meet basic needs for a period of time, including a bed and basic hygiene provisions. In many cities, alternative residential options are lacking and difficult to access, making the shelter system the only feasible choice for many individuals (Quirouette, 2016). Although some shelters allow individuals to stay for longer periods and offer additional services like case management, skills training, and counselling for mental health symptoms, most provide few direct services (Gilderbloom et al., 2013). Shelters may serve distinct purposes or clientele, including families, or be exclusive for men or women, teenagers, or victims of domestic violence. Emergency shelter policies vary regarding length of stay, which depend on space restrictions, weather conditions, and the total number of individuals experiencing homelessness in a community. Shelter users are typically obliged to vacate the facility in the morning and return only when the shelter re-opens in the evening (Gilderbloom et al., 2013). Most shelters require users to comply with rules including

strict curfews and limited storage; expect users to show some degree of motivation towards recovery from problematic substance use (if relevant); and demonstrate engagement with housing plans (Quirouette, 2016).

Emergency shelters are typically intended to meet the needs of clients experiencing recent, transitional homelessness and possessing a high degree of motivation, ability to access resources, and plans to quickly rejoin the housed community. Unfortunately, those who most commonly use shelters do not fit that standard, and, as a result, shelters often are inadequately resourced to serve the population that is in need of them (Quirouette, 2016). Therefore, emergency shelters often maintain a population of regulars who remain there for extended periods of time (Hoch, 2000). Moreover, individuals institutionalized into the shelter system, due to limited alternative options, are often deprioritized by over-worked shelter staff who focus their energy on those deemed to have greater promise for change, including first-timers or individuals without active addiction. A study of emergency shelters in North America suggests that there exists limited specific regulation governing how emergency shelters are set up and managed. For example, there are few policies surrounding appropriate staff-to-client ratios, and inconsistent shelter regulations lead to different standards regarding issues like security and substance use across various sites (Gilderbloom et al., 2013).

Although individuals using emergency shelters utilize significantly more services than individuals with permanent housing (Addorisio et al., 2021), emergency shelters remain the dominant form of assistance for those who are experiencing homelessness (Sylvestre et al., 2016). Canadian politicians continue to favour and fund

emergency shelters, perhaps due to political decisions or an unclear understanding of the existence of effective and economical alternatives (e.g., Housing First models).

Moreover, the provision of shelter beds varies widely across Canada, both within and across provinces and local municipalities. In 2022, the majority (89%) of shelter beds in Canada were located in the provinces of Ontario (42%), British Columbia (18%), Alberta (15%), and Quebec (14%; Statistics Canada, 2024). Importantly, the number of shelter beds increased by 21.6% between 2021 and 2022, and the province of New Brunswick had only 254 beds that same year (Statistics Canada, 2024).

Connection Between Homelessness and Service Use

An important goal of the current dissertation was to understand how individuals experiencing homelessness are made aware of and use available services, given that adequate service use may help them retain stable, long-term housing. How they interact with services is influenced by the intersection of individual characteristics and system level factors. For example, the frequency of shelter use can influence housing procurement as first-time shelter users are more than twice as likely to exit into newly acquired housing than recurrent shelter users (Chen et al., 2020). Their increased likelihood of successful housing procurement is likely due to increased connection to their social networks and available resources (Chen et al., 2020). People who obtain government-subsidized or supportive housing rather than privately rented housing are more likely to maintain their tenancy in the long-term (O'Donnell, 2021). Past experiences of housing instability predict future experiences of that same or other types of housing (Glendening & Shinn, 2017). Other psychosocial factors linked with re-entry into bouts of homelessness include pregnancy, eviction from current housing, low

income prior to shelter entry, and younger heads of households (Glendening & Shinn, 2017). It should be noted that these are strongly correlated attributes, but the strength of the correlation often has less to do with the degree of acuity of the individual than the way the social support ecosystem responds to these needs (Glendening & Shinn, 2017). That is why these observable features only account for 25% of the variance in predicting housing instability, suggesting many other factors are at play (Glendening & Shinn, 2017).

There is a growing research track towards understanding the prevalence and qualitative nature of service use in New Brunswick, and that data will likely be available by 2026 (Woodhall-Melnik et al., 2022). As well, current studies under way such as the NB Housing study by the University of New Brunswick and Horizon Health Network are starting to understand and shape pathways to access. Despite the lack of a clear database listing all available services, there remains a range of services available within the Fredericton region for individuals experiencing various forms of homelessness. Research suggests that organizations specializing in facilitating the connection between those experiencing homelessness and the services they need, including bringing medical interventions into the community rather than in the hospital, have been deemed especially useful (Horizon Health Network, 2024; Khanassov et al., 2016; Stafford & Wood, 2017).

The Fredericton Suicide Prevention Committee's '*Helping Tree*' is an example of a positive local initiative designed to inform the public of resources addressing various societal problems including homelessness. It lists contact information to services including: Community Action Group on Homelessness, Salvation Army, Community

Kitchen, local food banks, Community Health Centers, Fredericton Outreach, and three different emergency shelters (i.e., adult only, women only, and youth). The *Helping Tree* also lists services related to employment, grief, violence and sexual assault, legal problems, addictions, mental health, and financial issues (*The Helping Tree*, 2024). The range of needs that are recognized by all these sites is evidence of the complex nature of individuals and their unique patterns around mental health and substance use.

Intersectional and Marginalized Identities of Homelessness

Marginalization refers to the treatment of an individual or group as less-than and can occur on the basis of concurrent identities, including experiences of homelessness and economic status (Schütz et al., 2019). Marginalization can also occur on a spectrum, and one's degree of economic marginalization is a potent example as it can produce experiences of abject poverty or sudden poverty that both cause and exacerbate individual experiences of homelessness (Giannini, 2017; Mostowska & Dębska, 2020). Marginalized individuals are traditionally disproportionately represented in samples of unsheltered people, and homelessness constitutes an additional marginalized identity for many. For example, a large-scale study in the US found that individuals who reported experiences of discrimination were more likely to experience homelessness, defined as 1+ months of not having their own place to live, even when other demographic variables such as age and gender were controlled for (Otiniano Verissimo et al., 2021). This study also highlights a dose-response pattern, wherein participants enduring more types of discrimination were more likely to experience homelessness. For example, despite accounting for only 5% of the housed population, 20-40% of unsheltered individuals in the US identified as 2SLGBTQIA+ (Giannini, 2017). Experiences of discrimination

often precipitate youth running away from placements or foster care and lead to their first experience of homelessness; and suicidal ideation among 2SLGBTQIA youth without housing has been documented as being 20% higher than for housed queer youth (Ecker, Aubry & Sylvestre, 2019; Ormiston, 2022; Rhoades et al., 2018; Robinson, 2018). Since the pathways in and out of homelessness occur at the intersection of structural, institutional, and individual factors – the availability of resources that respond to needs of marginalized individuals at each stage plays a valuable role in reducing extended homelessness (Paat et al., 2019). Understanding the interplay of such personal and structural attributes leads researchers and policy makers closer to understanding the risk potential for vulnerable individuals and communities.

Risk-Need-Responsivity Model and the Criminalization of Homelessness

As experiences of homelessness are often closely connected to interactions with the criminal justice system, it follows that the risk-need-responsivity (RNR) model, prominent in the fields of criminal justice and rehabilitation (e.g., Andrews et al., 1990; Bonta & Andrews, 2016; Taxman, 2014), would be useful for understanding individuals experiencing homelessness and their response to available community services.

Within the RNR model, risk evaluation identifies who should receive a select intervention. Those with the highest likelihood of recidivism based on standardized assessment or vulnerability assessment tools (VATS) should receive the most intensive services. A needs evaluation determines what should be treated, including malleable risk factors for criminal behaviour. Responsivity indicates how treatment should be delivered to maximize treatment engagement and considers what treatment works best for whom and under what conditions (Skeem et al., 2015). Taken together, the RNR model explains

that behavioural change like reductions in criminal behaviour require modifications in areas of vulnerability associated with criminal behaviour. These include reduced reinforcement for antisocial behaviour and increased reinforcement of prosocial behaviour within multiple contexts (e.g., family, interpersonal relationships, academic/occupational). Hypothetically, were the RNR model used to reduce chronic homelessness rather than criminal activity, evaluating risk and needs would include the use of standardized measures (e.g., VI-SPDAT; Brown et al., 2018), and responsivity would maximize the fit between available services and the identified needs. In the traditional RNR model, homelessness is a responsivity factor for criminal behaviour because it can interact with criminogenic factors that directly increase risk of recidivism (e.g., substance use, previous criminal history, interaction with antisocial peers).

Individuals experiencing homelessness remain over-policed, and criminal offences act as a barrier to service access that can help them exit from homelessness (Weissman, 2017b). Those unsheltered for longer periods of time are more likely to be arrested and re-arrested because of their heightened visibility on the street (Roy et al., 2016). The criminalization of homelessness is also partly a matter of spatial justice (i.e., how physical spaces are created or maintained to facilitate or impede access for specific groups; Castells, 1983; Harvey, 2003; Soja, 1989). These thinkers would argue that the conflict between individuals experiencing homelessness, and the law is related to how individuals in power define public and private spaces and behaviours they deem appropriate for each. For example, through legislation and zoning bylaws, powerful groups are able to socially control less powerful ones. Urinating in a laneway becomes a felony or indictable sexual offence, sleeping on a park bench becomes loitering or

trespassing, and being loud late at night becomes disorderly conduct. The law, per se, does not respond well when private behaviours are forced out into the public. Being unsheltered increases the likelihood of criminal justice involvement because poverty-driven offences (e.g., minor theft), increases in surveillance, and the penalization of daily activities (e.g., unlawful dwelling) are common among street communities (Giannini, 2017; Roy et al., 2016). Hence, more than three-quarters (76%) of North American adults who have experienced homelessness report being arrested at least once in their lifetime (Gonzalez et al., 2018), and in corollary evidence, individuals with histories of incarceration are 50 times more likely to experience homelessness compared to individuals without such histories (Dum et al., 2017). Indeed, an American study found that 15.3% of the adult jail population included in their sample was unsheltered immediately prior to their current bout of incarceration (Listwan et al., 2018). Though this study makes reference to American rather than Canadian data, these types of studies were included in the literature review to broaden the research pool. While granting that social policies do differ between Canadian and American contexts, research focusing on Housing First and other housing interventions have similar enough aims to make the North American context relevant to the present dissertation.

The high rates of incarcerated individuals experiencing some form of homelessness can be explained by a lack of wraparound supports, especially the lack of stable housing available upon release, a situation exacerbated by the virtual impossibility of achieving housing supports when possessing a criminal record. For individuals currently on probation, access to stable housing is especially useful because it ensures consistency in opportunities for daily activities and community building with prosocial

associates (Listwan et al., 2018). Furthermore, previous negative interactions with the criminal justice system mean that unsheltered individuals are more likely to mistrust the police and less likely to report being a victim of crime (Roy et al., 2016, 2020).

Being unsheltered following release from incarceration is linked to increased recidivism (Harding & Roman, 2017), and the persistent homeless (i.e., on average, 15.8 episodes of homelessness over their lifetime) had the highest proportion of felony convictions, according to a recent U.S. study (Harding & Roman, 2017). Listwan and colleagues (2018) evaluated the implementation of a housing-first intervention for individuals with chronic histories of incarceration (i.e., at least four jail admissions in the last 5 years). Those not receiving the housing-first intervention were 21 times more likely to be arrested (Listwan et al., 2018), highlighting the positive impact of these interventions for individuals with histories of incarceration.

Responsivity Contextualized by the Behavioural Model for Vulnerable Populations

The Behavioural Model for Vulnerable Populations (BMVP) is based on the original Behavioural Model (BM), which was developed to describe factors that shape why individuals utilize health services (Andersen, 1995). The original BM proposed that individuals seek out health services based on three factors: (1) predisposition to use health services (i.e., predisposing domain), (2) factors that enhance or act as barriers to use (i.e., enabling domain), and (3) the need for care (i.e., need domain; Andersen 1995). The BM is dynamic in nature such that outcomes of service use at one point in time impacts subsequent use in the future (Andersen, 1995). The Behavioural Model for Vulnerable Populations (BMVP) expands on the original model by adding specific considerations of vulnerable populations (i.e., the vulnerable domain) to each of the

three factors (i.e., predisposing, enabling, and need) when considering specific health behaviours and outcomes related to this unique population (Gelberg et al., 2000; Levesque et al., 2013; Linton & Shafer, 2014). Although these models are designed specifically to explain the use of health services, they can be applied more broadly to service utilization (Bessaha et al., 2020; Kosteniuk et al., 2021; Simmons et al., 2021; Small, 2010). Each traditional domain and unique additions of the BVMP are outlined below (Gelberg et al., 2000, p. 1276-77):

1. The **traditional predisposing domain** typically includes demographic characteristics, including age, gender, employment, and level of education. The *vulnerable predisposing* domain includes social structure characteristics, such as immigration status, literacy levels, living conditions, criminal history, and mental illness.
2. The **traditional enabling domain** includes personal resources (e.g., insurance, income levels), community resources (e.g., region, available resources), and health service resources (e.g., volume of resources, distribution processes). The *vulnerable enabling domain* includes personal/family resources (e.g., availability and use of information, public benefits) and community resources (e.g., availability of social services).
3. The **traditional need domain** includes perceived level of need and objective evaluations of population-level health needs (e.g., population health risks). The *vulnerable need domain* includes self-perceptions of need and objective need concerning conditions that are directly relevant because of their disproportionate

representation in this population (e.g., tuberculosis, sexually transmitted infections, HIV/AIDS).

Beyond traditional health practices (e.g., exercise, diet) which the BM considers when predicting service use, the BMVP also considers access to food sources, personal hygiene, and risky sexual behaviours in service use prediction. Notably, the *outcomes domain* (i.e., how and if services are used) encompasses both traditional and vulnerable components and includes perceived and objective health status as well as satisfaction with care (Gelberg et al., 2000). In particular, the interplay of the predisposing, enabling, and need domains is linked to the level of *responsivity* an individual has to services (i.e., how likely they are to use services that are available). A recent scoping review conducted by Grech and colleagues (2024) evaluated 15 articles applying the BVMP model to people experiencing homelessness. Grech and colleagues (2024) provided three key findings: first, the longer an individual experiences homelessness, the less likely they are to access health care. Second, certain populations including indigenous individuals, people with mental illness, infectious diseases, and women, all have higher rates of unmet needs. Finally, individuals are most likely to access health care if they receive professional support and perceive their healthcare needs as a high priority.

Why Service Use is an Important Aspect of the Study of Homelessness

In the current dissertation, service use is defined as a measure of individuals' actual use or likelihood of using services. Service acceptance and use are guided by one's perceptions of risk, need, and responsivity, as noted above. Extant research focuses on the risk and need factors associated with homelessness and associated negative outcomes (Anderson & Christian, 2003; Liu et al., 2021; Philipps, 2012; Stafford &

Wood, 2017), but there is less available research examining factors that increase or decrease the likelihood of service utilization (see Gruch et al., 2024 for a review). Indeed, there remains a limited focus on responsivity (i.e., determinants that facilitate a match between user desires and available services; Andrews et al., 1990; Lemieux et al., 2020). This gap may be due to the increased difficulty associated conducting research at the intersection of domains of functioning. The identification of factors underlying a person's motivation to engage in service use is imperative to efforts to improve policies and supports for individuals experiencing homelessness.

A strategy to maximize the use of services is to ensure an appropriate fit between what individuals experiencing homelessness deem important and the services available to them. Understanding the factors that increase service use will provide insight into streamlined intervention and prevention efforts from service providers. This knowledge can help providers decrease associated negative outcomes (e.g., mental and physical illness), improve prevention efforts (e.g., meeting needs of individuals in precarious housing), and increase the possibility of stable housing via interventions addressing behaviours or skills identified by the individual service users. At the organizational level, identifying responsivity factors may lead to policy change to increase appropriate service use. The three studies included in the present dissertation covered multiple vantage points about specific facets of the homelessness continuum. Study 1 examined the perspective of staff members navigating service delivery in the emergency shelter system. Studies 2 and 3 leveraged the lived experience of individuals using the emergency shelter and residing in the supported housing complex, respectively, to better understand barriers and facilitators to service use among this vulnerable population.

Furthermore, examining service use from user and provider perspectives offered insight into structural characteristics of the system that can help improve the fit between available services and the desires of individuals who would use them. The lack of clarity about how service characteristics meet perceived needs, or impede individuals' journeys to care, provided a strong rationale for further research in this area (Barile et al., 2020). The current dissertation examined responsiveness to service use factors across two housing models (i.e., shelter versus supportive housing) to identify services most essential in each, as well as factors that increase or decrease their use. The resulting data highlights discrepancies in the needs of individuals experiencing each model and identifies perceived best solutions for positive change.

CHAPTER 2: STUDY 1 – SERVICE PROVIDER PERSPECTIVE ON RESPONSIVITY AND SERVICE USE

Why is the Service Provider Perspective Important?

Much of service provision in the homelessness sector occurs through frontline staff, sometimes called frontline workers (Waegemakers Schiff et al., 2021). Frontline workers exist in all social support settings, and in the homelessness support sector, they facilitate relationships and connections with clients at emergency shelters and other housing support spaces. Service providers are tasked with following policies of their employer organizations and implementing changes face to face when they are introduced. Therefore, staff factors can play an influential role in predicting resulting service use, especially culture-shifts within a provider organization (Bower et al., 2018; Olivet et al., 2021). Staff members are de facto intermediaries between policy makers and service users because they are well positioned to effect positive change. Under-staffing, turnover, and vicarious trauma, burnout, and even PTSD, are significant issues for frontline workers in the homelessness sector (Lenzi et al., 2021; Schiff & Lane, 2021; Waegemakers Schiff et al, 2021; Yamada, 2022). These factors limit continuity of care and negatively impact resulting care. As such, understanding service provider perspectives, and strategies they think may improve their working conditions, will facilitate an improvement in service provision.

Role of Service Providers and Agencies in Barriers and Facilitators to Service Access

Service providers and agencies can have a profound influence on the barriers and facilitators to service access. Levesque and colleagues (2013) conceptualize services

accessibility with five components: (1) approachability, which refers to whether individuals have the capacity to seek out and identify services that would meet their needs; (2) acceptability, which encompasses factors that determine the likelihood that individuals will accept the service; (3) availability and accommodation, which refer to physical access and in a timely manner; (4) affordability, whether an individual has capacity to spend resources and time to access a service; and (5) appropriateness, which refers to the match between available services and client need.

These five criteria discussed above are interconnected in affecting service access, and service providers and agencies play a role in shaping each of them. For example, a service with poor availability characterized by limited opening hours may also have poor approachability by only advertising the service online. By conceptualizing access as an integral component of services, researchers emphasize that services must adapt to individual and broader demographic characteristics of their clientele, as well as social and economic factors of the system in which these individuals live (Lee et al., 2021). This framework helps contextualize important components of service use and how they interact with one another to have summative effects on broader service engagement.

Barriers to Service Use

Approachability. Inadequate marketing of services may lead to them being unseen by those who need them. In particular, services that lack community outreach and appointments or that require access in person are unlikely to be approached by potential service users (Canavan et al., 2012). Evaluating barriers to care should consider an individual's understanding of which services to acquire and where to access them (Addoriso et al., 2021; Meschede, 2011), as many individuals learn of services via word

of mouth from other people experiencing homelessness (Barile et al., 2020). Procedural exclusion criteria inhibit access to services among individuals who may benefit from them (Quirouette, 2016). For example, those with substance use or mental health diagnoses may be precluded from accessing certain services. For example, while many emergency shelters require abstinence, harm-reduction approaches to substance use are often preferred among this population (Canavan et al., 2012; Pauly et al., 2019).

Acceptability. A focus-group qualitative research project demonstrated that acceptability is influenced by past negative service provider experiences (e.g., judgmental or hostile staff), which lessened their desire to engage with services (Ha et al., 2015). Experiences of homelessness remain highly stigmatized and individuals experiencing concurrent disorders like substance use often experience multiple marginalization. As a result of these experiences, individuals experiencing homelessness may have specific cognitions (e.g., “they see me as a number,” “they’re not going to help me”; Black et al., 2018) that impede service use. Some may believe that their problems will improve without intervention, that health services are inadequate to meet their needs, or want to solve their problems independently (Roche et al., 2018).

Stafford and Wood’s (2017) case studies highlight the impact of professional oversight on acceptability of a service. For example, a woman who had experienced sexual abuse during her adolescence was self-medicating through persistent substance use. This pattern was not appropriately addressed during medical and psychiatric admissions. This problematic pattern remained untreated and diminished her acceptability to appropriate housing providers. In general, individuals experiencing chronic homelessness are significantly more likely to have histories of untreated trauma

and consistently negative experiences with services of various kinds (Stafford & Wood, 2017)

A de facto accessibility barrier arises as some health professionals hold strong biases toward individuals who are experiencing homelessness and act in prejudicial ways towards them (Gwadz et al., 2019; Olivet et al., 2021). Youth experiencing homelessness report having case workers who “don’t even give a fuck” about them, are insensitive to their struggles and are “just there for the paycheque” (Gwadz et al., 2019, p. 211). Service users labeled by providers as difficult (e.g., hard to serve, resistant) often receive less or inadequate care, widening the service gap for those most in need (Quirouette, 2016).

Although people experiencing homelessness with concurrent mental health and substance use disorders utilize more community support services than those without such diagnoses they also face considerable accessibility barriers and are more likely to be unsheltered (Bonin et al., 2007; Harding & Roman, 2017). These individuals have smaller support networks and are less likely to connect to allied services (Paat et al., 2019). The social networks of individuals experiencing homelessness are less likely to be populated by friends and family who can advocate for their care (Bonin et al., 2007). However, social networks of individuals experiencing homelessness are more complex than may be described in research, because academic researchers occasionally fail to recognize street kin as legitimate social forms (Bourgois & Schonberg, 2009). These relationships and social networks can be stable, and provide support in other ways, such as communicating news in the network, shifting resources of various kinds, and offering emotional support as needed (Weissman, 2012; 2017b).

Recent research has highlighted the value of various perspectives provided by those involved in service provision and use and those having experienced homelessness (Ecker, 2016; Levesque et al., 2021; Patterson et al., 2015; Sylvestre et al., 2018; Weissman, 2017b). Front-line service providers are well positioned to provide insight about the systemic barriers they face in shaping the acceptability of a service.

Availability and Accommodation. Individuals' needs are best met when the mission and values of service agencies align with those needs (Kneebone & Wilkins, 2016; Ramsay et al., 2019). An incongruence between service provider values and the needs of individuals experiencing homelessness can cause barriers to service use. For example, certain emergency shelters will not accommodate, or outright refuse to provide services to individuals who struggle with current addiction (O'Carroll & Wainwright, 2019). These pre-requisites are especially salient given that estimates of substance dependence among individuals experiencing homelessness are about ten times higher than the general population, at close to 40% (Fazel et al., 2014; Motta-Ochoa et al., 2023; Stablein et al., 2021). Many shelter services imposing pre-requisite conditions (e.g., no current substance use) are thus unavailable to this vulnerable cohort (Meschede, 2011), and inflexible eligibility criteria can force clients into crisis before more tailored services become available (Black et al., 2018). Limiting shelter availability through inflexible eligibility criteria means certain clients in need are turned away (Jackson et al., 2014). Moreover, the inflexibility characteristic of these shelters may make other housing models like tiny homes and encampments more desirable alternatives.

Diurnal and nocturnal restrictions and service schedules significantly impede the availability of services targeting those experiencing homelessness. For example, limited

opening hours are a deterrent to service use, especially for those without consistent means of telling time like a watch or cellphone, or have to walk long distances to access service locations. The typical restrictions on shelter access, which preclude individuals experiencing homelessness from using the space during the day, can lead to public confrontations and difficulty managing personal belongings. Certain shelter policies, such as requiring individuals to line up outside and strict curfews can be perceived as infantilizing (Magwood et al., 2019; Roche et al., 2018).

One study found that individuals' internet access decreased by 68% when they experienced homelessness, compared to when they were housed (Eysenbach et al., 2018). Moreover, long waitlists often encourage feelings of disengagement, resentment, and mistrust of the system among those in most need of care (Quirouette, 2016). The lack of timely referrals to health services is another barrier to comprehensive health care (Khanassov et al., 2016; Roche et al., 2018). Ensuring positive experiences with community care appointments by facilitating access to patient advocates can help lower barriers to care and limit trauma associated with avoidable emergency department visits. In contrast, stigmatizing or infantilizing attitudes by health care workers can alienate users and act as a barrier to care (Coe et al., 2015; Roche et al., 2018). Staff members are often inadequately trained to address the complex needs of individuals experiencing homelessness (Canavan et al., 2012) and may feel ill-equipped to deal effectively with the multitude of complex issues presented by their clients (Jackson et al., 2014). The lack of comprehensive or consistent training may force staff members to provide services outside their area of competence (e.g., mental health counselling to clients in crisis), impeding appropriate client care.

Affordability. Affordability of service use encompasses factors including the time required, money spent, payment terms, prerequisites (e.g., referral requirements) and transportation availability. For example, a lack of affordability of digital technology (e.g., cell phones) creates access barriers to a myriad of online support resources (e.g., educational videos, support-groups, virtual health visits; Humphry, 2014). Although some research suggests individuals experiencing homelessness do have access to cellphones, the maintenance and use of these phones is more complicated than in the general population (e.g., lack of access to data, places to charge them, greater rates of theft; Heaslip et al., 2021). The term digital divide has been used to explain the discrepancy in technology use among other vulnerable groups like those living in poverty. This digital divide leads to a common outcome for many marginalized and vulnerable groups – a reduction in service use.

Appropriateness. Appropriateness refers to the match between available services and client needs. Unfortunately, even appropriate services (e.g., emergency shelters, health care clinics, hospitals), work independently from one another (Kozloff et al., 2013). Siloed care provision across domains of social welfare leads to inefficient care provision including service duplication or individuals in need being rejected because of exclusion criteria (Canavan et al., 2012; Meschede, 2011). A lack of communication among referral sources can oblige individuals to repeat their stories multiple times, evoking user frustration, an insidious barrier that can decrease the desire to access services in the future (Black et al., 2018).

Even when case managers are directly involved in service provision, they and the client do not always agree on the type or degree of services that are required (Meschede,

2011; Mulkern & Bradley, 1986). A U.S. study comparing perspectives, at different steps of the continuum of care, found that providers stressed the need for mental health and substance use services whereas consumers were more focused on housing and medical concerns (Meschede, 2011). However, both groups agreed the system was too rigid and inflexible. Two more recent studies examining consumer and provider perspectives on primary care among individuals experiencing homelessness found that although both groups prioritized access to care, their perspectives diverged on other components of care (Steward et al., 2016; Varley et al., 2020). For example, service consumers rated shared knowledge as a much more important component of care than did providers. In contrast, service providers ranked perceived patient control of their care as critical to care while consumers did not (Steward et al., 2016; Varley et al., 2020).

Facilitators to Service Use

Approachability. Services that prioritize approachability are more likely to facilitate access to services. For example, employing well-trained outreach workers who spend time maintaining contact, as they competently help the client navigate the service system, may increase service access (Rosenheck & Lam, 1997a). Staff members who take time to build relationships with clients are seen as more approachable, which can lead to greater service use (Black et al., 2018; Quirouette, 2016). A community-based, low-barrier, interdisciplinary approach has been shown to improve overall efficiency in use of health care services (e.g., lowering rates of emergency department visits; Hemphill et al., 2020). When interdisciplinary teams coordinate complex care services through staff member collaboration, better overall service is achieved (Khanassov et al., 2016).

Acceptability. Individuals are more likely to use services they perceive as personally acceptable. Staff members can build trust with service users by being respectful, engaging in regular contact, and using an approach that maximizes client agency (Canavan et al., 2012). Clients especially appreciate staff perceived as supportive and non-judgmental (Black et al., 2018; Ha et al., 2015). Providing opportunities for staff to learn about the factors leading to homelessness has been suggested as an avenue to build staff-client rapport (Meschede, 2011). Staff training on addiction and mental health can enhance acceptability of a service as staff will be perceived as better able to address client needs (Jackson et al., 2014). Relationships between shelter staff and clients are contextualized by the inherent power differential (e.g., staff members can revoke services at any point). As a result, case workers must constantly negotiate competing priorities between care and control while ensuring they maintain the acceptability of the service they provide (Quirouette, 2016). Some interpersonal factors shown to facilitate service use include feeling emotionally supported by other users, observing peers using services, and perceiving staff members as trustworthy and non-judgmental (Pedersen et al., 2016).

Acuity refers to the degree of difficulty associated with a specific person's complex care needs. Many individuals experiencing homelessness present to services as high acuity, due to the tri-morbidity they experience. This high needs or acuity profile is especially true for those experiencing recurrent homelessness, as severity of presenting problems tends to increase with time. In order to help high-needs clients, service providers require emotional, psychological, practical and conflict training to adequately meet their needs. Insufficient knowledge and training in how to handle the urgency and

often crisis status of these cases, results in poor service delivery and negative experiences for providers as well as service users. Individuals experiencing homelessness with higher levels of education, more intact social supports, and the skills and capacity to navigate the healthcare system, are better able to access services, and require less support from frontline staff (Rosenheck & Lam, 1997a).

Availability and Accommodation. The utility of a service depends on crucial characteristics. For example, a housing program may depend on the availability of social assistance, health, and childcare subsidies, which provide greater agency and flexibility and is therefore preferable to public housing for many clients (Kneebone & Wilkins, 2016). The cost of healthcare services can act as an important barrier to service use, and the provision of multiple funding sources within and across agencies plays a role in shaping what resources are available (Gallardo et al., 2020). There remains a gap of available resources for individuals experiencing homelessness, exemplified by Canadian hospitals being unable to discharge patients to appropriate destinations (Jenkinson et al., 2021). Requiring patients to return to emergency shelters or the streets exacerbates health inequities faced by this population as these locations lack health-sustaining resources required for recovery (Jenkinson et al., 2021).

Affordability. The more affordable a service, the more likely it is to be used. In the U.S., individuals with health insurance are significantly more likely to use hospital, mental health, and substance use treatment services (Linton & Shafer, 2014). Although affordability is embedded within the Canadian health care system, additional insurance coverage can help individuals receive services beyond their basic health needs (e.g., specialized services in the private sector). The affordability of appropriate services (e.g.,

housing, primary health care) leads to profound cost savings in the long run (e.g., fewer emergency department visits and extended hospitalizations; Culhane, 2008; Hoch & Trenaman, 2020).

Appropriateness. An appropriate service is tailored to suit the needs of its target population and may include collaboration between agencies to achieve better client responsivity. For example, services that address individuals' basic needs while simultaneously providing vocational and life skills have been linked to better physical and mental health outcomes (Kozloff et al., 2013). Furthermore, having appropriate assistance and support in the transition from homelessness to stable housing is instrumental in achieving and maintaining permanent housing (Mares & Rosenheck, 2010; Goering et al., 2014; Patterson et al., 2015). The At Home/Chez-Soi Canadian housing research project found that 62% of individuals included in Housing First condition, which included appropriate staff support, were continuously housed for the final six months of their project (Goering et al., 2014). In contrast, only 31% of the treatment as usual condition had that same success (Goering et al., 2014). Service providers may be able to assume this role for individuals without adequate support (Paat et al., 2019).

Understanding Responsivity to Services Within an Access Framework

Responsivity refers to the factors that maximize one's ability to effectively engage with resources or interventions (Andrews et al., 1990). A prerequisite for service use is the accessibility of said service, and one's level of access is determined based on the fit between individual characteristics (e.g., perceived level of need, motivation to access services) and the characteristics of the system (e.g., price of services,

availability). This fit also can be understood as a responsiveness factor for overall service use.

Study 1 of the current dissertation evaluated barriers and facilitators of service access from the perspective of service providers. Research questions for Study 1 sought to understand how barriers and facilitators to access of services are shaped by service providers and highlight suggestions for positive change from their perspective.

Research Questions

1. What are barriers and facilitators to service use from a service provider perspective?
2. What do emergency shelter staff perceive as factors most important to increasing responsiveness to service use?
3. Are there barriers and facilitators that are uniquely highlighted relative to those suggested prior to the COVID-19 pandemic?

Method

Participants

Fifteen staff members met eligibility criteria for the initial study (i.e., working at the John Howard shelter over the last two years), and 11 (73%) agreed to participate. Given the relatively small sample size, to ensure the protection of clients' identities, only demographic information that cannot lead to client identification was provided (see Table 1).

Although 15 was a more desirable N, 11 interviews are a valid representation of the staff perspective from this shelter. Moreover, because previous community research has examined the service provider perspective (Cusack et al., 2021; Henwood et al.,

2011; Kerman et al., 2021), this foundation of research can be used to buttress the service provider perspective when making comparisons to service users (in Study 2 and Study 3).

Table 1

Demographic Characteristics

% (<i>n</i>)	Full Sample (<i>N</i> = 9 with background data, 11 total)
Age [<i>M</i> (<i>SD</i>)]	31.2 (15.28)
Gender	
Women	77.8% (7)
Men	22.2% (2)
Education Level	
Completed high school	22.2% (2)
Community college	11.1% (1)
Undergraduate degree	66.7% (6)
Employment [%]	
Employed part time	44.4% (4)
Employed full time	55.6% (5)

Procedure

Qualitative Interview Guides

Preliminary versions of semi-structured qualitative interview guides for both service providers (Study 1) and service users (Study 2 and Study 3) were created simultaneously. Questions were open-ended and covered two main topics: (1) background information to contextualize their current experience (e.g., how do you [service provider] interact with individuals experiencing homelessness (2) perspective on service use and availability of services (e.g., what, if anything, do you think is missing from available services?). Carefully worded open-ended questions can encourage rich talk, which refers to the language and phrasing people use when they speak freely and comfortably (Magnusson & Marecek, 2015). As recommended by

Kallio and colleagues (2016), preliminary interview guides were refined based on consultation amongst the research team, and the modified version of these guides were shared with other key stakeholders including staff members, individuals with lived experience, and outreach workers, to ensure comprehensive coverage of research topics. Stakeholders were asked to review the organization, content and language in the guide, and to provide strategies to increase engagement from interview sources (see Appendix A for final version).

The iterative process used to create these interview guides was in line with a participatory action framework, which aims to embed the perspective of individuals with direct experience of a system or agency, into the data collection and analytical process (Levac et al., 2019). These potential research participants (i.e., staff members at John Howard) also contributed to co-researcher roles at this stage of the process. For example, primary results from Study 1 were presented at a staff meeting to gain insight to contextualize interpretation of these data and guide questions that should be asked in Studies 2 and 3. Addressing a problem as complex as homelessness requires reciprocal collaboration among researchers, policy makers, and frontline staff members (Gaetz, 2014). The traditional process through which research projects are conceptualized and executed often fails to include potential end users in the world of policy and practice. Therefore, it is important to consider innovative methods of knowledge mobilization to ensure that the valuable data collected is accessed by those with the ability to shape public policy. Social science researchers can assume a knowledge translator role in aiding the implementation of their research into social policy (O’Sullivan et al., 2021).

Data Collection Process

Data for the current dissertation were collected in sequences that allowed preliminary findings from each study to inform data collection in subsequent studies. Previous researchers (Baker & Edwards, 2012; Guest et al., 2006; Marshall et al., 2013) recommend a minimum sample of 12 participants to reach saturation for each group, as novel themes are considered to emerge infrequently with additional participants. Although the present study fell slightly short of this number, the sample represents a sizeable proportion of service providers employed by the agency and, thus, staff perspectives are likely broadly representative. University of New Brunswick ethics approval was obtained for this study (REB-2020-116).

John Howard Society staff were invited to participate via email rather than in-person, to ensure they did not feel undue pressure to participate. The primary investigator also proposed the research project to staff members in person at the shelter and shared contact information with them. To ensure that participation in the interviews was completely voluntary, staff were not informed of who agreed or declined to participate. Once participants had agreed to participate (via email or in-person), they were provided a consent form outlining the current project (see Appendix C) and asked to complete a background questionnaire (see Appendix D). They subsequently engaged with a member of the research team in a 30- to 45-minute interview over the telephone, Microsoft Teams, or in person, based on their preference. Immediately following each interview, participants received a debriefing form via email that explained the study, how the results would be disseminated, and researcher contact information (see Appendix E). In particular, they were informed that a summary of the results would be disseminated to the John Howard Society Shelter to inform effective services and that

they may request a copy of the results upon study completion. All participants were remunerated with a \$10 Tim Hortons gift card. Interviews were transcribed verbatim by members of the research team.

Data Analysis Approach (Thematic Analysis)

Thematic analysis (TA) is a method of data analysis that falls within the qualitative research framework and is not tied to any specific theoretical orientation (Braun & Clarke, 2012). Because TA is a broad analytic method, it has been recommended that researchers outline the steps and decisions they made to inform the type of TA they used and to rationalize their decisions (Braun & Clarke, 2006). The coding and analytic process uses both inductive and deductive procedures, as it is impossible to hold only one perspective while analyzing data (Malterud, 2001). For example, preconceived notions, media portrayals, and familiarity with extant research on homelessness lead to some deductive reasoning being present in analyses of this data. Being intentional, deliberate, and consistent in the coding process helps minimize the infiltration of bias into the analysis (Stiles, 1993).

Braun and Clarke (2006) outline six fundamental steps involved in TA: (1) familiarization with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing potential themes, (5) defining and naming the themes, and (6) producing the report. As recommended, each of these steps were followed during the current study's analytical process. The first step, familiarization with the data, included reading the interview transcripts critically to begin making meaning of the data and taking note of any broad, prominent patterns. The aim of this step was to notice how participants engaged with the interviewer and how they may conceptualize the world around them. It

was important to read the entire set of interviews to gain a comprehensive overview of the material.

The second step was generating initial codes. Codes provide a way to organize data that are relevant to the research questions and act as categories in which data may be sorted. Many initial codes were revised and transformed upon additional review of the transcripts. Although TA does not provide specific guidelines for how to sort the data into codes (e.g., sentences versus paragraphs), it is important to code most of the data to ensure that important information shared by participants in their interviews is not missed. Braun and Clarke (2006) explain that an adequate number of codes are needed to capture the diversity of perspectives and that codes should appear across interviews to indicate a discernable pattern in responses.

The third step involved searching for themes, which was an active process of meaning making. Themes help make sense of the connections between codes and tell an *overall* story about the data. The fourth step involved reviewing potential themes in an iterative process to ensure that selected quotes are reflective of patterns that arise in the entire set of interviews. For example, I often considered what percentage of the total data was coded into a particular theme. Finalized themes needed to have enough depth to convey the richness of the data but be concise enough to not overwhelm the reader of the final report. It was important to consider the salience of themes on their own (i.e., how important they are to the overall story) and how they worked in relation to each other (e.g., does one theme contextualize another).

The fifth step of TA involved defining and naming the themes. Their names must be unique, insightful, and have a singular focus. Although themes can be related, they

should not overlap to avoid redundancy and should be pertinent to the research questions. The quote selection process was extensive (e.g., choosing many potential quotes at the outset and narrowing down over time) to ensure the *best* quote was chosen to exemplify a particular theme.

The sixth and final step of TA was producing the report. The purpose of the final product is to provide a comprehensive interpretation of the interview data in a compelling narrative. In other words, I connected the identified themes in a logical and meaningful way to tell an overall story while ensuring any claims made in the global narrative were supported by quotes from the data. The flexible nature of TA and lack of theory-imposed limitations made it an ideal approach for my dissertation.

Researcher Frame of Reference

An important component of qualitative research involves acknowledging how an individual's experiences and unique frame of reference shape their research design and analysis (Stiles, 1993). As such, it is vital to acknowledge how my values and experiences have shaped my interest in the topic. I was raised in a multi-generational household and am a third-generation Canadian. My parents and grandparents are entrepreneurs who experienced significant upward mobility through their lifetimes, achieving a degree of financial stability above that of the generations before them. Their experiences and values, such as an emphasis on education, have shaped my worldview while allowing me to live a relatively privileged lifestyle. I attended a private high-school and college, which provided a clear advantage on the path to graduate education. In addition, my parents funded my university pursuits across Canada. I must acknowledge I have faced limited adversity, in part due to the sacrifices they made. As a

result, my privileged societal position will inherently shape the way I initially evaluate the data.

Although this primary response is out of my control, some notable experiences have granted me exposure to others with different and valuable lived experience, which have shaped my resulting worldview. For example, as a youth, I worked as a leadership counselor at a YMCA Camp that fully subsidized 20% of their campers. As a result, many adolescents who attended camp had limited resources and often came from precarious living situations. This early experience working with vulnerable youth helped me to acknowledge my privileged position in society. During my undergraduate studies at the University of British Columbia in Kelowna, volunteering at a halfway house gave me first-hand experience interacting with many individuals who had experienced the rotating door from incarceration to homelessness.

My interpretative lens is influenced by a belief that marginalized individuals face multiple intersecting difficulties and that their voices are infrequently and inadequately represented in policy decision making. My lived experience as a member of the queer community has strengthened my desire to amplify the voices of individuals who are traditionally marginalized. My invisible queer identity makes me less likely to make assumptions about participant identities during my interviews. Furthermore, the overrepresentation of 2SLGBTQIA+ individuals who experience any form of homelessness makes my interest in this stream of research much more personal. In addition, my research approach has been impacted by my graduate training in clinical psychology, which emphasizes person-centered and strength-based values. To account for the inherent influence of my biases, I kept a detailed account of my rationale for the

various decisions I made during the coding process. Ongoing feedback from my supervisory committee helped safeguard against biased interpretations.

It is also important to consider how participants interviewed for the current dissertation (i.e., service providers and service users) perceived me, and how this may impact the information they were willing to share. To increase my credibility and affiliation with both groups for the present dissertation I deliberately took several actions. Before conducting any interviews with service providers, I attended a staff meeting to introduce myself and present the goals of the current project. I answered staff questions to demonstrate my knowledge of the literature while developing rapport with potential participants. I provided as much flexibility as possible in scheduling and let staff ask further questions about me and my research at any point in the process.

Prior to conducting interviews with service users, I went to the shelter for a few evenings during intake hours (e.g., when most service users are present) to make myself a more familiar presence. I explained who I was, what my research was intended to achieve, and engaged in friendly conversation. I was mindful about my appearance and did not wear brand-name clothing or jewelry to appear as approachable as possible. I parked away from the shelter to keep participants from seeing the older Audi I drove at the time. I was open and honest in answering any of their questions about who I was and was non-defensive if they denied participation in the project. Of note, once I completed a few interviews for Study 2 and Study 3, participants started to speak to their friends about me as a safe person to whom they could talk. As a result, a few participants who had initially refused interviews became amenable to the project and approached me to

take part. I believe the relationships I was able to create with these participants led to their candor and honesty during the interviews.

Results and Discussion

The following section provides a synthesis of the perspectives of shelter service providers regarding factors impacting homelessness, housing acquisition, and barriers and facilitators to service use. Table 2 provides an overview of themes and key points highlighted by service providers in the study. Titles which are bolded indicate that the theme is unique to the current study (i.e., staff perspectives). Moreover, citations following statements made by staff participants demonstrate extant research with similar findings. Within each subsection, themes are ordered according to the extent to which they were discussed by participants, while accounting for their salience, novelty, and potential policy impact.

Table 2

Themes from Service Provider Perspective

Provider Perspective Themes (Study 1)
Perspectives on housing <ul style="list-style-type: none"> Desire for affordable housing Barriers to obtaining housing Housing market changes
Evaluation of shelter environment <ul style="list-style-type: none"> Positives of the emergency shelter <ul style="list-style-type: none"> Importance of flexibility in shelter regulation and policy enforcement Positive staff relationships Negatives of emergency shelter <ul style="list-style-type: none"> Limited hours Lack of skill building Policies as deterrents
Staff experiences at shelter <ul style="list-style-type: none"> Challenges staff face at work Systemic barriers impeding job performance Advocating for emergency shelter resources

Staff perspectives on service use
Services available and used by shelter clients
Perceived barriers to responsive service use
Systemic barriers
Impeding beliefs
Practical barriers
Facilitators of service use

Suggestions to maximize engagement
Systemic changes
Practical solutions proposed

Transitions to permanent housing
Importance of appropriate supports to facilitate transition

Staff issues concerning substance use
Prevalence of substance use disorders
Impact of substance use on service engagement

Staff perspectives on COVID pandemic
Difficulty enforcing regulations
Decrease in same-day service availability (e.g., no walk-ins)

Staff responses to police intervention
Differential perspectives on police presence

Cultural impact of service engagement
Contribution of faith-based organizations

Perspectives on Housing

The desire for clients to have access to affordable housing was as pervasive among staff members as it was among shelter clients (see Studies 2 and 3). One participant stated: *“I think ideally shelters would be putting themselves out of business, you know, by getting people housed.”* (S_10). Staff members explained that clients’ most frequent plea was the desire to move into a place of their own. The lack of affordable housing and decrease in vacancy rates in any city amplifies the difficulties in securing housing options for those currently experiencing homelessness (Rukmana, 2020). For example, one employee explained that the limited number of affordable units are substantially more likely to be rented to a student than to someone experiencing homelessness, regardless of available government subsidies: *“... [it’s]the lack of*

availability, and it's the lack of affordability in the city, as well as just the fact that landlords have preferences.” (S_03). They elaborated, stating that obtaining housing is challenging for individuals who have been unsuccessfully housed in the past because landlords are hesitant to accept them based on their housing history: “... *[if] they've been housed a couple of times already in the city, and landlords talk [to each other] so no landlord, even if we were to offer them a subsidized housing offer from social development, the landlord would say no.” (S_03).* Landlords hold substantial power in determining availability and quality of housing options for these individuals (Elsinga, 2015). Given the limited number of landlords in Fredericton, they hold even more power over whether individuals may be permitted to reside somewhere than do landlords in larger cities. Displacing or evicting problematic tenants can be an opportunity to obtain higher rental prices with new contracts (Soederberg, 2018). In addition, even when housing is available, its characteristics may not be a match for client needs:

“If a client is like 70 years old, you need a house that's [suitable] for elderly people that doesn't have stairs or something ... we have a bunch of clients that are very in need of housing. But there just isn't any housing that matches [their needs] or any housing at all.” (S_06).

Staff members were optimistic about the potential positive impact of a recently funded supported housing complex (the Oak Center, as described in Study 3). They believed these units would provide a way to house individuals with complex needs and a history of unsuccessful tenancy.

Shelter employees also spoke about how the housing market drastically changed in response to the COVID pandemic, as an influx of individuals from other provinces

had inflated property values, making it more difficult to secure appropriate housing options (Chapman et al., 2021). Inflated property values impact housing obtainment in multiple ways. First, they led to reduced housing availability because of interprovincial migration. For example, estimates of interprovincial migrants from Ontario to New Brunswick increased from 4,405 in 2019/2020 to 9,895 in 2021/2022 (Statistics Canada, 2023). Second, inflated property values also make purchasing a house unaffordable for many individuals, especially those without generational wealth, driving up demand for rental units and property, compounding the already limited supply. Finally, as property taxes and other fees rise because of inflated property values, rental cost must increase to cover owners' growing costs.

Evaluation of Emergency Shelter Environment

Staff members perceived benefits to the emergency shelter environment. They believed the shelter provided a place for individuals experiencing homelessness to stay warm and sleep, meet their basic hygiene needs, and foster an opportunity to connect them to other community services. Employees also perceived their level of tolerance as a team to be higher than staff members at other shelters in town. One interviewee expressed this belief by stating: *"We put up with a lot. So, you know, if you yell at a staff member and swear, then we'll ask you to please quiet down, whereas I think most shelters would kick you out."* (S_08). This participant indicated that greater tolerance allowed for stronger relationships with staff members, which is an important predictor of service use (Peters et al., 2022). They also reported that, in contrast to what individuals may experience at other shelters in town, shelters users are allowed to be intoxicated at admission: *"Or the fact that we won't turn people away just because they*

might be intoxicated coming into the shelter.” (S_10). This policy was thought to substantially reduce barriers to access to the shelter. Shelters can act as a safe haven from illicit substance consumption in a public space while remaining a risk environment because drug use must be hidden from staff (Wallace et al., 2018).

Employees felt strongly about limiting the number of bans they imposed on emergency shelter users. Staff members felt this leniency was especially important given many users had been permanently banned from other shelters in town. Employees felt that their shelter was the users’ “last chance” and were hesitant to limit their access to it. One staff member explained:

“If they get kicked out or lost their spot or whatever, there’s nowhere else to go except here or on the streets. So this would be like their last resort.” (S_11).

Given this leniency, employees felt that clients at this shelter often had higher acuity needs than those in other shelters: “...we get the most complicated individuals in Fredericton... so sometimes it is hard...we do have to tolerate more behaviour than usual.” (S_06).

Positives of the Emergency Shelter Environment

Staff members explained that the shelter offered a physical space for clients to meet with their housing or intensive case manager as a means of connecting them with other community services. Moreover, shelter employees vocalized that they took phone messages from other service agencies and delivered them to clients (e.g., reminding them about an upcoming appointment at the local health clinic). One interviewee explained:

“[The community agency] will contact us through the shelter and just ask us to either let them know to give him a call or we’ll organize appointments through them and just talk to them and be like the messenger between the two.” (S_01).

Staff members believed that helping to reduce the administrative burden of connecting to community resources increased the likelihood of appropriate engagement from shelter users. This perspective is consistent with research suggesting that practical and administrative burdens like transportation and scheduling are salient barriers to service use among this population (Hauff & Secor-Turner, 2014). Staff members stressed they were as flexible as possible within the constraints set by the organization. For example, when shelter clients expressed disdain at the limited 15 minutes allotted for showers, staff members adapted:

“And then we changed to half an hour, like 30 minutes. So I think that was a good move. We take into account if people don't get along, like if they come to us privately and [say], ‘Listen, I really... We don't get along for whatever reason, like do you think I could go to a different bed...’ We could definitely do that for them.” (S_11).

Staff members reported that flexibility is often impeded by external constraints such as shelter policies, lack of funding, and training. This view is consistent with Canadian research highlighting that community organizations serving individuals experiencing homelessness are under-resourced to meet clients’ support needs (Kerman et al., 2022). Irrespective of systemic limitations, shelter staff emphasized their attempts to build strong relationships with shelter clients through humour and genuine curiosity. They believed that positive interactions helped improve their clients’ quality of life:

“Some of them talk more than others so you end up having some conversations with them and some of them are a bit more like, you can’t play with them, but kind of interact a bit more and joke with them a bit more than with others, so I think that can make their day a bit better.” (S_02).

Employees felt this positive regard for their clients helped ensure mutual respect between them and shelter clients. They believed the shelter ran more smoothly as a result of their efforts:

“I think it's grown to be a mutual respect with staff and with folks that are staying there. They just they know what to expect now and they know what's acceptable and what's not and they're doing really well.” (S_03).

Negatives of the Emergency Shelter Environment

When asked about the limitations of the shelter, participants were quick to emphasize the temporary and emergency nature of the service. They stressed that, although clients were provided with certain necessities including a bed to sleep on and a shower to use, shelter users had many needs that were not being met. Staff members spoke about the lack of permanent storage for client belongings, the ban on food or medication dispensing because of COVID pandemic regulations, and limited opportunities for recreation. They explained that, at another location in town, shelter residents were only allowed to stay inside between 9PM and 7AM: *“they don't have any access to the building or the property during the daytime” (S_07)*. These limited hours often forced individuals onto the street for extended periods of time with limited options for shelter or recreation. Employees also felt that the shelter was unable to foster skill building among residents: *“besides keeping people alive we’re not doing [anything];*

there's no skill building occurring.” (S_08). They believed that providing opportunities for clients to learn marketable skills was an important step in building readiness for housing and employment maintenance (Bretherton & Pleace, 2019).

Employees indicated that certain shelter policies may act as deterrents for clients. For example, staff remarked that the co-ed nature of the shelter environment may make some women feel uncomfortable, shelter users who are in romantic relationships are unable to share a bed with each other, and banning substance use within the shelter may reduce shelter access. Moreover, if residents were to leave the shelter past 11 pm, they would not be allowed to return until the following day. The limitations on re-entry were perceived as particularly impactful for shelter users who smoke tobacco, as having to abstain from nicotine use for over 8 hours was a deterrent to shelter use. Systemic characteristics of a shelter like specific program availability, service location, and sanitation practices, play a significant role in maximizing access (Shier et al., 2007).

Experience of Staff Members in the Emergency Shelter Environment

Staff members outlined their specific responsibilities and explained how they provide care at the shelter and connect shelter users to other services in the community. Most employees reported learning about community resources through a shelter-created document titled the *‘Helping Tree’*. This document outlines community services that individuals can access according to different domains of need. Although staff outlined multiple obstacles they face in providing care to clients, they also spoke about positive relationships they have with other service providers. For example, interviewees described sending shelter clients to the local health clinic, connecting them with the local government social services agency (i.e., Department of Social Development), and

referring them to a regional non-profit agency focused on supporting safer sex and drug use in the community (i.e., AIDS NB).

Challenges Emergency Shelter Staff Face at Work

Most staff members reported difficulty with the rule enforcement included in their work responsibilities. For example, some felt that shelter clients believed any rule infringes on their freedoms:

“We needed to make sure that there were rules, but as soon as you crack down on rules they're going to say, ‘You know we hate that place because they live outside and there aren't a whole lot of rules outside’.” (S_03).

Staff members opined that rules were especially difficult to enforce when they were contrary to their own beliefs or desires:

“You know, you wish that you could let them stay at the shelter longer on rainy cold days, but you know, you can't. It's things like that, you know, that you wish there was something that you could do but you know that there isn't.” (S_07).

Staff outlined difficulty with balancing what they perceive to be two opposing responsibilities, (1) flexibility and openness and (2) boundary enforcement: *“It's hard to balance boundaries and being sort of a figure of authority with also being friendly” (S_10).* This dual-role conflict is consistent with a recent systematic review by Peters and colleagues (2022) which found that boundary negotiation is a common struggle for staff members working with individuals experiencing homelessness. Staff often felt the shelter was understaffed, which amplified existing concerns about compassion-fatigue, and led to perceived sub-standard care (Waegemakers Schiff & Lane, 2019). Staff members in shelter environments often carry high emotional burdens, have heavy

workloads with low wages, and receive insufficient training – all factors that negatively impact employee mental health (Kerman et al., 2022). In the current study, one participant vocalized:

“Being short-staffed and staying overnight would have been ... the two most difficult things for the workers themselves. And because of that, sometimes it would be really tiring to provide the perfect services we could have if we were not staying overnight.” (S_08).

Others expressed that the shortage of staff members and limited training contributed to feelings of exhaustion post-shift: *“... it is a bit hard, sometimes I kind of feel drained after a shift because of having to put up with a bunch of stuff” (S_06).*

Shelter staff expressed frustration about certain interactions with shelter clients (e.g., denial of assistance). One staff member recounted a challenging experience wherein they had offered support to an individual that was subsequently refused: *“When I would [offer to] provide some support system that could help them sometimes people would refuse it.” (S_05).*

Staff members spoke at length about systemic factors that impacted their ability to perform their job at a desired level (e.g., limited funding, employee turnover, occupational burnout, lack of appropriate training; Olivet et al., 2010; Yamada, 2022). One participant explained that the lack of service availability made them feel ineffective at their job: *“I don't think there's a single service in the city that's not completely at max capacity right now... so much of our job is referral to different services and there's nothing left... so that's a big challenge.” (S_03).* Others expressed feeling unprepared or unable to deal with the complex mental health needs of many clients: *“Even though we*

do have training, a little bit of training on that, we're not licensed psychologists or anything ... that's not enough ... they do need to be seeing a counselor.” (S_05). Lack of appropriate training is often cited as a barrier to appropriate care provision in the shelter context (Kerman et al., 2023). Although staff yearned for extra learning opportunities, no interviewee explicitly discussed their own professional responsibility to enhance their competencies independent of whether the employer is providing such training. For example, none spoke about attending online webinars on topics of interest (e.g., maximizing treatment engagement). It is possible staff had independently sought out additional learning, but the interview questions did not explicitly ask about this possibility. Instead, staff members tended to focus on their employers’ responsibility to provide this training in their interviews. Recent research by Lenzi and colleagues (2021) found that the availability of relevant training and appropriate supervision was positively related to work engagement and negatively associated with employee burnout among staff serving individuals experiencing homelessness. Specifically, training with high perceived usefulness was most protective against burnout symptoms (Lenzi et al., 2021).

Advocating for Additional Resources in the Emergency Shelter System

Shelter employees craved additional training opportunities and believed they would be in a better position to help shelter clients as a result: *“I think if I had more knowledge on it, I think that would help them a lot, because I know to ask a lot of questions about things and I don't always know the answers to it.” (S_11).* Staff members were especially interested in receiving more training in mental health, addictions, and conflict de-escalation. Staff members expressed that alternatives to

traditional police presence would likely result in more compliance for shelter residents who were breaking a rule: *“I think using a social worker instead of the police would be a lot more helpful because they don't particularly like the police just because they usually get in trouble with them a lot.”* (S_01). Research on the use of co-response teams (i.e., a law enforcement officer paired with a mental health professional) to behavioural crises has shown increased access to care and cost savings while limiting arrests and repeat calls for service (Kridler et al., 2020). Modifying traditional policing practices in this way is likely to increase service engagement and minimize harm (Batko et al., 2020; Cohen et al., 2019). Non-police crisis response teams, which divert calls away from police for mental health or substance use crises, have also been deemed effective. For example, the Crisis Assistance Helping Out on The Streets (CAHOOTS) program in Oregon diverts between 5-8% of calls that would have been traditionally responded to by police (Spolum et al., 2023).

Given that participants felt systemic factors impacted their job performance, it follows that they would yearn for changes at the macro level to address the root causes of homelessness. For example, one participant explained that their job would be much easier if more affordable housing existed: *“What would make my job easier is just more, more housing ... and more service providers to help with that transition”* (S_03). Staff members emphasized the importance of additional support staff to adequately meet client needs both inside and outside the shelter (Olivet et al., 2010). For example, they explained that housing would be incredibly difficult for shelter clients to maintain without appropriate transition support. Although staff members did not specify who would be best suited to provide such support, they spoke about various domains with

which an individual in transition may need help. Specifically, staff members described a need for support with financial planning (e.g., appropriate budgeting), start-up costs (e.g., furnishing their new space), tasks of daily living (e.g., cooking and cleaning), and mental health (e.g., medication reminders).

Staff Perspectives on Emergency Shelter Client Service Use

Services Available and Used by Clients

Shelter staff members spoke comprehensively about the services clients had access to at the shelter and in the community. They referenced services for multiple domains of functioning including physical health like the pharmacy, hospital, and downtown health clinic; addictions services including detox at the hospital, AA/NA programs, faith-based residential facilities and community harm-reduction agencies; mental health mobile crisis services; and basic needs like food offered through community kitchen and laundry services. Participants stressed the need for recreation, employment training, clothing procurement, and warming centers in the city. When asked why they believed service users engaged with services, they reported that clients did so for many reasons: “... *there wasn't a single reason why people would come to the shelter, it's very personal, a lot of the info is different from one another ... it was different for every single person.*” (S_05). The variability in service users’ motivations for service engagement strengthens the rationale for highlighting their lived experience (see Studies 2 and 3).

Perceived Barriers to Responsive Service Use

Systemic Barriers. Staff members spoke about the negative impact of systemic barriers such as chronic understaffing and limited opening hours on service use. These

systemic barriers lead to practical obstacles to service engagement, including long waitlists:

“The mental health system here isn't the greatest and there's a huge waiting list, so it can be up to six months before you can see somebody just for your initial appointment, [and] some of them don't have that kind of time, they need the help now and they can't get it, which could be really problematic.” (S_01).

Other systemic barriers include the lack of affordable housing and limited staffing across public sector services. Staff members also felt that complex client needs make it difficult for government policy to identify and fund appropriate services (Olivet et al., 2010; Wusinich et al., 2019).

Impeding Beliefs. Feelings of fear and shame due to substantial societal and service-related stigma were cited as significant barriers to service use. *“So I think that a huge reason [to avoid services] is they're afraid of being judged for either having mental health issues or using drugs or being in trouble with the law.” (S_01).* Consistent with previous research (Kerman et al., 2019; Kryda & Compton, 2009), staff members indicated that negative past experiences have entrenched unhelpful beliefs about usefulness of services among service users: *“... building that trust, perhaps because of negative experiences in the past, kind of takes a while.” (S_08).* These experiences complicate the service use process and highlight the need for empathetic staff members who are equipped to challenge clients' negative beliefs.

Some staff members believed that rules or prerequisite conditions make engagement more difficult for clients: *“... sometimes rules are applicable to why they might not want to, or some people are very nervous.” (S_09),* and others believed that

clients lack insight about the struggles they are experiencing: *“Sometimes they, sometimes they just really don't want help, and they don't think there's [an] issue, so that is also a really big problem when they don't see the issue themselves.”* (S_01). One interviewee explained that if clients feel disrespected or punished for using a service, they will be unlikely to use it again, consistent with prior research by Bond and colleagues (2022): *“And I think that's actually a way that some clients sort of exercise agency, [by] choosing not to use services in places where they feel disciplined or disrespected or not taken seriously.”* (S_10). Negative past experiences with a service diminish service users' desire to engage again (Black et al., 2018; Wusinich et al., 2019). The negative impact of this avoidance is amplified in a smaller city like Fredericton, New Brunswick, where there are fewer overall resources to choose from. Disengagement from a service addressing a particular need (e.g., mental health services) becomes more problematic when there are few, if any, other services targeting that same area of difficulty. When limited resources exist, individuals are left with the limited choice to either continue using a service they disliked or to risk not having their needs met due to unavailability of service. Should these individuals choose to decline service use, they would likely experience an exacerbation of symptoms and worsened psychosocial outcomes over time.

Practical Barriers. Practical barriers often impede service access and engagement (Bond et al., 2022). For example, some staff members highlighted the challenge of clients making and keeping appointments without a phone:

“Some of them don't have a phone, so it can be hard to get in contact with them or to locate them. So, if they have appointments, you just have to depend on them

coming to the shelter in order to talk to them ... Or some of them don't have a good sense of time [when] they do have appointments with somebody.” (S_01).

Opening hours play an important limiting role in service use. For example, staff members explained how the mobile crisis hours may not be aligned with the needs of the community:

“A lot of services stop working at midnight and on the weekends. It's like 10 or 11:00 PM. So if somebody is being suicidal and [they] need a certain helpline ... usually that happens after midnight, so if that was to happen they don't have that service, so they have to wait until the morning.” (S_02).

This discrepancy between the needs of individuals experiencing homelessness and the availability of current services highlights the importance of further research and of knowledge mobilization back to the community. Modifying opening hours to better match these needs may improve the fit between available services and individual needs. Finally, consistent with previous research (Ha et al., 2015; Sylvestre et al., 2016), transportation to services can act as a huge barrier to service access:

“I remember people saying that they had to walk all the way to downtown from somewhere else to get food ... the Fredericton kitchen ... they were only open for a certain number of hours, so it was pretty limiting. (S_05).

Participants stressed the importance of having services within walking distance to maximize engagement. They felt having services in the city center would lead to increased uptake. At the time of interviews, there were no drop-in centers available for individuals experiencing homelessness in Fredericton. Staff suggested that having warming shelters in the city center would address the problem of limited shelter opening

hours: “*So 7 hours of the day they are left to the elements ... that’s quite a lot of hours ... especially in the winter.*” (S_07). The limited opening hours are consistent with the traditional emergency shelter model which expects users to leave in the morning and return at night (Gilderbloom et al., 2013). It also is possible that opening hours are limited due to funding constraints (Gilderbloom et al., 2013). Research suggests that day centers provide an opportunity for individuals experiencing homelessness to acquire material resources and provide a space free of social stigma where they do not have to justify their presence (Johnsen et al., 2005).

Staff Perceived Facilitators of Service Use

Staff explained that external services perceived as non-judgmental are much more likely to be engaged with by service users (Armstrong et al., 2021; Carver et al., 2020; Schmidt et al., 2023). One interviewee explained how they stress this aspect of a substance use harm-reduction service when recommending it to client:

“So usually we just tell them to go there and it’s judgement-free completely. They can go there, they can get their clean stuff, they can dispose of anything they need to and not be judged because of it.” (S_01).

Research suggests that staff members have a considerable influence on the perceived acceptability of a service, as those services with more approachable staff members are most likely to be appropriately used (Armstrong et al., 2021). Staff emphasized the importance of warm, patient, and open staff attitudes to increase engagement, and that positive attitudes profoundly influence the service environment. As a result, staff members understand that they have a significant impact on the perceived value of any service: “... *the most important factor in service utilization [and*

what] determines the outcome of that client's experience is their interaction with the people who are actually offering that service.” (S_10). Staff members attributed a substantial portion of clients' desire to use the service to their ability to create a safe community:

“I think that there's definitely a sense of community that is a big draw for people and I know that because clients have said that before. Especially if your lifestyle is sort of, you know, inherently like unstable, I think being able to go to the same place every night and see the same couple of staff members on rotation and see the same group of people can be like very comforting.” (S_10).

Staff members felt they were fostering a safe and accepting environment at the shelter and believed it was an important facilitator for shelter use (Kerman & Sylvestre, 2020). One staff member recounted how they helped a client navigate community resources when they identified a particular need:

“One of the residents was looking for some clothes from donations, but because of COVID we got rid of all the donated clothes. So we introduced the service in New Brunswick that had the van going around the community ... it was really cool to [help her] get some clothes that she wanted despite COVID, so it was really cool to see that connection between different services in Fredericton.” (S_05).

Staff members felt that clients were more likely to engage with services when the initial connection was facilitated by them. *“Sometimes for them, hearing us say, ‘oh, you should go there,’ or do try to encourage them ... they might look at it a different way because nobody else has said it that way.” (S_02).* Staff expressed pride in the

relationships they had fostered with other services in the community and felt these connections facilitated prompt, integrative care for their clients:

“There is a small community of services that can be provided ... it's been so helpful to just call somebody up and get the information ... it gets resources up quicker and ... that's improved within the last two years significantly.” (S_03).

Staff members felt that services worked especially well when flexibility was embedded into their model (Carver et al., 2020; Parkes et al., 2021): *“... doing what needs to be done so that this client uses this service and making it something that they want to use. So, I think that's very effective.” (S_10)*. Based on the literature, a flexible service would operate within trauma-informed guidelines, offer drop-in services, have extended opening hours, prioritize individual client needs, and treat clients with ongoing respect (Rice et al., 2023).

Suggestions to Maximize Service Engagement

Shelter workers had many suggestions to help maximize service engagement within and outside the shelter.

Systemic Changes. Above all else, staff members emphasized the need for additional housing: *“Obviously, there's only so many subsidized units in the city, and there's only funding for some caseworkers, and so that's, again more structural issues.” (S_10)*. Staff members emphasized the importance of funding additional mental health and addiction services, consistent with other research (Canavan et al., 2012; Olivet et al., 2010): *“I would definitely look into somehow getting them more resources to mental health and addiction and treatment centers, like rehab centers, because there isn't a lot of space in those and it's really a case-by-case [need].” (S_01)*. Shelter employees

believed that the hours of existing services could be extended to better serve the needs of clients (Gallardo et al., 2020). Moreover, interviewees expressed that because current services are structured in silos, developed primarily to address one need (e.g., mental health, physical health), there is a lack of integrated care available:

“... service gaps with folks who are struggling with addictions and mental health ... there are folks that will deal with one or the other... mental health staff are hesitant to take on new clients with brain injuries or who have suffered strokes or anything like that that could cause long term damage because it's not a mental illness and it's not necessarily treatable in the same way, so there's quite a large gap there we're finding.” (S_03).

Research suggests that individuals experiencing homelessness benefit from, and engage with, comprehensive tailored care that includes connections between relevant organizations (Ponce et al., 2018). To facilitate a move towards integrated care, staff members in the current study advocated for additional staffing at the shelter and for more case managers to be hired. Staff stressed that excellent client care would be more feasible if they had a more manageable workload, which is consistent with findings from previous research (Olivet et al., 2010; Lenzi et al., 2021; Kerman et al., 2022; Kerman et al., 2023). For example, staff reported that certain clients are being removed from case manager caseloads prematurely to allow for coverage of more urgent cases.

Participants felt that increasing training and recreation opportunities for individuals experiencing homelessness was an important target for change. *“So just finding something to do would be nice ... being out someplace warm and doing a hobby or something, getting a new skill would be a good idea, yeah?” (S_06).* They believed

that helping these individuals gain marketable skills would increase their self-efficacy and help them succeed in maintaining housing long-term. A recent meta-analysis by Weightman and colleagues (2023) found that including non-housing support needs in case management services was associated with more successful engagement with these services. These non-housing support needs included support related to education, employment, finances, and independent living skills (Weightman et al., 2023).

Staff members believed that government and nongovernmental agencies in the local municipality could address the barriers created by limited shelter opening hours by offering warming centers daily:

“If each of the churches of the big churches downtown took one day a week and ran a warming center, you know, [I think that] that would be of such benefit to them ... just a place where they can be safe and they can be warm.” (S_07).

Beyond the provision of physical respite, day centers create space for individuals experiencing homelessness to exist without needing to justify their presence or feel unwelcome (Johnsen et al., 2005).

Practical Solutions Proposed. Staff members highlighted two practical changes to improve the services at the shelter, transportation and staff attitude. First, to address the transportation barrier, staff members believed a transportation service could be implemented to help bring clients to important meetings and appointments:

“I was trying to raise money before the virus to get a van, [and] this van will go run around and pick these people up and bring him to the group and then bring him back after the group, and you know, while it's sitting idle it can pull out as an option and help people get from and to their appointments” (S_04).

Facilitating transportation to services would substantially reduce this important barrier to access for service users (Ha et al., 2015). Second, staff members believed that developing a culture of tolerance across other shelters would help increase appropriate engagement: *“And everyone, even myself, we deserve to have a day where we're angry, it's normal to feel that, so I feel like just more shelters that kind of tolerate [client moods] and understand more of that would be nice.” (S_06)*. This view is consistent with research suggesting that staff have substantial influence on the perceived usefulness of a service and that tangible ways to increase the approachability of staff members include learning client names, actively listening to and addressing their concerns, and validating their experiences (Bond et al., 2022).

Emergency Shelter Client Transitions to Permanent Housing

Asked if they had witnessed any shelter clients transition into permanent housing, almost half of the staff interviewees reported having seen (or heard of) a previous shelter client obtain housing. They expressed that individuals who were most likely to succeed at maintaining long-term housing were mostly self-sufficient at the shelter: *“... so it really is more of the people who are more stable and able to provide for themselves that were able to get housing.” (S_01)*. Interviewees emphasized the importance of client self-confidence and belief that they will be able to sustain their housing. Staff members felt that individuals who had minimal substance use and had found employment also were more likely to obtain permanent housing. On a systemic level, one interviewee described the importance of housing location in ensuring housing maintenance:

“One of the things that comes to mind [and] maybe feels manageable is an emphasis on the location of subsidized housing and having it be in [certain] parts of the city ... there are I think clients who find it very challenging to step outside of their normal routine and be in an area that’s unfamiliar, and be away from the people they know ... paying attention to where subsidized housing is located and making sure it meets the needs of the people who are using it.”
(S_10).

When asked about barriers to successful transitions to housing, staff members highlighted the practical barriers that complicate housing procurement and maintenance. Difficulty acquiring furniture, learning to manage finances, and deficits in adaptive skills (e.g., cooking, cleaning) were noted as potential barriers.

“They did not have furniture or plates and utensils and that was, I think that's kind of hard [because] they're trying to make that leap of either getting housing, and [for] some of them it's getting clean, but in their house, there is absolutely nothing to sit on.” (S_02).

Evictions shortly after housing procurement are a common occurrence, and staff members explained that guest policies can be challenging for these individuals to navigate:

“They've been living outside with their friends this whole time and now they get housing, and all of their friends are still sleeping outside. So immediately, of course, they're going to bring them in and let them sleep in their apartment and so it's the guests that are often the downfall for people's tenancy because landlords don't really like guests being over all the time [and] there are policies

[that dictate] you can't have people living with you while you're in subsidized housing.” (S_03).

Staff members stressed the importance of appropriate support during this transition. They explained that staff shortages and huge caseloads assigned to case managers limit their ability to help clients successfully navigate these transitions. Moreover, once a client has had one eviction, landlords are less likely to house them in the future: “... many [landlords], because they have had one very bad experience with them [as tenants] they just put a stop to it.” (S_06). A review conducted by Boland and colleagues (2018) evaluated positive factors of tenancy sustainment among individuals with a history of homelessness across four levels: individual, interpersonal, community, and structural. The researchers found the strongest predictors of prolonged successful tenancy were participation in specific programs in the Housing First umbrella, the provision of social support from friends, family, or staff members, and the onset of older age (Boland et al., 2018).

Staff Issues Concerning Substance Use

Rates of substance use disorders are high among individuals experiencing homelessness. Research suggests that almost 40% of those experiencing homelessness meet the criteria for an alcohol use disorder, and 25% meet criteria for a different drug use disorder (e.g., stimulants, opioids; Stablein et al., 2021). According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., DSM-5; American Psychiatric Association, 2013), an individual meets the criteria for a substance use disorder when they have at least two of the 11 symptom criteria and continue using substances despite substance use related problems or harms. The severity of the disorder

is specified based on the total number of symptoms an individual has across four domains: (1) impaired control, (2) social or relational impairment, (3) risky patterns of use, and (4) pharmacological criteria (American Psychiatric Association, 2013). In the current dissertation, the term *substance use disorder* is used in reference to the DSM-5 diagnostic operationalization. In contrast, the term *substance use problems* refers to individuals' perceptions of how substance use affects their lives more broadly. It is a term that allowed participants to more freely conceptualize the impact of substance use, including effects on interpersonal and emotional domains, which are not captured in the DSM-5 criteria. Finally, a few participants used the word addiction to describe their own experience with using substances, their perceptions of others using substances, or in reference to community services. This language was preserved to accurately reflect their perspectives.

Staff members discussed their perceptions of the impact of substance use among emergency shelter clients. Most staff members reported their belief that problematic substance use negatively impacted many individuals experiencing homelessness who visited the shelter. One interviewee reported that substance use was the most prominent barrier to service access: “...*crystal meth to me, that's the biggest problem I find, and really breaks my heart and I believe it's the nastiest thing that this world has seen.*” (S_04). Research with persons experiencing homelessness and severe mental illness has found that co-occurring problematic substance use was linked with poor outcomes (Gonzalez & Rosenheck, 2002). Further, perceived need for services predicted greater service use, suggesting that maximizing client motivation and readiness for change is especially important among those with substance use disorders (Gonzalez & Rosenheck,

2002). Individuals seeking treatment for their substance use often display a preference for harm-reduction approaches, and these approaches have been shown to be effective in the literature (Carver et al., 2020; Mostofi & Collins, 2023; O’Leary et al., 2024). A recent study found that tailoring substance use treatment for individuals experiencing homelessness, by either ramping up or scaling down the degree of support in response to client need, was perceived as especially important by service users (Paradise et al., 2023).

In the current study, staff members felt strongly about offering more comprehensive addictions services:

“We need a better detox in the city or something bigger and with the shelter in it, where ... we can offer them to go into that shelter and then go into a program and you know, give them that extra push that they wouldn’t normally have.”
(S_04).

Staff members also discussed the conditions for substance use in the shelter environment. They explained that enforcing regulations against consuming drugs or alcohol on site often frustrated shelter clients:

“We don’t allow the distribution or dealing of substances at [the emergency shelter] ... someone wanted to go use in the bedroom and staff said, ‘Well, I’m sorry like you can’t do that’. And as a response you know they throw the drugs at the staff.” (S_08).

Although substance use is prohibited at the shelter, they do allow individuals to store their illicit substances in brown bags and to retrieve them at the end of their stay.

Staff Perspectives on the COVID Pandemic

The impact of COVID was thoroughly commented on by staff members who explained that the pandemic had a significant impact on the shelter environment, and on what service providers could safely provide to service users (Goodwin et al., 2022). Shelter staff were required to ask illness screening questions, bed sheets were washed and changed daily, and masks were required until clients were in their beds. Shelter capacity was substantially reduced due to distancing requirements, food could no longer be served, and recreation events which normally contributing to a sense of community, were cancelled: *“a lot of the kind of aspects that made it feel a little bit more like home have been removed because of, you know, necessary safety precautions.” (S_08)*. Shelter employees felt it was difficult to enforce COVID regulations at the shelter: *“... they’re [the shelter clients are] kind of in their own bubble ... we [have] to force them to wear a mask now, and they’re not really happy about that.” (S_04)*. Their stated comments are consistent with research suggesting that shelter staff often lack the training and equipment required to adequately protect themselves and their clients against infectious diseases (Baral et al., 2021). Because some chronic physical ailments held by shelter clients mimicked COVID symptoms, staff members felt that risk management decisions based on screening questions were difficult to manage:

“[I’ll ask them] do you have a chronic cough and they’re like ‘Yeah, because I have a smokers cough’, so it’s hard to tell the symptoms sometimes... do you have a runny nose? ‘Yeah, because of the cold outside.’ It’s really hard to make out what is just a normal thing from them and what could be COVID.” (S_06)

Staff members also perceived the mental and physical state of clients to be deteriorating at a faster rate: *“Especially during COVID, [they] have nowhere to go [or]*

are experiencing significant mental health and poor physical health ... then they present the shelter with medical concerns that should be requiring hospitalization.” (S_08).

Research suggests that individuals experiencing homelessness have a higher risk of poor outcomes following infection (Tsai & Wilson, 2020). Furthermore, when clients were experiencing these difficulties, walk-in services to address them were no longer available:

“I think COVID was definitely a huge factor because a lot of things shut down and it's harder to get in contact [if they] have to have appointments ... they can't just walk in and [say] 'I'm not feeling good'.” (S_01).

This perspective is consistent with research by Perri and colleagues (2020), who found a drop of service availability during the pandemic, and the flexibility of drop-in services has been shown to be particularly effective in addressing the needs of individuals experiencing homelessness (Rice et al., 2023).

Given the shelter was only open during the evening, individuals experiencing homelessness had few options or facilities to turn to during the day, which is especially problematic in the winter months: “... *they don't really have a lot of places to go, especially with COVID right now ... they just can't hang out [in many] places so, when the weather is not the greatest it can be a bit of an issue.” (S_01).* Overall, interviewees felt the pandemic had a significant negative impact on the shelter environment and their ability to connect with clients:

“I think ... working during COVID has been hard because ... in terms of relationships, the protocol that we need to follow to keep people safe is sort of like a barrier to having a relaxed environment ... not being able to see people's

faces is really hard ... it's really hard to understand what people are saying sometimes ... your [facial expression] is such a big part of getting to know someone and interacting with them, so I think that's definitely been sort of difficult.” (S_10).

Staff Responses to Police Intervention

The issue of police and enforcement arose in multiple contexts, and although staff members recounted mostly positive interactions with police officers, they expressed some reservations. Mostly, they felt respected by the officers and relied on them for rule enforcement at the shelter (e.g., escorting clients who were banned from the premises). They perceived police officers to be compassionate and fair:

“All the times that I've had to experience with them, like seeing how they ... talk and how they deescalate behavior with the client, I feel like it's really good ... they're really patient with them, they're very nice to them to be honest.” (S_06).

In contrast, when the researcher team interviewed individuals experiencing homelessness, some vocalized that they felt harassed by and unsafe around police presence (See studies 2 and 3; McNamara et al., 2013), and in the current study, staff members indicated that many shelter clients were reticent to engage with police officers due to previous negative experiences or a history of incarceration:

“So a lot of them are in contact with the criminal justice system and have been in and out of jail and are frequently in trouble with the police, either caught doing drugs or fighting, assault anything like that. So when we do have to call [the police] to move them along, they can be a little bit stubborn just because [they don't] particularly like them and don't want them around.” (S_01).

Despite feeling generally positive towards the officers, some staff members felt that broader policing practices in the community were unduly harsh:

“[The police] have been even giving out loitering fines to homeless folks who just have nowhere else to be, and just keep on getting them to move along, and that's just the life of the homeless person.” (S_03).

Similarly, research conducted with individuals experiencing homelessness in Colorado suggests that ticketing and arrests for occupying public space increases their perceived stress and decreases their feelings of safety on the streets (Robinson, 2019).

Staff members also discussed how police are often asked to respond to situations as a last resort when other services like mobile crisis are not available. For example, one staff member explained:

“If I pulled somebody up and he's threatening stepping off the bridge, and I got a hold of him here and [we need intervention] here now, not you know, tomorrow morning at 8:00 o'clock, and we've had cases where we've been on the phone on hold,...it's at night and we just felt feel helpless. The last resort is calling the cops and hav[ing] them formed.” (S_04).

A study in the U.S. by McNamara and colleagues (2013) found that police officers believed policing homelessness fell outside their scope of practice. One officer explained that arresting individuals was easier than finding an institution or organization to help them (McNamara et al., 2013). He elaborated that finding appropriate services for these individuals is too time consuming in the context of his current workload, and that dealing with other crimes needed to be prioritized (McNamara et al., 2013).

Cultural Factors Impacting Engagement with Services

Staff members indicated that religious organizations offer many services for individuals experiencing homelessness and were generally receptive to these initiatives. For example, it was noted that some churches operate drop-in sessions and clothing drives, and host AA/NA meetings:

“There are so many religious services in the city that are so supportive for homeless folks, and there's one guy in particular who found so much help and solace with knowing that this church was behind him in moving in, and they provided him with so many different services and supports and all kinds of stuff.”
(S_03).

Faith-based organizations contribute substantially to services available for individuals experiencing homelessness (Thurman et al., 2021). For example, a study conducted across 11 American cities found that almost 60% of emergency shelter beds were provided through faith-based organizations (Johnson et al., 2017). Other services provided by faith-based organizations include outreach, education, healthcare, food, substance use support, and transportation (Thurman et al., 2021). Although such organizations provide many important services provided by such organizations, they may fail to foster independence and promote the message that individual success is contingent on a commitment to religious faith and values (Daby, 2023). A qualitative examination of one religious organization found that workers explained individuals' inability to be helped by the organization as a personal rather than structural flaw (Daby, 2023). This perspective indeed may reinforce victim-blaming narratives that permeate social understandings of homelessness.

In a similar vein, one interviewee indicated that shelter clients may benefit from services tailored to Indigenous individuals, if requested:

“It might be good sometimes for some of the Indigenous guests, if they, I haven't really heard them ever request to have like an elder or somebody to come talk to, when I guess that would be in my opinion, that would be something good to have if needed” (S_02).

Given the overrepresentation of Indigenous individuals in populations experiencing homelessness, offering culturally relevant services may be especially important (Kidd et al., 2019). Finally, staff members brought up the language barrier that exists with some individuals experiencing homelessness: *“I have met people who have moved here from other countries that are homeless, and because of the communication barrier, it's very hard to understand them or understand what they need sometimes, or vice versa.” (S_09).* Staff members believed that access to translators, or staff providers with knowledge of multiple languages, could help address and mitigate this barrier.

Conclusion

The first study of the current dissertation garnered insights about the emergency shelter system from a service provider point of view. Given that service providers implement change at the individual level, and staff-related factors can play a large role in predicting resulting service use (Bower et al., 2018; Olivet et al., 2021), leveraging staff perspectives and insights will result in meaningful change. Staff members discussed their perspectives on multiple factors influencing clients' experiences homelessness including: the shelter environment, barriers and facilitators to service use,

the impact of the COVID pandemic, substance use, police interactions, and need for culturally relevant services.

Staff members described the negative impact of macro-level factors (e.g., lack of affordable housing, understaffing) on their daily experiences of providing care. They reiterated that, although the shelter environment meets some client needs, it was not intended to provide long-term care. Staff members emphasized the importance of relationships with clients as a facilitator to service engagement and strongly desired additional training opportunities to feel empowered and better able to meet client needs. Although the service provider perspective offered valuable and tangible recommendations for change, it is likely to be best contextualized by insights from those with lived experience using these services. As such, studies 2 and 3 of the present dissertation aimed to center service user perspectives.

CHAPTER 3: STUDY 2 – SHELTER CLIENT PERSPECTIVE ON RESPONSIVITY AND SERVICE USE

Introduction

As illustrated in Study 1, the service provider perspective highlights important targets for change from those delivering interventions, yet it is also crucial to examine service user perspectives to best understand and prioritize their needs. As experiences of homelessness continue to rise in the country (Quayum et al., 2023), and emergency shelters remain a dominant form of assistance geared towards homelessness (Sylvestre et al., 2016), it is especially important to consider barriers and facilitators to access to this environment. Centering the lived experience of individuals experiencing homelessness will maximize responsivity to available services and the needs of those who use them. Although it is important to empower service users' agency in choosing appropriate services (Anderson, 2010), there is less research on their perspectives concerning service utilization. Indeed, they often have a limited ability to defend their interests due to the transitional nature of their experience and a lack of access to resources and stability. Identifying appropriate targets for intervention is predicated upon a proper understanding of what emergency shelters are and input from individuals who engage with the service. The social and economic costs of homelessness (Culhane, 2008; Hoch & Trenamen, 2020), paired with the substantial negative impact it has on individual lives, bolsters the rationale for identifying macro and micro-level solutions to change.

Patterns of Service Use for Individuals Experiencing Homelessness

Individuals experiencing homelessness use services differently from the housed population. They are more likely to visit ER departments, access acute services for foundational needs like food and clothing, and are at higher risk of tri-morbidity of chronic physical, mental, and substance use disorders (Addorisio et al., 2021; Gilderbloom et al., 2013; Player et al., 2020; Raven et al., 2020). In addition to health inequalities, individuals experiencing homelessness must cope with myriad challenges such as social isolation, feelings of worthlessness, and sleep deprivation that all make service access and engagement more challenging (Grech, 2019; Miler et al., 2020; Schein, 1996). The compounding effects of multiple adverse life experiences and situations shape individuals' paths to homelessness and their responsiveness to available services (Addorisio et al., 2021).

Individuals with marginalized identities are more at risk of experiencing homelessness, and this shapes their perspectives on emergency shelter and broader service use. Racialized and Indigenous peoples are vastly overrepresented in the emergency shelter population, accounting for over 30% of shelter users but only 5% of the Canadian population (Baral et al., 2021). Furthermore, in 2016, Indigenous populations' shelter use was 8.9 times greater than for non-Indigenous populations, and emergency shelters rarely provide culture-based interventions.

Identified Barriers to Service Use

Approachability. Many shelter and other service programs for individuals experiencing homelessness are not designed in accordance with the desires of the service users (Tsemberis & Eisenberg, 2000; Shier et al., 2007). A lack of information

and transparency about available services may limit individuals from developing a sense of agency in their own care and treatment decisions (Kerman & Sylvestre, 2020). Some individuals have described service delivery systems as a complex maze, difficult to navigate and inadequately suited to meet their diverse needs (Applewhite, 1997). The complex needs of individuals experiencing homelessness (e.g., legal assistance, mental health support, substance use) further complicate the approachability of services because these services often target only one component of need (Jackson et al., 2014).

Acceptability. Many emergency shelter users who experience homelessness have a number of internalized personal barriers, including ingrained beliefs about the acceptability of services they may access, that their agency and independence may be limited by accessing specific services (Ha et al., 2015), and that they are unable to prioritize their needs (e.g., physical health vs. mental health; Forchuk et al., 2008). These beliefs decrease motivation for initial contact with services, and a resulting lack of engagement prohibits corrective experiences that could challenge these beliefs. Further, negative self-esteem can dampen the determination and desire required to achieve stable housing (Applewhite, 1997) and may be associated with setbacks in personal and social interactions that may have led to their primary loss of housing.

The fear of being judged is especially salient for some individuals, and this fear creates an accessibility barrier as the homeless label continues to carry significant stigma in society (Canavan et al., 2012). Furthermore, negative experiences can create a pervasive sense of distrust towards health professionals and institutions, resulting in an acceptability barrier in the form of reluctance or unwillingness to further engage with services (Canavan et al., 2012; Olivet et al., 2021).

Availability and Accommodation. Many individuals experiencing homelessness feel obligated to abide by rules they dislike or disagree with out of fear of service loss and often feel powerless in the face of unfair or inadequate treatment because so few options are available to them (Kerman & Sylvestre, 2020). Lack of technological access can act as an obstacle to service use (Heaslip et al., 2021). For example, certain services operate solely through tele-health, others require multi-factorial authentication to maximize privacy, and virtual communication limits need for in-person visits. Although most individuals experiencing homelessness do have access to cellular devices, specific barriers make their use more challenging (e.g., no WIFI available, lack of data, limited charging ports, broken technology; Heaslip et al., 2021; Reitzes et al., 2017).

Availability of prescribed medication is critical for many individuals experiencing homelessness, as medication compliance is key to managing tri-morbidity of poor physical and mental health with concurrent problematic substance use (Player et al., 2020) and has a large preventative impact on worsening health conditions (Coe et al., 2015; Roche et al., 2018). Lost or stolen medication is a common barrier to medication compliance (Coe et al., 2015). Furthermore, adequate provision of medication and appropriate health care follow-up at no cost is critical, as low attendance at follow-up visits is yet another prominent reason for medication nonadherence in this population (Coe et al., 2015).

Affordability. A potent example of an affordability barrier to service access for those experiencing homelessness is a lack of appropriate transportation to services (Ha et al., 2015). Lack of bus fare or taxi vouchers can represent an expensive deterrent to

seeking adequate care, especially when services are dispersed geographically (Applewhite, 1997). Another affordability barrier is access to inexpensive grocery stores, as food deserts contribute to food insecurity among those experiencing housing instability (Chang & Chatterjee, 2022).

Appropriateness. Appropriate community-based care is impeded, especially for those with chronic and severe mental illness, when service delivery systems are fragmented, complicating access (Rosenheck & Lam, 1997b). Although programs that offer multiple services in one location have been shown to be more effective, they remain the exception in most major cities across the world (Canavan et al., 2012). As noted earlier, appropriateness can be improved by ensuring information sharing among service providers (Black et al., 2018) and by offering life skills training while addressing basic needs (Kozloff et al., 2013).

Identified Facilitators to Service Use

Approachability. Individuals experiencing homelessness have expressed a preference for a one-stop-shop model with a single access point for services addressing mental health, health care, and other basic needs (Pedersen et al., 2016). To further qualify approachability, having primary medical and social service providers work together has been shown to best meet the needs of disadvantaged populations (Khanassov et al., 2016; Schmidt et al., 2015).

Acceptability. A qualitative study conducted by Kerman and Sylvestre (2020) found that the interpersonal interactions embedded within service use were key to how participants perceived the health and social services they received. Fair and respectful treatment was described as “being greeted warmly” and the security of enforced zero-

tolerance policies for violence and discrimination against service users. Some participants related that their positive experiences with service providers helped them regain a sense of personhood and develop agency for change (Kerman & Sylvestre, 2020).

Availability and Accommodation. Availability is affected by modes of resource allocation which vary greatly across geographic regions (Latimer et al., 2017). In Canada, a provincial health insurance number enables access to many medically necessary services, facilitating service use (Argintaru et al., 2013). Furthermore, having a primary health care provider significantly reduces the likelihood of having unmet needs (Argintaru et al., 2013) and centralized services (e.g., healthcare and pharmacy in same building) are associated with an increase in service utilization among individuals experiencing homelessness (Ramsay et al., 2019).

Affordability. Research suggests that appropriate services are most likely to be used when they are affordable (Richter et al., 2021). For example, housing subsidies made available to individuals experiencing chronic homelessness engender a reduction in emergency medical service use (e.g., hospitalizations, emergency department visits) and subsequent shelter stays (Richter et al., 2021). The affordability of appropriate services (e.g., housing, primary health care) leads to profound cost savings in the long run (e.g., less emergency department visits and extended hospitalizations).

Appropriateness. Coordinated care models, outreach services, and tailoring of services are often cited as solutions to address complex service needs of individuals experiencing homelessness (Hirst & Cuthill, 2021; Rice et al., 2023). Research in the primary care context suggests that tailored services contribute to a perceived superiority

of service experience, increasing likelihood of long-term engagement (Jego et al., 2018; Kertesz et al., 2013). Investigating the lived experience of individuals living in an emergency shelter will help identify characteristics of services that are deemed most appropriate.

Research Questions

1. What are the barriers and facilitators to emergency shelter use from a service provider perspective?
2. What are the barriers and facilitators to community service use from a service user perspective?
3. How do identified barriers and facilitators compare between service providers (Study 1) and emergency shelter service users?

Method

Participants

Fifteen participants were interviewed for the current study. Some were in their first discrete experience of homelessness ($N = 11$), whereas others had lived through up to twenty distinct experiences ($N = 4$). Participants struggled to quantify the total amount of time they had spent homeless and often presented a range of years. On average, participants had experienced 3.7 years of absolute homelessness (i.e., being unsheltered or residing in an emergency shelter) over their lifetimes. However, the distribution of time they spent homeless ranged from a few months to 17 years. Most participants were men (73%), ranged in age from 23 to 75 years, and two-thirds of participants were under 50. When asked about the highest level of education they had completed, over a third of participants reported they had not graduated high school

(40%) and over half had received their GED (53%). Finally, all participants reported receiving social assistance at the time of their interview.

Procedure

Participants were recruited from an adult-only shelter through weekly in-person visits from June to December 2021. Shelter restrictions included no pets or couples, and beds were allocated according to gender. Given an inherent power differential, multiple steps were taken to ensure voluntary participation. Current service users who frequented the emergency shelter were asked to participate in an interview. If they agreed, the researcher provided a copy of the informed consent form (see Appendix F) and verbally highlighted the primary points of the consent form to address variability in literacy.

Although participants were offered to participate in the study at the shelter in a reasonably private kitchen area that was not currently being used, they were informed in the consent process that confidentiality could not be guaranteed because the interviews were conducted in the shelter. Written or verbal consent was acquired before interviews began (see Appendix B for qualitative interview guide). Participants were verbally asked questions from the background questionnaire, and their responses were recorded on the form (see Appendix G). To avoid coercion, participants were not remunerated for completing the interviews.

After being interviewed, participants received a debriefing form including an explanation of study goals, and researcher contact information (see Appendix H). The main points of the debriefing form were also conveyed verbally by the researcher. Interviews were then transcribed verbatim by members of the research team and imported into NVivo software for line-by-line coding. Ethics approval was obtained for

this study from the University of New Brunswick research ethics board (REB-2021-039).

Results and Discussion

Table 3 provides an overview of themes and key points highlighted by service users in this study. Titles which are bolded indicate that the theme is unique to the current study (i.e., emergency shelter user perspective). In addition, citations following statements made by participants point to extant research with a similar pattern of results.

Table 3

Themes from Emergency Shelter Client Perspective

Emergency Shelter User Themes & Key Points (Study 2)
Transitions into homelessness Cycles of housing procurement and housing loss
Difficulty with housing procurement Desire for a home Impact of financial insecurity
Perspectives on shelter environment Positives Meeting basic needs Sense of community Negatives Environmental considerations Staff attitudes and behaviours Education and employment
Solutions for shelter environment Increase privacy Formal communication/outlining available services Communication tools and reminders Transportation Recreation activities/sense of community Increased training opportunities Storage solutions Shelter services Emphasize lived experience & provide further training
Perspectives on service use Patterns of current service use Barriers to service use Impeding beliefs

- Environmental deterrents
- Practical barriers
- Lack of knowledge
- Staff attitudes and behaviours
- Facilitators to service use
 - Adaptive beliefs
 - Appropriate tailoring
 - Positive staff influence
 - Support systems
- Community solutions to service use**
 - Policy & macro level recommendations**
 - Practical recommendations**

Shelter perspectives on substance use

Client physical and mental health

- Tri morbidity among individuals experiencing homelessness**
- Inconsistency in discrepancies in services**

Experiences with police and incarceration

- Relationship between homelessness and incarceration**
- Negative impact of fines and over-policing**

Impact of COVID pandemic

- Denial of access to public spaces
- Reduced service access

Shelter Clients' Transitions into Homelessness

Shelter users reported varied experiences of homelessness. For example, some noted that their homelessness began in childhood by running away from home, whereas others retained housing until losing it for the first time in older adulthood. Participants also recounted experiencing homelessness in various provinces and cities across Canada. Research highlights a duality in mobility among individuals experiencing homelessness. Factors that produce homelessness can anchor individuals in the geographic location, such as poverty limiting mobility, or compel migration to a different location, like individuals searching for employment in a different city (Kaufman, 2021). In a study of over 2,000 individuals experiencing homelessness, 88% endorsed mobility within cities and 29% moved between cities. Kaufman (2021) found

ten reasons explaining inter-regional mobilities, the four most common were: (1) interpersonal network changes including trying to get closer to forms of social support (endorsed by 26.1% of their sample), (2) place and mobility, with 17.2% of their sample reporting being attracted to specific locations or leaving other spaces, (3) work and personal finances such as a loss of employment or searching for labour opportunities (14.6%) and (4) healthcare and social services, with some participants moving to facilitate greater access to appropriate healthcare (8%).

When asked what perpetuated their initial loss of housing, individuals referenced multiple intersecting causes. Specifically, they discussed: (1) chaotic home environments, (2) eviction, (3) grief, (4) intimate relationship dissolution, (5) maladaptive substance use, and (6) incarceration. One participant vocalized how his substance use contributed to his experiences of homelessness:

“I drank back then too. And that was big, like a big downfall for me, to drink. It was like my nemesis, cause it kind of led me into, like a gateway into everything that I experienced. But, definitely, it contributed to me being homeless”
(JHS_005).

Some participants recounted a repetitive cycle of housing procurement and loss. One individual explained that, despite having assistance to get settled into housing, he lost it within a year: *“This one shelter ... they helped me get housing and they helped me to move my stuff and get furniture and everything – helped me settle down and then I lost that place a year later.”* (JHS_011). This participant’s experience highlights the importance of providing ongoing support once individuals transition into housing to ensure its long-term maintenance (Marshall et al., 2022). Research by Marshall and

colleagues (2022) indicates that individuals experiencing homelessness often continue to struggle with mental illness, problematic substance use, employment, poverty, and lack of social integration following housing procurement. Without adequate support in this transition, individuals are at considerable risk of losing their housing (Marshall et al., 2018).

A study conducted by Pierce and colleagues (2018) evaluated the outcomes of the DayBreak housing program in Dayton Ohio, a city of 135,000 people. The DayBreak program is a two-year transitional housing program for youth offering support across five core areas: housing, physical and mental health, adaptive life skills, income and employment, and education. Across the course of the program, youth transition from living in an apartment with a highly structured environment which requires meeting with program staff at least once weekly, and being enrolled in an education or training program, to living in an off-site apartment with more independence. The DayBreak program offers rental assistance, which diminishes over time and provides aftercare for two years post discharge. Overall, clients who engaged with the DayBreak program for at least one year had substantially higher educational progress and employment outcomes (Pierce et al., 2018).

Shelter Clients Perspectives on Difficulty Navigating Housing Procurement

Desire for a Home

Every individual living at the emergency shelter expressed a profound desire for housing, and emphasized they felt that their life was negatively impacted without it: “*I didn't really live my life. I'm just in and out of rehabs, shelters, on the streets. Brutal. I just want an apartment and go to work every day.*” (JHS_001). Interviewees explained

that living in the shelter put constraints on their agency. For example, they were unable to cook for themselves, had to abide by curfew rules, and live with roommates they could not choose. Although participants vocalized a strong desire for housing, few were able to describe specific desired characteristics above affordability:

“It’s been so long since I had my own, I don’t know. I don’t know. Like, I really don’t know, what to say ... They say home is where the heart is, home is the happiest. Home is anywhere for me. I don’t know. Somewhere I can relax.”
(JHS_007).

A few participants expressed a desire to move into the supported housing complex located in the same building above the emergency shelter. Those who did felt that the support embedded in that structure would be suitable enough to meet their needs: *“You know they might make an apartment available upstairs that I can move into. That’s ideal.”* (JHS_014).

The lack of access to affordable housing was a primary concern among shelter residents. However, beyond cost constraints, participants spoke about practical barriers to housing obtainment. For example, a lack of references from previous landlords can make it difficult to acquire a unit: *“The rents are exceedingly overpriced, the places are crap. There really isn’t any good housing that you can get into without having a number of previous references, and all these other things.”* (JHS_010). Another barrier to housing obtainment underscored by interviewees were long wait times for subsidized units: *“I’ve been on the list for the last three years.”* (JHS_013). Their experience is consistent with government data suggesting that single individuals spend an average of 18.9 months waiting for housing in Fredericton (Government of New Brunswick, 2019).

As of February 1st, 2024, there were 10,733 households on the waitlist for a subsidized unit in the province (Silberman, 2024). Overly long wait times led to a sense of hopelessness among shelter residents and disappointment that subsidized housing units were an unobtainable goal.

Impact of Financial Insecurity

The necessity for affordable housing stems in large part from the significant financial strain experienced by all interviewees residing at the shelter. All participants were obtaining government assistance, and most were profoundly frustrated by their experience procuring it. One participant explained that he lost financial assistance for a year: *“I was blamed for things I didn’t do, then I ended up having to couch surf because I lost income assistance completely, for about a full year.”* (JHS_013). Participants were exasperated at the bureaucratic process involved with receiving their government assistance cheque and annoyed at the deductions they occasionally experienced and felt they had limited recourse in resolving those disputes. Research suggests that individuals experiencing homelessness have greater difficulty accessing financial benefits, which is a contributing factor to homelessness (Wallace & Quilgars, 2005).

Shelter users’ limited income impacts their agency in numerous ways. For example, individuals living at the shelter have few available recreation opportunities and are unable to seek them out because of lack of funding: *“Yeah, I find it’s really hard, being out on the streets because you know you don’t have anything to do and especially when you don’t have money. Where do you go?”* (JHS_006). Smaller cities are even less likely to have a variety of free activities and warm spaces for individuals to visit. At the

time of interviews, Fredericton did not have a drop-in center for individuals experiencing homelessness to frequent.

Another participant recounted being unable to obtain new identification because he could not afford the cost associated with it. Persistent economic strain has a significant negative impact on quality of life, and early economic disadvantage is a substantial predictor of homelessness later in life (Embleton et al., 2016; Gaetz et al., 2018; Shelton et al., 2009). Moreover, recent research suggests the relationship between severe mental illness and experiences of homelessness is mediated by financial strain (Elbogen et al., 2021).

Service User Perspectives on the Shelter Environment

Participants were asked about their current living situation and explored positives and negatives of the shelter environment. Most participants felt the emergency shelter was better than others in the community because of its relative leniency (e.g., more flexible hours, no sobriety requirement). Many participants had been banned from other shelters with more stringent regulations:

“They wouldn't let me back in. So, I came here. This one's a little bit more relaxed. Yeah, they'll allow you to be yourself more than other ones do. It's hard to be yourself sometimes cause you want to fit in.” (JHS_002).

Given that Fredericton only had three emergency shelters available for adults (one co-ed, one for women, and one for men) at the time of interviews, the impact of receiving a ban was especially salient. Receiving a ban from one shelter substantially reduces the likelihood of an individual being able to successfully seek shelter elsewhere given the limited availability.

Positives of the Emergency Shelter Environment

Participants reported that the emergency shelter helped them meet their basic needs. It provided a safe place for them to sleep, do laundry, shower, and eat (Gilderbloom, 2013; Sylvestre et al., 2016). Interviewees felt the shelter provided more privacy than others they had used in the past and were pleased with having a bathroom attached to each room. They were also pleased about the cleanliness of their rooms and the food that was provided. This set up stands in contrast to the environment described in many other shelters which housed many people per room, were overcrowded, had inadequate ventilation and unhygienic bedding (Moffa et al., 2019). Some participants vocalized that they were especially grateful for the sense of safety the shelter provided: *“Yeah, I actually feel safe there. I feel at home, kind of, you know, because that's the way they make you feel.” (JHS_006).*

Participants valued the community they created at the shelter. One resident spoke about the support their roommate provided: *“I actually had my roommate, she helped, umm, she helped me out a lot.” (JHS_011).* Some participants spoke very highly of shelter staff members, noting that they were understanding, facilitated connections to services, and cared about the shelter residents. One resident said: *“They make sure we're safe and okay. They give a shit if we're alive and breathing” (JHS_014),* and another explained: *“I just think they do everything they can to help.” (JHS_007).*

Negatives of the Emergency Shelter Environment

Although participants were grateful for certain shelter features, they outlined multiple negatives that impacted their desire to engage. Their frustrations can be broken

down into two primary themes: (1) environmental considerations and (2) staff attitudes and behaviours.

Environmental Considerations. Participants had qualms with the heightened surveillance at the shelter. One participant explained that staff members made frequent night room checks:

“I think like once, it's fine instead of going – coming back three or four times, because like sometimes they would shine a flashlight if it's dark in your room, so it kind of bothers, and I know it bothers my roommate a lot when they come in – And also, when there's two people in the room, you're not allowed to close our doors, right?” (JHS_011).

The lack of privacy is directly related to a perceived lack of safety, which undoubtably influences their comfort level with staying in the shelter. It is possible this lack of privacy results in hypervigilance, which may make it more challenging to allocate mental and physical energy to other responsibilities. Although participants understood that staff must balance between ensuring the safety of residents and giving them privacy, many expressed that having to keep their doors open at all times was especially challenging. Participants were also frustrated by the lack of storage available for their personal belongings. *“When you don't have a locker, you have to lug everything around with you and things get stolen all the time.” (JHS_008).* This issue was especially significant for individuals who had been incarcerated as they reported that all their belongings were gone when they returned, forcing them to start from scratch.

Staff Attitudes and Behaviours. Consistent with extant research, participants explained that staff attitudes can play a large role in impeding shelter use, as well as

community services more broadly (Barile et al., 2020; Black et al., 2018; Pedersen et al., 2016; Peters et al., 2022; Rice et al., 2023). Some participants felt talked-down-to by staff members, which led to resentment of the shelter and made them feel they were less deserving of care. For example, one participant said that staff spoke to them in particularly demeaning ways: *“The staff wouldn’t talk to us... or they talk to us like we are children, not adults.” (JHS_014).*

When residents feel disrespected by staff members, they are less likely to communicate honestly with them about the concerns they have and may be more likely to intentionally break rules (Paat et al., 2021). Being the target of disrespect fosters the development of cynical beliefs, which contributes to greater disrespectful or rule-breaking behaviour (Stavrova et al., 2020). The presence of norm-violating behaviour in one’s environment, conceptualized as actions that contradict typical societal expectations, increases one’s propensity towards that same behaviour (van Kleef et al., 2015). Numerous theories exist to explain this phenomenon, including reinforcement theory. Reinforcement theorists suggests that positive response to norm violation, such as positive social responses from friends or experiences of agency, tend to reproduce such actions (Skinner, 1963). Cultural support theories tend to explain deviant or violating acts as a function of human ecology and that particular spaces produce types of hierarchies and inequities that lead to problematic behaviour (Anderson, 1994). As a result, these responses suggest that within the culture of these spaces there is an incongruence between the social and psychological standpoints of residents and providers. The tension between staff and residents also may contribute to a less comfortable environment, making the shelter a less appealing service for other clients.

Another participant explained that the staff's strict adherence to curfew makes it challenging, especially because individuals experiencing homelessness do not always have easy access to means of telling time.

“Curfew. It's too early. I'm old c'mon let me go out and the thing is they don't give no grace period. That's really hard sometimes. If I was having a seizure at 3 minutes to 11, I would have gotten a ban no matter what.” (JHS_014).

Participants felt that certain staff members held biases or judgment towards certain clients of the shelter (Paat et al., 2021). They expressed that once a staff member had formed a belief about them, it felt as though all their behaviour was coloured and interpreted through that lens. For example, one participant said: *“I mean they get something in their mind, they just figure you're a lowlife of society anyway, so you're probably doing wrong.” (JHS_002).* Importantly, every situation has multiple perspectives, and the study design did not allow for garnering of staff perspectives on specific interactions. For example, it is possible emergency shelter users held their own beliefs that colored their interpretations of staff behaviour. Shelter clients did not discuss the potential impact of their own behaviour on resulting relationships with staff.

The inherent power dynamic between staff members and residents of the shelter complicates open and honest communication because disagreements may lead to the client experiencing unwanted consequences such as a ban from the shelter. Emergency shelter users are in a vulnerable position and have little agency in defining what they would like help with and how they want the help to be delivered (Pollock & Taket, 2014). Shelter policies that allow for flexibility in client care give staff members significant authority in making unilateral decisions about punishments, which may be

administered unequally among residents. Discrepancies in these decision-making processes are likely to exist between staff members, and the frequent staff turnover further complicates this issue. Finally, it is possible that staff lack adequate knowledge and training to navigate complex client presentations, which impacts their ability to appropriately meet the shelter clients' needs (Jackson et al., 2014; Korab et al., 2023).

Pollock and Taket (2014) examined the impact of participatory practice implementation and found that these practices led to improved self-esteem likely due to increases in service user senses of agency and autonomy. These authors provided recommendations for organizations to maximize user inclusion in service delivery: (1) staff must recognize the expert opinion of service users, (2) actively engage in processes that challenge the inherent power dynamic between staff and clients, and (3) the organization must be committed to sustaining change over time (e.g., training new employees in the model).

Education and Employment Experiences Among Emergency Shelter Clients

Related to their experiences of financial insecurity, many shelter residents expressed frustration at the limited occupational opportunities. Successful employment and housing procurement are directly related and have significant impact on individuals and their social networks (Bretherton & Pleace, 2019; Shier et al., 2012). Most participants were interested in work involving trades (e.g., construction, landscaping, welding). Although many disclosed a strong desire to find work and educational prospects, they also spoke about how studying and working would be challenging in the shelter environment:

“I really would like to get into housing for now until I can just go to school again. I can’t see myself doing school from the shelter, just to me it’s impossible. I mean, it’s not impossible, but it would be hard, yeah.” (JHS_005).

Research on educational outcomes suggests that youth experiencing homelessness are substantially less likely to attend school (Miller, 2011). Barriers to accessing education opportunities exist at the institutional level (e.g., transportation limitations, poverty), the family level (e.g., parental mental health), and individual levels (e.g., behavioural issues, physical health concerns; Parrott et al., 2022).

Some participants explained that their history of substance use problems and lack of education contributed to their difficulties finding employment: *“I don’t have an education, so I kinda have a hard time getting work and, uh, my addiction kind of messed things up too.” (JHS_007).* A lack of education or problematic substance use makes it harder to gain employment and housing, a situation which comes full circle in encumbering opportunities to gain an education or lessen substance use. This pattern is consistent with recent research suggesting that physical and mental health issues can serve as substantial barriers to employment among women experiencing homelessness (Groton & Radey, 2021). Qualitative research has highlighted how substance use is a predisposing, precipitating, and perpetuating factor to unemployment among individuals experiencing homelessness, and that substance use impeded these study participants’ ability to obtain and maintain employment and education (Poremski et al., 2014).

Participants felt that employers were unlikely to hire individuals experiencing homelessness and that it was more difficult to commit to a work schedule when living in the shelter. Related qualitative research with individuals experiencing homelessness in

Alberta indicated that their relationships with employment agencies were influenced by their state of homelessness (Shier et al., 2012). Providing vocational training opportunities at the shelter would be an invaluable asset for many individuals residing there. *“It’d be nice to have more programs like that, so I can get back to work. Maybe find your skills, what you’re good at. Stuff like that.” (JHS_007)*. Providing avenues for residents to develop marketable skills will help bolster their self-sufficiency and housing maintenance through increased likelihood of long-term employment (Bretherton & Pleace, 2019).

Client-Provided Solutions for the Emergency Shelter Environment

Amplifying the voices of those with lived experience was a key objective of the current project. Interview participants proposed many solutions they felt would improve their quality of life in the shelter environment.

Increase Privacy. Participants expressed a strong desire to be able to close their door in the shelter. They suggested making a written agreement with staff members to set expectations:

“Probably being allowed to close your door, trusting those two tenants with an agreement, of course, like make sure, like if you're going to let somebody move into your home, you're going to want to lay down some agreements, right? For both to sign and be on the same page with, right?” (JHS_012).

Other individuals believed that privacy and safety could be increased if shelter clients were alone in their rooms: *“Okay, but the best thing would simply be [to] put people in individual rooms at least. Just because putting people and strangers together often doesn't work.” (JHS_010)*. Overall, participants were yearning for increased agency

surrounding what they were allowed to do in the space they occupy, such as being allowed to choose their roommates.

Formally Communicating / Outlining Available Services. Participants felt that access to services would be widely increased if information about available services was outlined in the shelter: *“Like I said, like they should have more information about that in the shelter.” (JHS_011)*. Printed informational flyers posted on the wall in the shelter might help increase service awareness and use. It is possible that having staff offer shelter clients assistance in calling to book services may help increase service engagement. One participant reported that staff members taking messages and providing reminders for appointments sometimes increases opportunity for service engagement:

“So they take messages to see- Yeah, and reminders too. Remind you that you have an appointment to remind you I need that passport.” (JHS_008).

Finally, ensuring that staff members are aware of available services and access protocols would likely be helpful, as they are essential knowledge translators for individuals experiencing homelessness (Korab et al., 2023). Although shelter residents perceived most staff at the shelter to be knowledgeable of resources available, they felt their insights were not always shared equally across service users. Furthermore, developing organizational procedures that promotes awareness of new programs rolled out in the province would also increase access.

Communication Tools and Reminders. Individuals residing in the shelter felt that they had limited access to the online world. Many believed having access to communication devices would be helpful: *“What else do you think you need on the day-to-day that you don't have access to? A phone. Yeah, definitely a phone.” (JHS_001)*,

“They should have maybe one computer or two here, or a phone so you can call, right?” (JHS_011). Even though shelter residents reported staff members sometimes provide them with messages, at the time of interviews they were unaware of a formal process by which messages were taken and shared. It is possible that staff varied in their willingness and capacity to take and convey messages to different residents. Although it is important to acknowledge the practical barriers to providing individual reminders to shelter users, having a message board where staff write notes based on the calls they receive, or the development of another formal, private message-taking process, may be warranted.

Transportation. Participants vocalized a desire for consistent access to means of transportation to and from the shelter (Murphy, 2019; Sylvestre et al., 2016). Many expressed that unlimited access to bus tickets, or to drives when the weather was poor, would be especially helpful: *“Transportation in the wet weather would be, in the winter weather too, would be good. Even in the heat, it's exhausting.” (JHS_002).* Although emergency shelter clients do have access to bus tickets, they must report where they are going to staff in order to get them. Moreover, some participants explained that the bus schedule can be unreliable, especially on weekends, making it a challenge for them to easily move within the city.

Recreation Activities / Sense of Community. Creating a sense of community was of utmost importance for many participants. They expressed a variety of suggestions for increasing the recreation and community opportunities in the shelter context (i.e., a place to stay during the day, facilitating activities that increase

confidence, increasing physical activity opportunities, and more formal resident meetings):

“I would say, you know, maybe more places for homeless people to shower or even somewhere people can hang out, you know? We don't have money. There's nowhere to go and what do you do?” (JHS_006).

Given that community integration is an important predictor of housing maintenance (Marshall et al., 2020), facilitating activities that connect these individuals to community organizations should be prioritized. Research examining community integration among individuals in a Housing First program in Ottawa found participants experienced little community belonging and feared judgment from others (Bassi et al., 2020). In contrast, an examination of community integration among Housing First program participants in Lisbon found a substantial increase in social service use and community activities (Ornelas et al., 2014). Given that Housing First programs are quite variable in nature, it is possible that different environmental conditions present in each program, and that the studies examined Housing First in two different countries, explain this discrepancy. To increase community integration in Housing First models, accounting for potential barriers to physical (e.g., health, poverty, service inaccessibility), social (e.g., neighborhood opportunities for engagement), and psychological (e.g., disinterest, fear of judgment) integration will be important (Bassi et al., 2020).

Increased Training Opportunities. Participants expressed a desire for more formal and informal training opportunities for themselves. They were looking for opportunities to develop skills that could be later leveraged for work and lifestyle

improvements. For example, one participant spoke about wanting help identifying feasible volunteer and work opportunities:

“Just more, I think there needs to be more programs, more options for volunteer or, uhm, we need more of them. It’d be nice if they could help you find work, more work. Find your skills, I’m not sure.” (JHS_007).

In particular, participants wanted to find programs that were in line with their existing strengths:

“It’d be nice to have more programs like [trade education], so I can get back to work. Maybe find your skills, what you’re good at. Stuff like that” (JHS_007).

Employment programs can be successful in helping individuals experiencing homelessness find and sustain jobs that are in line with their strengths (Bretherton & Pleace, 2019; Loosemore et al., 2021). Finally, a few participants expressed that mental health groups geared towards social skills may be especially helpful:

“... that would be like psychological aid I guess - yeah stuff like that and a social, social skills, education on how to be more formal, I guess, and [in] the workplace, because I struggle, socially struggle.” (JHS_012).

Research suggests that those who have fewer interpersonal symptoms are more likely to be able to procure housing (Gabrielian et al., 2015). Providing additional social support training may help bolster confidence in building social networks once housing is procured (Carver et al., 2022).

Storage Solutions. To address the lack of permanent storage available, participants suggested implementing lockers: *“Yeah, with a key and you get a key and if they keep an extra key so if you lose your key and replace it with two dollars.”*

(JHS_008). A policy could oblige shelter users to be responsible for cleaning their locker at prescribed frequencies, with staff having access to the locker for certain reasons. Practice guidelines for day shelters created by Petrovich and colleagues (2017) recommend having storage spaces available to maximize the security clients feel when visiting the space.

Services at the Shelter. Rather than oblige shelter clients to travel to different locations for services, shelter users recommended that services come to the shelter. For example, one participant recommended having frequent identification card clinics at the shelter:

“Have like a lady that comes in maybe to the shelter like once a day, once a week and talk to people if they need help getting housing, or even an ID clinic, an ID person to come in, and I think that's an easier process instead of having them call John Howard.” (JHS_011).

Having health professionals and other service staff visit the shelter also may decrease transportation burdens that limit service use. This perspective is in line with research suggesting that individuals experiencing homelessness prefer a “one-stop-shop” model of service delivery (Pedersen et al., 2016). Benefits of an integrated service model include improved responsiveness to service, reduced duplication of services, greater equity and consistency in delivery systems, and opportunities for preventative action (Neale et al., 2012). Recent research suggests that people experiencing homelessness were more likely to use healthcare in outreach service centers rather than traditional primary care environments (Hirst & Cuthill, 2021). Qualitative interviews conducted by Hirst and Culhill (2021) indicated that people experiencing homelessness felt more

comfortable in these settings, that the environment was more relaxed, and that they were more convenient because all their healthcare needs were met in one spot.

Employ Staff with Lived Experience and Provide Further Training.

Participants felt that staff members would be better equipped to understand their difficulties if they had lived experiences of homelessness, and/or more extensive training:

“I'd like to see the people that aren't in our shoes be in our shoes for a week or two and see how it feels. Maybe their frame of mind would change a little bit more. And be more understandable, like understand people like us.” (JHS_006).

Ensuring that staff members have adequate training and education on the tri-morbidity that individuals experiencing homelessness often have would maximize their self-efficacy at work. Because negative staff attitudes can be an immense deterrent to service use, it is crucial that staff are appropriately trained (Planey et al., 2019; Schiff & Lane, 2021). Moreover, the frequent turnover in shelter staff means that training should be delivered on a repeated and ongoing basis. Online training could offer cost-benefits in the long term and be available to new staff when they are onboarded (Chrysantina et al., 2022). In qualitative research asking shelter service providers about ideal training opportunities, participants emphasized the importance of relevant training (e.g., trauma-informed care), a desire to learn from other providers, and noted barriers they experienced (e.g., cost, location; Twis et al., 2021).

Patterns of Current Service Use

To contextualize the pattern of service use that occurred among interviewed individuals, it is important to note that most participants said they came to use shelter

services as a last resort. For example, one client reported that he used the shelter because:

“I needed help. I really did. I didn't know what to do, where I was going, what was gonna happen and once again, I was scared... it's like a security thing.”
(JHS_006).

Most participants (11; 73%) stated explicitly that they came to use the shelter because they could not think of another option. It is possible that the sense of urgency and despair individuals were experiencing may have shaped the way they perceived the services that were available to them. Moreover, participants reported that communication about available shelter services occurred almost exclusively via word of mouth from other individuals with shared lived experience, consistent with research by Barile and colleagues (2020). For example, one participant explained she had created a “street survival guide” that she shared with her friends. Another explained he was referred to the shelter by another client:

“I heard through somebody who was on the streets that I know, and he said, ‘hey did you hear about this new shelter that just opened up?’” (JHS_013).

One participant explained that shelter or service use is inherently limited when users are unaware of amenities they could access: *“Well, I don't really know much about services that are out there.”* (JHS_006). Despite the barriers that complicate service use for this population, most individuals in the sample reported using several local services. The community services they used offered a broad range of support, including harm-reduction for substance use, laundry and food access, medication provision, physical and mental health support, and internet access.

Barriers to Service Use in the Community

Interviewed participants explored barriers specific to services in the community. Although many barriers presented below are the same as those for shelter use, participants describe how these barriers uniquely apply to community services.

Impeding Beliefs

In the same way that adaptive beliefs can push individuals to use services, impeding beliefs can stop shelter residents from accessing services in the community (Heerde & Pallotta-Chiarolli, 2020; Magwood et al., 2019). One participant explained that it was difficult to accept help because of the shame and embarrassment he felt about needing it: *“It takes a lot to become humble enough to accept it. Where you are in the place in your life and it's not easy [because of] shame and embarrassment. People seeing you in places, it was, it is hard.”* (JHS_002). This quote is consistent with research suggesting that shame and psychological inflexibility were linked to unfavorable self-evaluations (Eswara Murty et al., 2021). Some participants felt that they would be imposing, that they did not deserve the help, or that there was no way to improve their current situation. Some participants expressed a deep sense of hopelessness. For example, one emergency shelter user uttered the following:

“I give up on things a lot quicker. I don't know. I think that things will never change. Yeah, like it seems like the more I try to get things accomplished, the further back I fall ... And when I do ask for help, it doesn't really seem like I'm getting the help that I wanna get.” (JHS_006).

It follows that this lack of hope for the future would make individuals reticent to seek services. Consistent with extant research (Eswara Murthy et al., 2021; Heerde &

Pallotta-Chiarolli, 2020), shelter residents further explained that it is difficult to ask for help because many of them grew up being punished for doing so as children. For many, their personal histories shaped their worldviews, and many were very self-critical. One participant explained that he often looks for faults within himself and others: “[I am a] very critical kind of person. I’m a very fault-finding kind of person I guess, and that probably has a lot to do with it too” (JHS_010). A qualitative study by Stonehouse and colleagues (2022) examined individuals experiencing homelessness apportioning of personal responsibility to their current experience. Although participants in that study acknowledged their personal responsibility regarding their experiences of homelessness to an extent, they also felt that greater recognition should be given to systemic barriers that impede their ability to acquire housing (Stonehouse et al., 2022). Participant narratives illustrated how one’s capacity for personal responsibility is simultaneously shaped by lived experience and current social context.

Environmental Deterrents

Participants explained that the physical environment can deter them from engaging with the services provided by that service agency. A systematic review of the acceptability of health and social interventions for those experiencing homelessness emphasized the importance of service programs that create a sense of safety and stability (Magwood et al., 2019). Similar to the limited safety experienced by some shelter users, one participant noted physical altercations outside service centers that makes them less likely to go:

“Like I don't you know, hang around downtown or anything like that. Well, now I have to because I have no choice, and it scares me. Because there is a lot of violent people out there, you know.” (JHS_006).

Another shelter user explained that he is hesitant to use services when there is a crowd of people present. Participants expressed frustration at the lack of places for them to go during the day: *“What are we supposed to do? There's nowhere for us to go.” (JHS_014).* They emphasized that staying outside all day, especially in the winter, is particularly challenging. For example, one interviewee highlighted the limited seating available in public outdoor spaces:

“Where in the hell are they supposed to sit, if they're out on the street all day, they can't sit anywhere. Because the benches are already taken off and we don't have any snow out there. It's beautiful weather, yet.” (JHS_016).

Shelter users clearly struggle to find appropriate safe spaces to occupy during the day, buttressing the argument for additional day (drop-in) centers (Johnsen et al., 2005; Kertesz et al., 2013; Kertesz et al., 2021; Rice et al., 2023). One doctoral thesis found that access to drop-in centers helped meet clients' basic needs, increase their independence, and foster beliefs of self-worth (Pleasant, 2016).

Practical Barriers to Service Engagement

Participants highlighted concerns with transportation across the city to reach various services (Murphy, 2019; Sylvestre et al., 2016): *“Here, they're supposed to have tickets for people who legitimately have appointments, and serious appointments, and they seem to give them out. And whenever I ask for tickets, say for probation I have tomorrow, I don't know if they're going to have any. I doubt it.” (JHS_013).* Participants

also felt frustrated that they had to repeat their stories for every referral: *“Repeat of the, of the same thing over, and over, and over again to the point where it's just crazy. Makes me crazy.”* (JHS_013).

Some interviewees brought up difficulty connecting with resources: *“If I have no way to contact people, like here, if you don't have a tablet, or a phone, or a computer, how are you going to like, fit, like search it out?”* (JHS_011). Participants did not explicitly discuss attempts they had made at seeking out resources; although some shelter residents felt there were not enough services to meet all their needs, they struggled to identify the specifics of the support they want.

Lack of Knowledge

Although most participants acknowledged they needed services, they felt their progress was halted due to this lack of knowledge: *“because you don't know how to access those, so like, that would be like, one thing that's hard ... like I didn't know there was other services like community kitchen. I didn't know that.”* (JHS_012). Shelter residents felt the city did a poor job of promoting the resources that were available: *“The city doesn't promote anything, [to] let people know ... they're not making people aware of what help is out there”* (JHS_016). These quotes highlight that it is crucial to ensure that potential service users are aware of services available to them (Kerman & Sylvestre, 2020; Quinn et al., 2018; Rizzo et al., 2022). Although shelter users did not discuss active strategies they used to acquire knowledge, they did express that most of their insight came from word of mouth from other members of their community.

Staff Attitudes and Behaviours

The impact of staff attitudes and behaviours on resulting service use cannot be overstated (Donley & Wright, 2012; Hoffman & Coffey, 2008). Over a third of participants expressed having negative interactions with staff in community services. One interviewee described feeling poorly perceived by staff: *“They just they look at you, [as though to say] ‘oh you’re not worth it really’. I don’t know, that’s how I feel ... I mean, there’s too much judgment going on, I believe.”* (JHS_002). Adverse experiences can colour individuals’ beliefs and make them less likely to seek out potentially beneficial services (Black et al., 2018; Ha et al., 2015). For example, one participant explained that she was reticent to engage in mental health services because of previous negative experiences:

“Whoever I’m talking to. Like, if I don’t feel comfortable with them, I won’t go. I’d like to go see a psychologist or psychiatrist or something like that, but I’ve done that before and the first time I went, they kept asking me, well, ‘why did your mom do this’ like ‘your mom did? Wait, why? Why would she do that?’ Well how am I supposed to know, I’m not my mother, right?” (JHS_006).

Interviewees were insightful about how the structure of services and staff behaviours can shape user behaviours (O’Shaughnessy & Greenwood, 2021). Leveraging their wisdom is crucial in molding services to best meet their needs. One participant explained that the services available were limiting his agency rather than fostering independence and choice:

“They start to treat it more like it’s a prison sometimes, people tend to think of things in terms of us and them, and there ends up being this great big divide and

it's actually counterproductive because it makes people more dependent.”
(JHS_010).

These quotes illustrate the significant qualms service users have with staff at certain services, and how important it is to amplify the voices of those with lived experience (Marshall et al., 2023; O’Shaughnessy & Greenwood, 2021; Weissman, 2018). Although it is crucial to leverage the wisdom of lived experience, it is also important to acknowledge that certain client behaviours can incite negative reactions from staff members. Both staff and client perspectives contain elements of a nuanced truth that are worthwhile to integrate when developing recommendations for change.

Shelter User Perspectives on Facilitators to Service Use

Participants repeatedly acknowledged the importance of key enablers to service use, including: (1) adaptive beliefs, (2) appropriate tailoring, (3) staff factors, and (4) support systems.

Adaptive Beliefs

Participants who held favorable beliefs about themselves and about the available services were considerably more likely to engage with them. Participants who displayed goals for the future and the self-efficacy to believe they could reach them were those who would use the services to help them reach these aspirations (Greenwood et al., 2022):

“And now I realize [that] you want to be the best you can be, and then the people that are good for you, they'll like draw themselves towards you. And so I push myself. I want the best kind of housing; I want to be able to someday put a down payment on a nice big house.” (JHS_012).

This characteristic is an important target for positive intervention, as research suggests that self-efficacy among individuals experiencing homelessness is lower than that of the general population (Maccio & Schuler, 2012). Many interviewees reported that experiencing homelessness had profoundly changed their worldview:

“I just learned like, like how soldiers adapt to the Warfield. I learned how to lay on the ground and not get bothered or have backaches. I learned how to survive the way of [how] a homeless person should, without having to die.” (JHS_013).

Those who were able to maintain hope in the face of this adversity were those most engaged with services. Moreover, individuals who had the capacity to identify their needs and the ability to advocate for themselves were in the best position to have those needs met. For example, one participant explained that he took it upon himself to search for shelters when he needed it: *“So like I said...I searched up shelters in Fredericton... I searched it up” (JHS_011).* It follows that fostering self-efficacy and hope in the shelter environment is an important facilitator to quality-of-life improvement (Greenwood et al., 2005). One shelter resident explained that volunteering helped him maintain that sense of hope for the future: *“I volunteered more days because, you know, I needed something to do, and it made me feel good.” (JHS_015).* Embedding a participatory model to services may provide a sense of agency to clients and make them better integrated to decision-making processes.

Appropriate Tailoring of Service Offering

Participants spoke about the importance of having appropriate services tailored to address practical concerns like flexible hours, drop-in services, and convenient locations. Research on primary care settings illustrates that appropriate tailoring leads to

superior service experience for individuals experiencing homelessness (Kertesz et al., 2013; Kertesz et al., 2021). One participant explained the benefits of services offered at the church: *“Some of the churches have good drop-ins and explain stuff like that to people visiting, and so on.” (JHS_016)*. Some participants advocated for a centralization of services to increase ease of access. This call for centralization is consistent with research that supports a one-stop-shop model of service delivery for vulnerable populations (Pedersen et al., 2016; Magwood et al., 2019). Furthermore, participants stressed that services which fostered their sense of agency were most likely to be used. For example, services offering gift cards for grocery stores rather than specific grocery items allowed users more flexibility in deciding which items they needed.

Positive Staff Influence

Staff factors can play a huge role in increasing service utilization among this population (Olivet et al., 2021). Staff members can act as an important support system for many individuals experiencing the social isolation of homelessness (Bower et al., 2018). One participant vocalized his positive experience with staff at a specific service location: *“I depend on, like I lean on [staff member] a lot. Staff at the AIDS clinic, they're just awesome. Yeah, I really, I think they're - they helped me a lot” (JHS_006)*. Staff members can act as an important source of knowledge mobilization for service clients. They can provide education about services that are available and facilitate some of the practical procedures necessary to gain access like explaining the referral process and reminding them of opening hours. Their embedment in their community gives them inherent knowledge about availability of other services. One participant explained that staff at one shelter connected her to another when they had no beds available: *“She [the*

staff member] was like “there's another shelter, I'm going to go call them for you”, and she even called a cab to take me here” (JHS_011). Staff members can also act as gatekeepers to certain services and provide coordination between different services. One shelter resident explained that their service provider helped connect them to services that would be useful:

“It makes it easier to access others because very often they will tell you about others and give you somebody's name or say, here's a phone number, call and see what you can get and so on ... I talked to my mental health worker about it first and she could say, no, no, that won't be a help to you. Or, yes, [it] would be good that you get in touch with them” (JHS_016).

It follows that adequate staffing, appropriate training, and efforts to retain staff to help with continuity of care are all important components of maximizing service use among individuals in this disadvantaged population (Rogers et al., 2020).

Interviewees also emphasized the importance of non-judgmental and receptive staff attitudes. When shelter residents felt accepted in a service location, they were more likely to return and engage with the staff members. Staff reactions played a significant role in whether clients would consistently return to the service: “Yeah, like if you're hungry or just need somewhere to go, or go use phone, or someone to talk to, they're always good” (JHS_007). A systematic review found that interventions using motivational interviewing techniques for adults experiencing homelessness were effective in maximizing treatment engagement (Orciari et al., 2022). Motivational interviewing emphasizes client acceptance and fosters strong relationships by acknowledging client autonomy. Evidence-supported strategies include having an

explicitly non-judgmental attitude, supporting client self-efficacy and belief in their ability to change, and reflectively listening to build client motivation for change (Orciari et al., 2022).

Support Systems

Although participants generally expressed that they had limited support in their lives, some did refer to family, and many participants explained that staff members at the shelter acted as a source of emotional and practical support for them: “... *they helped me [get] back on my feet.*” (JHS_001). These shelter residents believed they could rely on staff members to connect them to other resources. Some interviewees mentioned that family and friends helped them through emotional and practical avenues. One participant recounted that his family visits when they are able: “*they bring me cookies, oh yeah, they take me to dinner, you know, when they’re up*” (JHS_009).

Given that individuals experiencing homelessness are often moving between cities and provinces (Kaufman, 2021), some participants explained that they try to remain connected to personal supports online. For example, one participant said that she spoke to people she knows online to have her emotional needs met: “*I talked to them and things on messenger or whatever like that ... I talk to my sister and my mother, my father, bunch of friends*” (JHS_005).

Some shelter residents sought support from each other and felt they freely shared knowledge of services that may be mutually useful. One shelter resident who had recently moved to the area explained: “*I actually had my roommate, she helped, she helped me out a lot. So, Friday she’s going to bring me somewhere to get some snacks and some free, some free clothing*” (JHS_011). Literature suggests that social support is

limited among individuals experiencing homelessness (Lord et al., 2021; Malden et al., 2019); therefore, it is important to foster social, emotional, and practical support among these individuals to help re-build the social “safety net” that has often disintegrated throughout their life (Richter et al., 2021).

Community Solutions to Increase Service Use

Policy & Macro level Recommendations

Many of the recommendations highlighted in service users’ interviews were related to broader social policy. In contrast, none of their recommendations were related to changes in personal behaviour that could result in increased service use. For example, participants stressed the need for more affordable housing in their communities (Baral et al., 2021). *“I think there should be more affordable rentals for low-income people, my god. Like, more homes for people like us, you know” (JHS_006)*. Interviewees explained that affordable housing is a foundational need for them. Similarly, participants stressed the importance of appropriate funding for available services (Ramage et al., 2021).

Participants noted that there is a lack of services available on a continuous basis (Kerman & Sylvestre, 2020). For example, they explained that amenities are less available on weekends, and certain services like receiving specific clothes and food services, occur only a few times a month: *“There [should be] something in place for us for every day. Not just like once a month or twice a month ... what's hard is the gapping between the help.” (JHS_002)*. Participants believed that guaranteeing that services are available during those “down” times should be a priority and advocated for greater access to indoor recreational spaces during the day and more seating in public spaces. Finally, participants emphasized the importance of awareness of services and

hypothesized that having services listed in public spaces may increase uptake and engagement.

Proposed Practical Recommendations

Participants highlighted a multitude of concrete suggestions for beneficial services. For example, they yearned for more access to appropriate clothing choices and groceries they could acquire and cook rather than rely on prepared food. They also advocated for educational and occupational training. Some desired physical activity, as per one resident's comment: *"For myself, I'd like to get into kickboxing or something. Something physical, you know. When you're tired out at the end of the day. Something to build your confidence up, right?" (JHS_007)*. He explained that engaging in this activity would help bolster his self-confidence.

Participants said they would benefit from reminders for appointments: *"Yeah, and reminders too. Remind you that you have an appointment to remind you I need that support." (JHS_008)*. Implementing a reminder system would decrease the likelihood of clients losing access to services due to missed appointments. Given that certain services in Fredericton have no-show policies that result in ineligibility for a service for a period of time (e.g., three no-shows for addictions and mental health services requires a re-referral to the program), reminders would help facilitate continuity of care.

Shelter residents also had recommendations to ease the transition into long-term housing. For example, one participant said they would benefit from access to a furniture bank to furnish any unit they were able to acquire: *"I would need, like, to figure out how to get furniture, like a furniture bank or something, because [I know that] in Toronto, you can get furniture ... I mean it's used furniture, but the bed is new, and yeah, there's*

certain things you can get from [the] furniture bank.” (JHS_011). This comment, and another participant’s observation that larger cities have frequent identification card clinics, is consistent with research underscoring the discrepancy in service availability between rural and urban environments (Schiff et al., 2020).

Client Perspectives on Substance Use

Emergency shelter users spoke at length about their substance use during their interviews. Research suggests that almost 40% of individuals experiencing homelessness meet criteria for an alcohol use disorder, and over 25% are dependent on illicit drugs (Stablein et al., 2021). According to the Canadian Alcohol and Drug Survey, illegal substance use among the general Canadian adult population is estimated at 3% (Health Canada, 2021).

Interviewees outlined their beliefs about substances, provided reasons for their use, and relayed their experiences with services they had accessed to curb their substance use. Most participants recounted having substance use problems during their lifetime, with many using at least one illicit substance (e.g., methamphetamines, opiates, hallucinogens). Irrespective of their current use, most participants felt that their substance use had a negative impact on their life. One interviewee described the particularly negative impact of alcohol use on his life:

“I burned a lot of bridges with my family from drug use, like I got into crack cocaine back then and I continued on that journey... I drank back then too. And that was big, like a big downfall for me, to drink. It was like my nemesis, cause it kind of led me into - like a gateway into everything that I experience.”
(JHS_005).

Research suggests that problematic substance use has a significant negative impact on an individual's social support networks (Birtel et al., 2017; Rapier et al., 2019). Many participants vocalized that they use substances to numb the pain they are experiencing. Many participants inferred that they use substances as a coping mechanism to numb the pain and suffering they are experiencing. These comments are consistent with research suggesting that individuals experiencing homelessness can use substances as a way of coping with boredom, frustration, or their mental health symptoms (Johnson & Chamberlain, 2008).

Subsistence difficulties among individuals experiencing homelessness (e.g., acquiring shelter, food, clothing) is a barrier to substance use reduction (Baggett et al., 2018). One interviewee explained that she felt unable to stop her substance use, despite a desire to do so, because of her homelessness: *"I want to quit, but the thing is I'm not ready because of the situation I'm in."* (JHS_006). Others used substances to cope with other mental health symptoms. For example, one participant explained that smoking cannabis was less expensive than using licit medications:

"It's like, you know, I only smoke weed. I smoke weed for personal reasons... I use it because of my PTSD. I can't afford to go pay \$280 every two weeks for traumas at home ... It [cannabis] keeps me calm, and it keeps me ... able to [keep my anxiety down enough that I can] function ..." (JHS_015).

These statements are in keeping with coping motives theories of substance use (Votaw & Witkiewitz, 2021; Wolitzky-Taylor et al., 2018). Coping motives for substance use often contribute to the maintenance of substance use disorders, and individuals who endorse these motives often have limited other coping mechanisms (Wolitzky-Taylor et

al., 2018). Research by Foster and colleagues (2016) suggests that individuals who endorse coping motives for substance use are more likely to engage in poly-substance use. These authors explain that treatment tailored to multi-substance use and the development of adaptive coping mechanisms to address factors underlying these coping motives (e.g., anxiety, depression), will be most effective (Foster et al., 2016). Despite their history of substance use problems, five interviewees reported currently trying to curb or abstain from use. One participant explained that they consulted with a health professional for assistance:

“I’ve [been] trying to quit, been thinking really hard about quitting. I’ve been talking to the doctor and explaining to her what’s been going on in my life with drugs and other things and talking to her for help in that way. Yeah anyway she’s gonna put me on some meds, hopefully be able to turn me [away] from using drugs anymore.” (JHS_008).

Interviewees also outlined their experiences with various harm-reduction, detox, and rehab services such as AA meetings, the Village of Hope program, and hospital detox. One participant expressed gratitude for opioid agonist therapies in managing their cravings: *“I’m on methadone. I’ve been on that for years...glad I am still on it...it actually helps with my cravings” (JHS_006).* Another voiced that staying in detox was challenging when others in the treatment cohort were leaving as they miss their peers:

“I find detox is kinda hard, it’s like a hospital setting so [when] I get in there and I’ll look out the window, especially here ... you see people you know roaming around and so you just kind of want to leave” (JHS_007).

Participants spoke about the importance of personal readiness in terms of accessing substance use treatment. The stages of change model, often used to conceptualize recovery, explains that individuals pass through five stages of change from pre-contemplation to action and maintenance (DiClemente, 1999; Marvin & Buckingham, 2024). When discussing their current substance use, many shelter users seemed to be in the pre-contemplation or contemplation stage of change. Given that substance use treatments are most effective when they correspond to the clients' current stage of change (Bodley-Scott et al., 2024; Orciari et al., 2022), it is important to ensure that available treatments can cater to different levels of motivation. Shelter users felt that without a strong motivation for change, treatment would be unsuccessful:

“Well I went to rehab a couple times, but it was in my younger days, and what I found was, just [as] soon as I got out, first thing I did was hit the bar. Like to me it's mind over matter. You gotta be ready to quit what you're doing, if you're not, it's not gonna happen” (JHS_008).

Research suggests that motivational factors are predictive of adaptive substance use reduction (Battjes et al., 2003; Moore & Hardy, 2020). Participants who were trying to refrain from use felt challenged by the pervasiveness of problematic substance use in the emergency shelter environment. When asked to opine on the worst part of the shelter, one participant responded: *“I find when you're in situations there's a lot of drugs around you, and it's more easy to fall into that trap again, right?” (JHS_005).* Finally, they explained that they were looking for additional services tailored to substance use problems: *“I would like people to be able to deal with alcoholism and drugs. Have programs that they know was there that would help them.” (JHS_016).*

A systematic review by Barati and colleagues (2021) examined factors that increase risk for relapse through an ecological lens. The authors found that peer substance use at the interpersonal level and drug availability in the environmental level had a significant impact on risk of relapse. Individuals who live with peers who actively use substances, and increased environmental access to substances, are more likely to relapse (Kabisa et al., 2021).

Client Physical and Mental Health Experiences

Participants implied that physical and mental health are intrinsically linked aspects of health and impact one another in a bidirectional fashion. Difficulties with either or both are exacerbated by their experiences of homelessness. This finding is in line with research that highlights the tri-morbidity among individuals experiencing homelessness (Vickery et al., 2021). A large-scale study in Minnesota found that almost 80% of adults experiencing homelessness had a chronic health or mental health condition. Moreover, individuals were more likely to experience bi-morbidity or tri-morbidity than to have a single condition (e.g., physical health, mental health, and substance use conditions; Vickery et al., 2021). Residents at the shelter expressed that they struggled with various mental health problems, such as depression, anxiety, psychosis, bipolar disorder, OCD, and PTSD. Interviewees voiced a desire for access to greater mental health resources: *“I think that’s probably one of the biggest things is the shelters have to have more options for people with mental health” (JHS_015).*

The lack of mental health resources and trained intervenors in places of contact including shelters, hospitals, drop-in centers and food banks, complicates access to preventive and ongoing care. For example, many interviewees reported being connected

to others who had attempted or completed suicide and endorsed experiencing thoughts of their own suicide. One participant was explicit about his chronic ideation and suicide attempts, *“I’ve made [several] suicide attempts”* (JHS_016). Conservative estimates suggest that 25% of individuals experiencing homelessness have attempted suicide at least once in their lifetime (Flach & Razza, 2022). One participant conveyed frustration at the lack of knowledge about services available for those who are struggling:

“They don’t let people know, oh my god, there’s three different programs in mental health. There’s help for people who are thinking seriously about suicide, people who attempt suicide but fail. And for families to go through somebody in their family.” (JHS_016).

Shelter residents also emphasized a discrepancy between what is advertised and what is actually provided by services. This discrepancy may be related to funding and financial constraints experienced by non-profit organizations. For example, providers may have to modify or ration their service to remain eligible for government funding (Mosley, 2012). One participant used an analogy to explain her perspective on the inconsistency of mental health care availability:

“There’s not really any help out there. It looks like help ... It’s like when you go to Dairy Queen and I see the poutine up there and, oh my god it looks so good in the picture, and then you order it and it’s like ‘What the fuck is this?’ ... that’s what the services are like in Fredericton ... [they say] we’ll help and give you an appointment [and] we’ll do this too, but it’s on the surface because once you get in there, there’s no freaking help here. There are no psychiatrists.” (JHS_014).

A review of an updated service directory for adult mental health and addictions services in Fredericton suggests a promising 40 services (Government of New Brunswick, 2024). However, further inspection reveals that eleven are phone lines, seven are for addictions only, six have specific diagnostic eligibility criteria (e.g., early psychosis program), six groups do advocacy rather than direct client care, four are residential treatment programs run by hospitals, and two are funding opportunities. This process of elimination leaves only six services, further emphasizing the limited availability of services in the city and the discrepancy between resources advertised and those actually available.

Some participants had experienced hospital admissions for both physical and mental health reasons. Because of such factors as higher exposure to the elements outdoors, food insecurity, lapsed personal hygiene and self-care, substance use, and minimal healthcare oversight, those experiencing homelessness are at higher risk for multiple physical illnesses including malnutrition, skin diseases, musculoskeletal disorders, dental issues, respiratory disorders, and infectious diseases like HIV and Hepatitis (Onapa et al., 2022). This reality is consistent with the current study's participants who outlined a variety of physical ailments that impacted their mobility and quality of life such as strokes, hepatitis, and lupus. For example, one participant explained that he had a broken leg which never healed properly because of improper follow-up care. Interviewees voiced that the pain they experience is a physical barrier to access and engagement in services. One participant outlined how access to services is complicated by mobility impairment:

“Do you know how hard it would be if you have to walk all the way downtown to the, to the soup kitchen to just, to get a meal three times a day, that would be insanely hard. And if you couldn't do that because you were disabled, that would be impossible if you didn't have anybody to help you, know what I mean?”
(JHS_012).

Practical accessibility considerations must be embedded in program development and funding structures to ensure adequate opportunities for access among individuals experiencing homelessness. This need is especially crucial given the higher proportion of functional and mobility impairment among this population (Cimino et al., 2015). It follows that individuals with intellectual or specific physical disabilities are more vulnerable to homelessness (Beer et al., 2019).

Recent research examining disability among individuals experiencing homelessness found that over half (58.8%) reported having a disability, with physical disabilities being the most common (Guillén et al., 2021). Those with a disability experienced homelessness for substantially longer than people without one and reported difficulties with activities of daily living (Guillén et al., 2021). Individuals with a disability experiencing homelessness hold an intersectional minority status, which significantly increases the stigma they experience and thus decreases their help-seeking behaviours. It is crucial for social service providers to be mindful of how disability impacts accessibility among this population (e.g., consideration of wheelchair accessibility of services).

Shelter Client Experiences with Police and Incarceration

Data from the United States suggest that individuals currently experiencing homelessness represent up to a third of all incarcerated peoples (Forrest & Beckett, 2021). Sociological literature has explored in depth how individuals experiencing homelessness are over-policed in public spaces (Gaetz et al., 2014; Herring, 2019; Herring et al., 2020). A recent study estimates that the number of fines issued to individuals experiencing homelessness in the city of Montreal have increased eight-fold since the 1990s (Laniyonu & Brais, 2023).

Interviewees who disclosed experiences of incarceration were particularly sensitive to police interactions. These participants felt that their daily lives were disproportionately monitored by police. For example, one participant said: *“Cops are here [at the shelter] like 4-5 times a day during the week.”* (JHS_014). Interviewees also felt that law enforcement by police was harsher for them than for others: *“They would probably arrest me if I walked across the street down in the crosswalk, you know, cuz they get everything blown out of proportion.”* (JHS_016). They felt as though their hypervisibility on the street contributed to their experience and believed that police were biased and thus see them in a negative light: *“I’ve been brutalized, have been, umm, assaulted several times, by different officers and I’m just looked at as a bad person for my past, and not looked as if what I have for the future.”* (JHS_013).

Participants also recounted their impressions of negative interactions and experiences with police including perceived inappropriate use of force and overly harsh enforcement tactics. Some explained that police give them fines frequently, which may lead to periods of incarceration because they are usually unable to pay them:

“Yeah, so you get fines that you can't pay, or won't pay ... then I just go to jail ... next time they catch me, maybe I'll be indictable you know, maybe I'll have to do [time for] all of them. Maybe I'll be there a month ... lately, they pick me up and the last fine was 140\$ or six days [in jail].” (JHS_013).

This participant's experience is consistent with research highlighting the negative impact of fines on those experiencing homelessness, and their increased likelihood of conviction for petty crimes (Cooper, 2017). For example, between 2015 and 2018, the Austin City Police Department issued more than 10,000 tickets to individuals experiencing homelessness for crimes like panhandling or sitting on the sidewalk, while a point in time count reported 1,014 unsheltered individuals that same year (Aguilar, 2020; Goard, 2018). Seventy percent of those initial tickets developed into arrest warrants, and although 15,000 cases were brought for these crimes between 2011 and 2015, only 21 people appeared for their community court hearing (Aguilar, 2020). A study by Robinson (2019) examined the impact of homelessness policing practices on resulting behaviours and quality of life of individuals experiencing homelessness in Colorado. His research found that 89% of people who were sleeping outside before the camping ban was put in place continued to do so afterwards. Moreover, 53% of participants reported they felt less safe, 60% endorsed worse sleep, and 62% explained it became more difficult to find services after the implementation of these new police regulations (Robinson, 2019). The enforcement of ordinances of this nature can force individuals experiencing homelessness to violate the law by sheltering in place or move somewhere more secluded to avoid police, placing themselves at a higher safety risk because they are more hidden (Robinson, 2019).

Of note, some participants also recounted positive experiences and interactions with police. For example, one interviewee recounted a time when the police brought them to the shelter following a hospital visit. Another participant explained that the police accommodated his request: *“I asked the police department if I could stay in one of their cells, so they accommodated [me] twice last winter.”* (JHS_008).

Impact of COVID on Emergency Shelter Users

Given that interviews were conducted during the height of the COVID pandemic, participants spoke about how their lives were impacted by the protracted situation and how their already fraught living conditions were negatively affected. Shelter residents described experiencing varying denial of access to public spaces, reduced access to public transit, and being treated poorly by others who appeared to fear they were carrying the virus: *“I’m treated like that in a [lot of] places. It’s not proper. It’s not right.”* (JHS_014). In a similar vein, another participant expressed that the pandemic had made people *“change dramatically”* (JHS_006). When asked how their changed behaviour made him feel, he responded:

“It makes me feel sad, it really does, it really hurts because not everybody, you know [nobody] chooses to be in the situation that they’re in, right? ... I’d like to see the people that aren’t in our shoes be in our shoes for a week or two [so they can] see how it feels. Maybe their frame of mind would change a little bit more.” (JHS_006).

Some participants felt like services were more difficult to access: *“More line ups, I suppose”* (JHS_008) and were frustrated by the lack of drop-in services offered during this time. Given that many individuals at the shelter do not have consistent access

to a phone, requiring appointments to be made in advance can be an intractable barrier to service use.

Participants reported long wait times at the hospital and at health clinics, and most felt frustrated with the restrictions that were in place and admitted that they were reluctant to continue to abide by them: “... *now I just don't give a shit, I mean everyone's getting tired of it.*” (JHS_009). Although specific to the additional hurdles caused by the pandemic, an important insight here is that any additional barriers to service use may cause users to simply give up, as they are already struggling to comply, hence policy should prioritize the simplification of access processes.

In a Canadian policy paper, researchers stated how rural communities are particularly vulnerable to the negative effects of pandemics given their limited healthcare and social service recourse, which has a substantial impact on their ability to address their needs (Schiff et al., 2020). Again, tailoring services intended for this vulnerable population can increase uptake by selectively lowering access barriers during community-wide perturbations like pandemics, climate-related events like heat waves and floods, power outages, strikes and other disruptive incidents.

Conclusion

The second study of the current dissertation garnered insights about the emergency shelter system from a service user perspective. Service users are best positioned to help identify factors that maximize the responsiveness between available services and their unique needs. Participants in the present study discussed their transitions to homelessness, their experiences of the shelter environment, barriers and

facilitators to service use, and the impact of other factors on their daily lives (e.g., substance use, police interactions, the COVID pandemic).

Similar to staff members' perspectives (Study 1), emergency shelter users highlighted the negative impact of macro-level factors (e.g., lack of service and affordable housing availability) on their experiences of receiving care. Emergency shelter users emphasized the power differential between staff and service clients that impact their agency and decision making. In their interviews, they proposed individual changes (e.g., less nighttime checks) and systems level changes (e.g., increases in funding) that would improve their experience of the emergency shelter system. Although the current study examined emergency shelter users' navigation of service use, the final study of the present dissertation (Study 3) aimed to evaluate user experiences of a supported housing complex to ascertain whether that housing environment has an impact on patterns and perceptions of service engagement.

CHAPTER 4: Study 3 – Supported Housing Residents Perspective on Responsivity and Service Use

Introduction

Although emergency shelters continue to account for a large portion of assistance devoted to combatting homelessness, Housing First interventions have been associated with increases in long-term housing stability and provide significant reductions in the use of homeless shelters (Kerman et al., 2018). In a similar pattern, there is a larger body of research examining service use and responsivity in the shelter population compared to those in supported housing environments. Given the compelling research highlighting benefits of this housing model, it is important to consider barriers and facilitators to access this environment. Examining patterns of service use and understanding barriers and facilitators to engagement among individuals living in supportive housing environment will help maximize responsivity between their needs and available services. Leveraging their expert insights informed by lived experience can help inform meaningful policy change.

Housing First and Supported Housing

Housing programs for individuals experiencing homelessness have been shaped by different political agendas, one approach devoted to improving mental health and another focused on providing an alternative to living outside without any shelter (Henwood et al., 2011; Worton et al., 2019). These political agendas have resulted in housing being regarded as an input or intervention and simultaneously as an output or outcome. In principle, Housing First prioritizes housing before clinical support, in contrast to the treatment-first perspective, which prioritizes treatment before permanent

housing (Henwood et al., 2011; Stefancic & Tsemberis, 2007). Housing First is focused on harm reduction, as individuals are not expected or required to undergo treatment to access or maintain permanent housing (Jackson et al., 2014). In contrast, the treatment-first model, referred to as “Housing Ready,” posits that individuals experiencing homelessness must engage in services and be deemed stable before they are suited to access permanent housing (Stafford & Wood, 2017; Stefancic & Tsemberis, 2007).

Housing First

Housing First as an intervention involves the provision of housing afforded with a rental subsidy and accompanying support without any preconditions for eligibility (Kerman et al., 2018; Stefancic & Tsemberis, 2007). Consistent with responsiveness service models, the Housing First approach perceives permanent housing as an initial step in addressing ongoing homelessness because a focus on secondary needs (e.g., mental health treatment, substance use) is seen as implausible without first meeting the individuals’ survival needs (e.g., food and shelter; Baxter et al., 2019). Without access to stable housing, it is plausible that gains earned from other conventional services may be more difficult to maintain in the long term (Aubry et al., 2015). Housing First interventions have been associated with increases in long-term housing stability and provide significant reductions in the use of homeless shelters (Kerman et al., 2018).

Research suggests that Houselink, a community organization in Toronto, Canada, was the first organization (1977) to promote housing as a right without prerequisite treatment (Waegemakers Schiff & Rook, 2012). The term “Housing First” was coined by an American organization, Beyond Shelter, in 1988. This agency aspired

to minimize the use of transitional and shelter housing by providing service users with permanent housing as quickly as possible (Waegemakers Schiff & Rook, 2012).

The Housing First model, providing housing without prerequisites (e.g., not requiring abstinence or guaranteed employment), is supported by substantial empirical evidence, and individuals housed in accordance with this model tend to fare better than individuals in the emergency shelter system, generally reporting improved access to services and improved quality of life and physical health (Aubry et al., 2016; Kirst et al., 2015; Nyamathi et al., 2010). Furthermore, the Housing First model increases individuals' sense of agency, rates of recovery, and general community integration (Baxter et al., 2019). With more than 2000 participants in five Canadian cities (i.e., Vancouver, Winnipeg, Toronto, Montreal, and Moncton) over a two-year period, the At-Home/Chez Soi randomized-control trial of Housing First initiatives found that recipients were stably housed for longer, had greater reductions in use of health and social services, and reported higher quality of life (i.e., had access to existing resources like general medical healthcare) compared to those receiving treatment as usual (Aubry et al., 2015, 2016; Goering et al., 2014). In the last six months of the study, 62% of clients in Housing First programs were housed compared to only 23% of clients receiving treatment as usual (Goering et al., 2014). Housing First participants also showed a significant increase in social skills, medication adherence, and cooperation with service providers (Aubry et al., 2015). Individuals who experience Housing First interventions also have been shown to demonstrate different patterns of service use, with significant reductions in emergency department visits and inpatient hospitalizations (Kerman et al., 2018). Unfortunately, the most significant systemic barrier to the

implementation of Housing First programs is adequate access to affordable housing stock (O’Sullivan et al., 2021).

The provision of permanent housing is associated with significant cost savings from a service utilization perspective. Results from a New York housing program found that placing individuals into subsidized housing was associated with a \$12,145 annual net reduction in health, correctional services, and shelter service use per person (Culhane et al., 2001). Half the cost savings were related to reductions in psychiatric inpatient services and a quarter to the reduced use of emergency shelter services. One study found that 95% of the costs of supported housing, including operation and service costs, were accounted for by collateral service reductions attributable to housing placement (Culhane et al., 2001).

Similar theoretical arguments for Housing First initiatives have been made in the Canadian context, with scholars arguing that the provision of rent subsidies or increasing annual incomes would result in improved health and better future employment prospects for those experiencing homelessness (Kneebone & Wilkins, 2016). A compelling argument has been made for promoting the indexing of social assistance payments to other key drivers (e.g., housing and food costs) of the welfare of individuals with low income to enable them to remain housed without reliance on emergency shelters. A Canadian study evaluating the cost of homelessness found that annual costs to society of an individual experiencing homelessness with mental illness is approximately \$60,000 per year if they are living in one of Canada’s largest three cities (i.e., Toronto, Montreal, and Vancouver; Latimer et al., 2017). Notably, approximately 10% of those included in the study engendered costs in excess of \$93,000, reflecting

significant service use, much of it being spent on ambulance transportation, inpatient hospital stays, and justice-related costs (e.g., incarceration). This segment represents a small group of chronically homeless individuals who utilize the highest proportion of services in general (Latimer et al., 2017). Although individuals who experience chronic homelessness compose a minority of those experiencing homelessness, more than 50% of resources target this group (Baral et al., 2021), creating a compelling argument for evaluating whether available services are adequately serving individuals' needs. National research by Latimer and colleagues (2017) found that an individual's current level of need was the most predictive factor regarding the related annual societal costs. Individuals with high levels of need cost the most to support, providing a strong economic rationale for interventions tailored to those most in need, and is in line with the RNR model (Andrews et al., 1990; Latimer et al., 2017).

It is important to recognize that Housing First is not a panacea for the challenges experienced by individuals experiencing homelessness. When individuals are placed in independent housing without adequate preparation or support, they may face negative consequences, including: (1) being unable to manage funds to pay bills and prepare food, (2) having poor personal boundaries and letting too many others live with them (which often results in premature eviction), and (3) becoming more isolated from other services and supports (Quirouette, 2016). Although Housing First initiatives help address the fundamental need of shelter, they do not necessarily address all aspects of need. For example, individuals who enter a Housing First program use more food bank services than their unhoused counterparts, showcasing how Housing First models do not necessarily address food insecurity (Kerman et al., 2018). Moreover, Housing First

programs do not always embed appropriate layers of support to ease the transition from homelessness to a more stable housing situation.

There is limited evidence that Housing First interventions are applied consistently across sites, demonstrating a lack of fidelity to the original Housing First model (Waegemakers Schiff & Rook, 2012). The provision of housing, in combination with appropriate support services, seems best suited to support individuals' pathways to stable and *long-term* housing (Anderson, 2010). These findings suggest that the provision of housing alone is not sufficient to ensure adequate quality of life and highlight the importance of access to stable, secure, and affordable housing in tandem with appropriate supports needed to maintain it (Argintaru et al., 2013). Individuals experiencing homelessness placed in Housing First programs without informal supports are more likely to return to homelessness for longer periods of time (de Vet et al., 2017). However, providing permanent subsidized housing to individuals who experience chronic homelessness has shown high success in retention rates, with upwards of 70% of placed individuals remaining housed after their first year (Culhane et al., 2001).

Supported Housing Models and Support Variability

Supported and supportive housing models fall under the Housing First umbrella because they often involve the provision of housing without pre-requisite treatment conditions. Although there are some theoretical differences between supportive housing (i.e., housing coupled with on-site services) and supported housing (i.e., a choice-based, independent, permanent variation of supportive housing), the terms are often used interchangeably (see Table 7 for differences among models; Nelson, 2011; Rog, 2004; Sim & Craig, 2017; Tabol et al., 2010). For the current dissertation, the terms supported

and supportive housing are used interchangeably to refer to the lived experience of individuals residing in the Oak Center. With the implementation of a plethora of supportive and supported housing models since the 1990s, there is now considerable overlap between these two types of housing, suggesting a continuum of supported housing sharing a few core domains (i.e., consumer choice, housing type, resource availability, degree of flexible support; Nelson, 2011). Research suggests that consumer use of supported housing models increases housing satisfaction, reduces hospitalizations, and leads to a reduction in drug and alcohol use (Cheng et al., 2007; Nelson, 2011). Qualitative work suggests that individuals living in supported housing enjoy increased time flexibility (e.g., sleeping, eating, and showering at their leisure), privacy, and safety, addressing concerns characteristic of treatment first models (Jost et al., 2011). Individuals living in supported contexts versus living independently report higher community engagement, lower mental health symptoms, and greater overall quality of life (Kidd et al., 2013).

Supported housing is generally defined as subsidized housing with case management support that can involve various support models (e.g., assertive community treatment [ACT] for high need clients (Coldwell & Bender, 2007). ACT is distinguished from traditional case management approaches by characteristics including: the use of a multidisciplinary team, low client/staff caseloads to allow for the intensive provision of services, availability of community-based services, and 24-hour coverage by a treatment team (Coldwell & Bender, 2007). Proponents of supported housing believe that client agency is paramount and is the first step in the transition to stable housing (Tsemberis & Eisenberg, 2000). Emphasizing consumer preference has been linked to increases in

overall quality of life and improved functioning in the community, as rated by support workers (Nelson, 2011).

Housing program characteristics account for more variability in housing retention than interpersonal or clinical variables (Tsemberis & Eisenberg, 2000). Most supported housing models include the following characteristics: housing, a typical tenancy agreement, flexible levels of support, housing and service use that are mutually exclusive, clients have agency in selecting their housing, and they receive immediate placement (Tabol et al., 2010). A review of supported housing highlighted that housing with *any* form of support provided stability for individuals experiencing concurrent homelessness and mental health difficulties (Rog, 2004). In contrast, the inherent lack of agency that characterizes some residential facilities not abiding by a Housing First approach (e.g., strict schedules with little flexibility or personal choice) may decrease the likelihood of individuals engaging in services because residents value their independence so highly. Furthermore, research suggests that the ACT framework engages clients more intensely and for longer periods of time than other case management strategies and thus reduces rates of long-term homelessness and psychiatric symptom severity (Coldwell & Bender, 2007).

Group Intensive Peer Support. The group intensive peer-support (GIPS) model of case management was developed for veterans experiencing homelessness (Tsai & Rosenheck, 2012). The model is scalable, which is a crucial consideration if the goal is to address homelessness more broadly. In contrast to other case-management models that provide support on an intensive and individual level, GIPS provides support through weekly group meetings where clients may serve a dual role as a service user and an

active peer in the support of others (Tsai et al., 2014). The program emphasizes peer support, active participation, client choice, independence, and agency. Individual case managers are provided on an as-needed basis, but often the case management occurs during the weekly group meetings.

A study examining GIPS implementation found that provision of group case management did not worsen or enhance outcomes when compared to provision of services at the individual level (Tsai & Rosenheck, 2012). Given the high rates of staff turnover in the public health sector (Henwood et al., 2011), GIPS may be a suitable alternative that helps ensure continuity of care because it comprehensively integrates peer support (Tsai & Rosenheck, 2012). In comparison to individual case management, individuals who attend case management in a group setting facilitated through the GIPS program describe positive social and peer interactions (Tsai et al., 2014). Given that social integration is an important component of social housing and a frequent unaddressed need among individuals experiencing homelessness, the GIPS model appears to be a suitable, cost- and time-effective alternative to individual case management (Tsai et al., 2014).

Pathways to Supported Housing. Pathways to Supported Housing (PSP) is another supported housing model, developed in New York City. Clients can enter the program directly via intervention by community outreach workers or through referrals from other outreach programs, emergency shelters, or drop-in centers. Those deemed at highest risk for further vulnerability (e.g., elderly persons, women, history of incarceration) are prioritized for entry into the program (Tsemberis & Eisenberg, 2000). Once individuals are admitted, staff members provide support in selecting a living space

and assist them in the moving-in process (e.g., signing a lease, furnishing the space). To increase agency, program clients select their apartments from a few possible options and can decide to have roommates (Tsemberis & Eisenberg, 2000). The available apartments are studio, one-bedroom, and two-bedroom units scattered throughout the city's low-income neighborhoods, and the rent is 70% subsidized by the program. Furthermore, if immediate housing is unavailable, the program provides a room at the local YMCA or a hotel until an apartment can be secured. Various mental and physical health services are offered in vivo by program staff using an ACT-team format. The goals of the program are to meet clients' basic needs, enhance their quality of life, and increase social skills and employability. In contrast to a traditional ACT model, the PSP program allows clients to choose the type and intensity of services they use. Full-time facilitators also refrain from challenging the clients' points of view and approach substance use from a harm-reduction perspective.

The PSP program has two requirements: (1) clients are expected to meet with staff a minimum of twice a month, and (2) they must participate in a money management plan (Tsemberis, 2010). The PSP program achieved an 88% housing retention rate over a five-year period compared to treatment as usual (Tsemberis & Eisenberg, 2000). Research suggests that individuals participating in these programs experience long-term gains in quality of life, community functioning, and stability in housing (Aubry et al., 2015; Stefancic & Tsemberis, 2007). Providing tailored community services in tandem with housing subsidies can facilitate improvement in housing stability and clinical outcomes (e.g., reduced substance use; Cheng et al., 2007).

Systemic challenges play a significant role in limiting the wide-spread implementation of supported housing models. Many programs rely on external sources of funding, must collaborate with local agencies to provide services, and must navigate the scarcity of appropriate housing units (Tabol et al., 2010). Furthermore, the extant literature on supported housing models has been criticized for its inconsistent implementation of model elements. Tabol and colleagues (2010) found that less than 15% of key model elements were adhered to in the studies they reviewed. The inconsistency in implementation may be explained partially by an incomplete understanding of what supported housing entails and by challenges involved in properly maintaining supported housing models long term (e.g., cost and staff turnover).

Peer Support Housing. The peer support housing model can be understood as an additional layer that falls within the Housing First umbrella. Intentional Peer Support (IPS) is conceptualized as intentional because it is put in place through professional organizations (Barker & Maguire, 2017). Support through IPS can be delivered via mentorship or mutual support, meaning that those providing support could be peers or professionals. Support through IPS also can be informal, with participants advocating for one another, or it can be delivered through individuals trained to offer support in a structured fashion (Miler et al., 2020).

Although there are no specific guidelines for the implementation of IPS, these programs have a few key tenets in common: shared experiences, role modelling, social support, encouraging attendance, and fostering interest (Barker & Maguire, 2017). Shared experience with homelessness or residents cohabitating helps facilitate the development of rapport and trust between participants, and having prosocial

relationships is crucial in helping adults successfully transition out of homelessness (Rosenheck & Lam, 1997a). IPS role models who pattern successful and stable housing can help foster a sense of hope and motivation for positive change in the future among participants (Barker & Maguire, 2017). Furthermore, participants experiencing a structured peer housing environment can also create a sense of community and allow for the development of adaptive social and daily living skills (e.g., cooking, cleaning) and peer support interventions engender development of strong social bonds, which foster long-lasting interest and engagement with the services provided (Barker & Maguire, 2017). The heightened service use through peer support initiatives is hypothesized to contribute to an increase in employment among this population and emphasizes the value of peer support relationships. Indeed, peer mentors are perceived by IPS participants to have genuine, helpful intent, and their unique experiential knowledge qualifies them to facilitate support (Barker & Maguire, 2017).

A systematic review of the literature concerning peer support among those experiencing homelessness and substance use established that peer support interventions are related to a plethora of positive outcomes, including reductions in substance use, cigarette smoking, improvements in housing retention, improved health, and greater return to employment (Barker & Maguire, 2017). Unique benefits of the peer support model include positive role-modelling from those with applicable lived experience, an exploration of new alternatives for daily-living, and a superior relationship between supporter and recipient based on extensive contact and mutual respect (Davidson et al., 2012).

Due to the wide variation in peer support programs, there remains a lack of clarity and concrete agreement concerning what peer support work should involve and what language should be used to describe it. For example, it remains vague who should be able to act as a peer support mentor, whether the position should be paid or volunteer, and what the typical standards of compensation are for this role (Miler et al., 2020). Although variation in implementation may be warranted according to differing levels of need, it would be beneficial to provide clarity regarding these roles for both research and practice.

Distinct Patterns of Service Use Based on Need and Environmental Context

The service use demonstrated by individuals experiencing homelessness is directly related to their unique social context. For example, people experiencing homelessness are often forced to prioritize their immediate survival over their long-term needs and experience higher levels of violence than their housed counterparts (Addorasio et al., 2021). Individuals' use and sustained need of services varies based on the reasons they identify as contributing to their homelessness (Barile et al., 2020), and patterns of service use are related to the unique intersection of structural-level factors and individual vulnerabilities. It follows that individuals living in a supportive housing environment may identify different needs than those residing in the traditional shelter model.

Research suggests that individuals experiencing homelessness can be categorized based on their strongest need (Addorasio et al., 2021; Aubry et al., 2012; Barile et al., 2018; Morse et al., 1992). One study conducted at a shelter in St. Louis, Missouri found that individuals experiencing homelessness could be categorized into four meaningful

groups based on unique patterns of problems or service needs: (1) economically disadvantaged, (2) substance use problems, (3) mental health problems, and (4) socially advantaged (Morse et al., 1992; p. 235). Less than 5% of participants fell into the socially advantaged group, as they had higher mean income and larger social networks, twice the size of others included in the study. Individuals categorized in the socially advantaged group were more likely to be employed, female, and have social support problems (Morse et al., 1992). The socially advantaged group was also the most likely to receive housing assistance.

The economically disadvantaged group comprised most of the sample, and their needs were centered around socioeconomic issues (e.g., lack of available finances, credit needed to secure housing). Individuals in the substance use group were more likely to be male and exhibit a high degree of alcoholism and substance use. Those in the mental health group were most likely to present with symptoms of poor mental health based on the Brief Symptom Inventory (BSI), which represents nine symptom dimensions: somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobia anxiety, paranoid ideation, and psychoticism. Of note, both the substance use group and mental health group endorsed greater need for mental health treatment than the economically disadvantaged group. Similarly, Barile and colleagues (2018) identified distinct classes regarding individuals' pathways to homelessness that clustered around five primary issues: (1) disability or physical health issues (55% of the sample; e.g., mobility problems, medical diagnoses), (2) substance use or mental health problems (30% of the sample; e.g., current or past alcohol drug misuse, severe mental health diagnoses), (3) reported major life changes (e.g., recent divorce or relocation), (4)

financial crises (e.g., unexpected loss of income or savings), or (5) employment difficulties (e.g., unexpected loss of employment).

Barile and colleagues (2020) extended their previous research by applying the latent classes to patterns of service use of participants. They found that, regardless of cluster, all individuals reported they used basic-needs services the most, followed by food services, clothing supports, and emergency shelters. Individuals across all classes cited barriers to services including lack of transportation and restrictive program requirements. Individuals with disability or physical health issues used the greatest proportion of services, reported the highest level of unmet needs, and identified transportation as the most significant barrier to service utilization.

In the more recent study (Barile et al., 2020), individuals in the substance use group used fewer services than those in the physical health group. Moreover, individuals in the substance use group were most likely to report inappropriate, mean or abrasive staff behaviour as a barrier to service utilization. In comparison, the other three groups (i.e., reported major life changes, financial crises, or employment difficulties) reported fewer needs and less service use, perhaps because in general they had experienced homelessness for shorter periods of time. The largest cluster, those experiencing employment difficulties, reported that help in finding a job was their most pressing need and that insufficient income was the most significant barrier to stable housing. Most individuals in this cluster reported relatively short experiences of homelessness (i.e., under six months), which suggests that the provision of employment services could quickly help prevent these individuals from falling into chronic homelessness. With the employment difficulty group in particular, the number of resources needed to bridge the

gap to stable housing may be less than anticipated. In sum, these findings emphasize the likely reality that different barriers to service use occur as a result of individuals' varying pathways and exposure to maintaining factors of homelessness (Barile et al., 2020).

A study conducted in three Canadian cities found that a small percentage of individuals using shelters (2-4%) occupied over 25% of the shelter beds in Ottawa and Guelph and almost 40% of the shelter beds in Toronto (Aubry et al., 2013). Taken together, these findings suggest that a small percentage of individuals experiencing homelessness utilize a significant proportion of services (Latimer et al., 2017). Therefore, finding appropriate methods to transition these individuals into stable housing would likely lead to reductions in global service use over time.

Individuals experiencing homelessness who have the most complex needs are also the least likely to gain access to stable housing and appropriate services (Addorizio et al., 2021; Tsemberis & Eisenberg, 2000). Complex clients with high acuity needs are often dubbed difficult to serve and thus obtain less access to services (Quirouette, 2016). Furthermore, service use is unevenly distributed among individuals experiencing homelessness, with a small proportion accounting for the majority of hospitalizations and emergency department visits (Stenius-Ayoade et al., 2017).

Research Questions:

1. What are the barriers and facilitators to service use in a supportive housing model from a service user perspective?
2. How does the supported housing environment shape service utilization from the service user perspective?

Method

Sample Characteristics

Ten participants were interviewed between September 2022 and March 2023. I went to the Oak Center 28 times, for a minimum of 4 hours per visit, resulting in over 112 hours of recruitment time for phase 3 data collection. Based on only 30 apartment units being available in the Center, interviews represented a third of the total possible sample. Given the relatively small sample size, to ensure the confidentiality of residents' identities, only demographic information that cannot lead to their identification through triangulation was provided (see Table 4).

Table 4

Demographic Characteristics

	Full Sample
	% (n)
Age in Years [<i>M</i> (<i>SD</i>)]	50 (15.52)
Total Years of Homelessness	1.7 (1.4)
Gender	
Women	30% (3)
Men	70% (7)
Education Level	
Less than high school	30% (3)
Completed high school	40% (4)
Community college	20% (2)
Undergraduate degree	10% (1)
Employment [%]	
Employed part time	10% (1)
Receiving public assistance	100% (10)

Note. *N* = 10, one participant was both employed part time and obtaining public assistance.

As described in detail for Study 1, themes were synthesized using a thematic analysis (TA) approach (Braun & Clarke, 2006).

Service Users in Supportive Housing

Individuals who have transitioned into the supported housing project, recently created and now operated by the John Howard Society (i.e., OAK center), were invited to take part in an interview about their experiences using services in Fredericton, New Brunswick. Only adults (i.e., 19 years and older) were eligible to participate, as the service caters to adults and cannot accommodate children or other family members. Although the aim was to recruit a diverse population based on key demographic characteristics (e.g., gender, age, ethnicity), all willing participants were interviewed. Study 3 utilized the same interview guide as Study 2 (see Appendix B), with the addition of one question asking participants who have used the adjacent emergency shelter in the past to compare their experience using services across models (see highlighted yellow question in Appendix B). An ethics amendment was accepted by the research ethics board (REB-2021-039) to allow for the addition of this question.

The OAK center operates under a Housing First model, the only requirements of individuals gaining residency is connection with a case worker from the John Howard Society, and the degree of engagement is at the resident's discretion. Services offered at OAK center include full-time support from staff living on the resident's floor, case management, and peer support, with the amount of support dictated by each resident (A. McKay, personal communication, October 21, 2021). Two participants from Study 2 (i.e., emergency shelter users) had moved into the supported housing complex.

Results and Discussion

Table 5 provides an overview of themes and key points highlighted by supported housing residents. Titles which are bolded indicate that the theme is unique to the

supported housing resident perspectives. Moreover, citations following statements made by residents demonstrates the connection to extant research with similar findings.

Table 5

Themes from Supported Housing Resident Perspective

Supported Housing Resident Themes (Study 3)

Transitions into homelessness

Beliefs about homelessness and supported housing

Perspectives on supported housing

- Strengths
- Weaknesses
 - Physical space and environment
 - Staff members
 - Other residents
- Education and employment

Solutions for supported housing

- Improving physical space and practical services**
- Recommendations concerning staff**
- Tailoring and appropriate support provision**

Impact of financial difficulties

Service use in supportive housing

- Barriers to service use
 - Access problems
 - Mental health and substance use
 - Negative interactions and beliefs
 - Transportation
- Facilitators to service use & **suggestions for change**
 - Maximizing knowledge and increasing self-advocacy**
 - Increasing outreach, specific locations, and environment changes**
 - Appropriate tailoring of services**
 - Maximize positive staff interactions**

Protective factors to homelessness

- Suggestions for protective factors**

Substance use and addictions

- Beliefs about substance use
- Substance use in supported housing**
- Substance use services
- Suggestions for substance use**

Resident physical and mental health perspectives

Pandemic impact

Experiences of police and incarceration

Diversity and cultural considerations

Supported Housing Residents' Transitions into Homelessness

Supported Housing residents discussed their pathway to homelessness, and no two paths were alike. Participants attributed multiple reasons for their experiences of homelessness, including: (1) maladaptive substance use, (2) grief from the passing of a loved one, (3) mental health concerns, (4) relational conflicts, (5) financial troubles, (6) job loss, (7) extended hospitalizations, (8) incarceration, and (9) eviction. Although some participants pinpointed one reason preempting their experience of homelessness, others attributed their experience of homelessness to a constellation of factors. In contrast to emergency shelter users, some supported housing residents also pointed to practical concerns (e.g., job loss, financial constraints) as contributing to their experiences of homelessness. According to aggregate participant recounts, transitions into homelessness occurred across the lifespan, among all genders, and across the country. Overall, participants in the current study reported living, at some point, in multiple cities stretching across four Canadian provinces (New Brunswick, Nova Scotia, Quebec, Alberta).

Given the diverse experience of housing loss among the homeless population, and that individual needs may change over time, malleable interventions that can increase or decrease in intensity over time may be more effective. When discussing the onset of their experiences of homelessness, participants vocalized that precipitating

events leading to their experiences of homelessness were part of a negative cycle that felt uncontrollable and unavoidable. One participant stated:

“Okay, my plate was too full, and I kept piling on, like juggling. And I dropped the ball here, I dropped the ball there, and so on and so forth. And [when] I tried to pick it all back up again, I couldn’t.” (OAK_004).

Tailoring interventions to these proximal factors may help prevent people from prolonged homelessness. Beyond their initial transition into homelessness, many participants highlighted a recurrent pattern of housing procurement and subsequent loss. One participant explained:

“In, out, in, out, in, out. Establish apartment, establish a job, establish a place, start drinking, lose a place, lose a job, lose your stuff and back to jail. Over and over and over. I don't know how many times I've done that, and I'm here at it again.” (OAK_007).

This cycle illustrates that, without appropriate supports, the long-term maintenance of housing is unfeasible for recalcitrant participants. Although finding a place to live is a helpful first step in addressing the housing crisis, obtaining stable housing for the long term is what may lead to positive health outcomes and reducing public health-care costs (Boland et al., 2018). A recent systematic review examining factors related to housing stability found that engagement with psycho-social programming, adequate social support (from family and staff members) and older age were positively associated with long-term housing maintenance (Boland et al., 2018).

Residents’ Beliefs about Homelessness and Supported Housing

Individuals recounted their experiences of homelessness as having tangibly shaped their views of themselves, and a common theme was they felt perceived as “less-than” by others. One participant described this feeling as persisting even during periods of procured housing:

“I felt like the lower echelon of society... Even though I did have homes in the interim, I still felt very much like a homeless person, it felt like it never left, and now here I am again, even under different circumstances, and it feels like nothing's changed at all.” (OAK_002)

Research demonstrates that society continues to endorse negative beliefs about individuals experiencing homelessness. Tsai and colleagues found that 62% of those surveyed in their research believed homelessness was caused by irresponsible behaviour and over 40% attributed experiences of homelessness to laziness of the individual (Tsai et al., 2019). These findings were mirrored in the current interview transcripts, which illustrate that negative societal bias against homelessness has infiltrated the perspective of those with lived experience. For example, in the eyes of the interviewer, some participants rationalized why their experience was different from that of their peers as a way of guarding themselves against that negative stigma:

“And I worked my whole life. It's not like I was lazy. It's not like, you know, I didn't contribute to society [like others here].” (OAK_008).

Labelling theory explores the relationship between one’s self-identities and identities perceived by the social world (Goffman, 1986; Walter et al., 2015). The theory explains that individuals are not passive recipients of their identities, rather, they actively negotiate identities through their lifetime. Individuals’ negotiation between

private and public identities is complicated when the social identities are stigmatized (Barreto & Ellemers, 2003). When a person is labelled with a stigmatized identity, they may internalize negative stigma, which can influence their likelihood of engagement in adaptive or helpful behaviours (Link & Phelan, 2001).

Participants also spoke about the uniqueness of their experience compared to those who are stably housed. They explained how life without housing forces them to make difficult decisions that others often take for granted: “...*cause when you're homeless, you're, it's, it's hard. You know, you have to go, go through decisions that you normally would take for granted ... for the regular person, you know?*” (OAK_003).

Most interviewees felt satisfied with their housing at the supported housing complex and appreciated certain benefits including its location and privacy. Nevertheless, many yearned for a space that was entirely their own: “*I'd like to have my own piece of property and a little, little house on it.*” (OAK_005). For many, the desire for a space of their own was driven by limited agency with respect to decision-making in their unit (e.g., choosing their unit, decorating independently, inability to avoid the prevalence of illicit substances in the building). Evidence suggests that placing an emphasis on choice and mastery in service and housing provision among individuals experiencing homelessness is linked to better psychosocial outcomes (Manning & Greenwood, 2019; Martins et al., 2016). Greenwood and colleagues (2022) found that choice over services and housing quality mediated the relationship between Housing First programming and enhanced psychosocial functioning. These results support the assertion that maximizing choice in service delivery among this population is crucial.

Participants expressed that securing housing allows them to be themselves and to have a sense of hope for the future, uttering statements like “*housing means everything*” (OAK_002). Certain negative experiences characteristic of homelessness including a lack of control and reduced self-esteem are linked to hopelessness because they impede realistic goal setting (Gřundělová & Stanková, 2020; Kirst et al., 2014). Procuring housing can decrease stress levels, which provides opportunities to identify feasible life goals (Kirst et al., 2014). Gřundělová and Stanková (2020) found that hope among individuals experiencing homelessness can be fostered by using a person-centered approach that focuses on increasing self-efficacy, social support, and maximizing engagement with their interests. Some residents commented that supportive housing provided the assistance they needed to live. Some explicitly stated that being housed at the supported housing complex was keeping them alive: “*Means, means a lot [living at the OAK Center]. Means I’m not out in the damn cold, means I’m not dead.*” (OAK_009).

Although participants expressed views consistent with a Housing First perspective, almost all (90%) of them were not aware what the Housing First label meant. When it was explained that a Housing First umbrella implied that everyone deserved a place to stay without prerequisites, all participants strongly agreed with its premise: “*I agree with that idea for sure, because I think everyone, I mean, there’s homelessness everywhere, unfortunately, but I think everyone deserves not just a place to live, but a safe place.*” (OAK_006). It is paradoxical that while Housing First language is exceedingly common in public policy about homelessness, the majority of those with lived experience had no knowledge of the term. This discrepancy highlights

the divide that may arise when academic research fails to be adequately translated to the identified population. Education on terminology used in policy and academic circles may help individuals experiencing homelessness better advocate for themselves. An ability to use this language may further foster agency and advocacy among this population. However, low literacy rates and general staff shortages may make this type of intervention difficult to successfully implement (Rizzo et al., 2022). It also is possible that individuals experiencing homelessness have little interest in being involved in change stemming from academic research, given their traditional exclusion from the process (Fitzpatrick et al., 2011). Nevertheless, the lack of knowledge of this terminology among people with lived experiences of homelessness indicates a need for applied knowledge translation, an important aim of the current dissertation. Successful knowledge translation approaches emphasize ongoing communication between researchers and knowledge users (e.g., service providers and service recipients; Hasford et al., 2019).

Participants expressed frustration at the increasing costs for rent in their city. Their limited income adds a layer of complexity in acquiring accommodation, and the wait for subsidized units in the city is almost two years long (Government of New Brunswick, 2019). Difficulties in obtaining social assistance may further impede their ability to procure housing. For example, individuals experiencing homelessness may be less knowledgeable about available programs and face greater technical constraints to access like having no bank account (Chareyron & Domingues, 2018).

Although many residents had interviews with housing experts to identify their specific housing needs through the John Howard Society, they explained that the wait

for housing was extensive and that there was limited communication throughout the process:

“I had an interview with [the housing expert] when I first came to the shelter and she kind of did somewhat of a little interview like this with me, and I kind of gave her my background about how I got to the shelter and my end goal type of things. So that's about it.” (OAK_006).

Although systematic barriers influence the broader availability of housing stock, providing an online portal where individuals can assess their position on housing waitlists may be helpful. Given challenges concerning housing procurement, participants were often left inhabiting inadequate units. A few interviewees recounted living in rooming houses and storage units with no access to appropriate amenities.

Previous experiences with incarceration or homelessness causes potential landlords to pre-emptively perceive applicants as flawed tenants. Many landlords avoid providing tenancy to those with housing subsidies or vouchers because of perceived greater risk for housing damage and eviction (Evans et al., 2021). Rent-control policies imposed by governments also decrease the profitability of units for landlords, reducing the likelihood of them accepting renters with housing subsidies. Evans and colleagues (2021) explain how social policy that makes eviction more difficult leads to more stringent screening criteria on behalf of landlords, which likely disproportionately impacts those with histories of precarious housing or homelessness.

Experiences and Perspectives on Supported Housing

When asked to describe their current living situation, participants often compared it to the adjacent emergency shelter and other shelters they had visited.

Despite the frustrations participants held with their current housing, they all felt it was superior to the traditional shelter model. For example, one participant conveyed that he felt better able to express himself:

“Because in a room we can be more ... ourselves than we could in the shelter. In the shelter you have to go out at a certain time and can't come back in 'til a certain time. In a room you can stay all day long if you want.” (OAK_001).

Many interviewees emphasized their disdain for the shelters in which they had previously lived. For example, one said: *“You would rather sleep in a dumpster somewhere than you want to go to [another shelter in town]” (OAK_009).* Participants stressed that they were less monitored, had more agency, better food, more privacy, and felt safer in their current housing. In contrast, interviewees indicated they felt unsafe in the adjacent emergency shelter environment, and many recounted experiences of theft and violence. One participant said: *“I didn't wanna stay [at the emergency shelter] downstairs because people were coming into my room and just stealing things. Like everything I owned was stolen.” (OAK_008).* These feelings are consistent with literature indicating that many individuals facing homelessness believe the shelter environment fails to adequately meet their needs of security, agency, nutrition and autonomy (Gilderbloom et al., 2013; Mackie et al., 2019; Quirouette, 2016).

Perceived Strengths of Supportive Housing Model

When asked to explore the strengths of their current living situation, participants explained that living at the supported housing complex was giving them another chance at success. Although all participants outlined areas for improvement, most described feeling grateful for being eligible to live at the supported housing complex. They

expressed the satisfaction of having their own space and facilities with a lockable door: *the best thing is just to have my own bathroom ... not sharing the room with anyone.* (OAK_005). They were pleased with the low rent and location of the building and emphasized that having access to food and laundry services was an asset. Interviewees reported that staff, when they were perceived as “good”, were an especially important source of support:

“The [intensive case managers] are a really big part of the floor. They're a really big asset when we have good ones, like the girl that works on the second floor, that ICM worker, she's an asset to this place.” (OAK_009).

Research suggests that strong positive relationships between client and staff members are at the core of effective psychosocial interventions aimed at limiting harm from experiences of homelessness (Peters et al., 2022), and this was reiterated in the current interviews. Participants were especially pleased with the sense of community they enjoyed from living close to one another. One participant explained this feeling:

“Here at the Oak Center, it's a really decent community ... a lot of the people have their goals they're working toward ... being able to help each other, reinforce each other.”

Promoting a sense of community and individual empowerment (both interactional and interpersonal) has been shown to be an important component of effective interventions targeting homelessness (O'Shaughnessy & Greenwood, 2020).

Perceived Weaknesses of Supportive Housing Model

Participants discussed a variety of drawbacks about the supported housing complex. These weaknesses can be classified into three categories, including issues with: (1) physical space and environment, (2) staff members, and (3) other residents.

Physical Space and Environment. Participants expressed dissatisfaction with the level of environmental safety of the supported housing complex. Almost half of residents relayed specific concerns about the lack of monitoring for visitors, theft and burglary in the parking lot, and rampant substance use. For example, one participant expressed discomfort at being surrounded by individuals under the influence of methamphetamines: *“Like, there's people that are just way too high that are hanging around here and nodding out, or chanting, or just ... it makes me uncomfortable.”* (OAK_003). Given that the supported housing complex and emergency shelter included in the study were both housed in the same building, it is possible that patterns of substance use were influenced by the residents’ proximity to peers who were using. The visibility of substance misuse can act as an added stressor for individuals trying to refrain from use (Pratt et al., 2022). Previous research suggests that increased exposure to substance availability leads to heightened use (Kirst et al., 2014; Osgood et al., 1996). Substance use is also more likely to occur in environments with less oversight (Osgood et al., 1996). For some, providing an environment with less exposure to substance use may be beneficial. A systematic review of interventions to reduce homelessness found that abstinence-contingent housing paired with day treatment services compared to treatment as usual decreases total number of days spent without housing (Munthe-Kaas et al., 2018). Although this review found that Housing First approaches have moderate evidence for reducing number of days spent without housing, Munthe-Kaas and colleagues were unable to comment on whether Housing First approaches are preferable to abstinence-contingent housing. Taken together, these results suggest that having both

forms of support available in different buildings, and allowing individuals to choose between them, may be the most successful approach.

Although participants criticized the safety level of the supported housing complex, these same participants simultaneously expressed frustration at the degree of surveillance. Some participants described feeling like they were in a prison, whereas others were simply displeased with the ongoing monitoring. One interviewee vocalized this feeling: “... yes, I have a key, and I can come and go as I please, but sometimes I feel like I’m always being observed, with the cameras and all that.” (OAK_006). The dialectical response shared by participants of wanting increased safety alongside decreased monitoring places staff in a difficult position. Finding a middle path that addresses both ends of this spectrum would require a creative and collaborative problem-solving approach. For example, it is possible that engaging residents in creating an agreed-upon code of conduct could curb some of these concerns (Camardese & Youngman, 1996). Research on homelessness that embeds a participatory approach is more successful in clarifying barriers to service engagement among this population (Camardese & Youngman, 1996). It follows that centering a participatory approach at the supporting housing complex may yield the same results (Varosz, 2003).

A resident-created code of conduct also may address another concern vocalized by participants – the number of rules at the complex – and inconsistency in how they were enforced by staff members. The rules decried by participants included: (1) not being allowed to have overnight guests, (2) limitations on the layout and organization of their rooms, (3) assigned time for laundry, and (4) not being allowed to share their food or meals with others who were not residents of the supported housing complex.

Staff Members. Residents of the supported housing complex vocalized several problematic behaviours exhibited by staff members: (1) the differential treatment of residents, (2) lack of follow-through, (3) not enough staffing and too much turnover, (4) insufficient staff training and competence, and (5) inappropriate attitudes and dismissive behaviour.

Supported housing residents perceived certain staff as being lenient with some residents and harsh with others. Moreover, they expressed fear at the potential consequences of pointing out these inconsistencies: *“I have to say “yes...yes...when I know they’re wrong. I fucking know staff here; they make up their own rules.”* (OAK_004). In describing their perceptions of staff behaviour, participants did not allude to how resident behaviour could shape staff responses. Regardless of whether certain behaviours could elicit more stringent responses from staff, the inherent power dynamic between staff members and residents makes it difficult for residents to advocate for themselves when they feel they have been wronged. These interviews, conducted by a researcher not employed by the agency, provided a chance for residents to vocalize their opinions without fear of deleterious consequences. Participants felt strongly about the need for less favoritism displayed by staff members and that more consistent enforcement would drastically improve their living conditions. Considering an alternative perspective, it is possible that the interviewees who vocalized the greatest frustration about staff behaviour were also those who engaged in rule-breaking behaviour. However, the current study has no capacity to assess this hypothesis.

Embedding procedural justice principles into rule enforcement procedures may be helpful in increasing consistency in these practices. One qualitative study conducted

by Quirouette (2016) found that emergency shelter staff members' perceptions of clients as 'high needs' leads to more stringent rule enforcement practices. It follows that the creation of standard procedures or protocols for rule enforcement could lead to more equitable practices across staff members and shelter users.

Although they expressed understanding that bureaucratic regulations impeded staff to a certain degree, participants indicated that staff members rarely followed through on their promises (e.g., committing to help them complete a government form and then not doing it). Participants were frustrated that simple requests often took months to be met. One participant eloquently explained her frustration:

"I understand that, you know, with a non-profit organization like this there's that hierarchy that they have to follow to get things approved and everything, but it just, it seemed like it took so long. And that's part of the way that a system like that can fail." (OAK_002).

As a result of perceived staff inaction, participants had little confidence in staff's ability to help them with their problems. Participants noted that staff members would make promises to placate them, and subsequently fail to follow through. One participant complained: *"Everyone says, 'Oh great idea'. But nothing ever happens. They never give us the opportunity. [We are] never given the option to advance anything we say. So, it's all for show."* (OAK_009). Over time, this frustration can build to create profound resentment towards staff members and reduce the likelihood of seeking their support when needed. It is important to train, encourage and empower staff members to act appropriately, positively and quickly, to legitimate client requests and needs (O'Shaughnessy & Greenwood 2020; 2021). Encouraging staff members to promptly

address resident concerns will foster a stronger bond between them and their clients and likely improve the broader supportive housing environment (Peters et al., 2022).

Staff's limited ability to adequately address client problems can be partially attributed to a lack of staffing and frequent turnover. Frequent staff rotation can be explained by organizational factors that complicate the work of staff members, including low-wages, limited training, and lack of consistent supervision (Schiff & Lane, 2021). There are limited staff at the center, and the agency is regularly trying to hire new members for their team. Supported housing complex residents are keenly aware of this issue:

"I think, well, one issue they have here is staff. They have a hard time getting staff, or when they do get them, they have a hard time keeping them... And nobody tells them the difference [in how this center operates]. I'm usually the one to tell 'em, the new workers, what goes on." (OAK_010).

As a result of this lack of staffing, employees from the adjacent emergency shelter are often asked to cover shifts for the supportive housing complex. Although sharing of staff is theoretically sound, the rules and regulations of the environments are different, and participants explained that those differences are not adequately transmitted to these staff members. Furthermore, the shelter staff members do not have the same familiarity with resident of the supported housing complex.

Participants expressed that their safety concerns are exacerbated during overnight and weekend timeframes when staff members are unavailable: "... *cause often times staff aren't here when shit goes down.*" (OAK_002). For example, without

someone controlling access to the building, there is opportunity for individuals who have been previously banned, or who do not live in the building, to have open access.

Staff turnover remains a substantial issue at the supported housing complex and is a common issue in human service provision (Rogers et al., 2020). Recent research suggests that employee turnover in the homelessness sector happens when service providers experience one of the following: (1) a desire for career advancement, (2) incongruence between providers' values and needs and their work expectations, (3) mental health deterioration, (4) a lack of organizational support and stability, and (5) staff dismissal (Voronov et al., 2023). Voronov and colleagues (2023) provided suggestions to minimize staff turnover. Their suggestions include: (1) providing realistic job previews during interviews (e.g., explicitly highlighting positive and challenging components of the job), (2) increasing organizational supports to address job dissatisfaction and mental health deterioration (e.g., regular supervision meetings, debriefs after critical incidents), (3) increasing compensation, and (4) establishing workforce development strategies (e.g., increase training, create explicit routes for career advancement; Voronov et al., 2023). A recent systematic review identifying organizational-level practices that improve work experiences in the homelessness sector suggests that positive leadership perceptions and the use of educational stipend programs may maximize recruitment and retention (Flores, 2023). Effective leadership skills among management, and organizational justice management frameworks, have been shown to protect against emotional exhaustion and decrease staff turnover (Flores, 2023).

During seven months of interviewing participants at the supported housing complex, three different ICM's were responsible for managing one of the two floors. All three were reported to vastly different communication and work styles, and as a result, had differing expectations of their clients. The effect of this turnover is especially salient when working with individuals who have experienced homelessness, as they are more likely to be wary of newcomers. As a result, it is likely essential to require extra time to build rapport and a sense of trust between the residents and the ICM assigned to their floor. Residents expressed that by the time they created a good relationship with their ICM a replacement arrived, and the cycle had to begin again. Frequent turnover means there are few staff members with extensive organizational knowledge who are well positioned to share this knowledge with new hires (Schiff & Lane, 2021). Unfortunately, those positions of power in the organization, who have longer tenures and in-depth knowledge, are less likely to have time to interact with and guide front-line staff. It is important to consider whether certain strategies can be implemented to safeguard some of the front-line knowledge that is acquired. Strategies to do so may include keeping logbooks, the provision of ongoing trainings, and integrating supervision practices at multiple levels of the organization.

Beyond turnover issues, participants also expressed frustration at the lack of training held by certain staff members. Participants spoke specifically about the lack of experience with addictions and mental health: *“Most of them have no idea about addictions or mental health ... or how the homeless people act, or what they'll do or try to get away with things like that.”* (OAK_010). Residents explained that inadequate training makes staff unable to deal with the issues they encounter.

Supported housing complex residents spoke about feeling dismissed and treated unfairly by staff members. This finding is particularly salient because of the importance of rapport in help-seeking behaviour (Planey et al., 2019). Positive relationships are important for ensuring residents feel comfortable seeking services in the center setting. Interview participants were candid in expressing their feelings about staff members saying things like: *“Um, observing things that go on here that I felt or feel like staff just doesn't give a shit about, you know.” (OAK_006), “Cause he is mean, he is miserable. He doesn't care to help.” (OAK_009), “Couple workers here that talk to us like we're stupid children.” (OAK_009).* The inherent power dynamic further complicates these relationships, because participants felt that they cannot appropriately defend themselves without suffering repercussions.

Other Residents. The final area of concern voiced by supported housing residents involves their peers. Although most interviewees explained that the sense of community at the supported housing complex was one of its greatest strengths, they also expressed how living in close quarters with others can be difficult. For example, some participants expressed that they felt others were at the ready to “rat” on them to staff members. *“Everybody being together ... always gotta be an asshole in every bunch, right? And everybody starts everything. One person always could be ratting everybody out on a bunch of shit.” (OAK_009).* Another point of contention between residents, explored in Study 2, was the widespread use of illicit substances which created a rift between those who use and those who do not.

The tension between certain residents led to rumours and gossip being spread around the complex. Taken together, the resident dynamics within the complex helped

breed a sense of mistrust, which made it more challenging to build a positive community. One resident explained he felt he could not trust anyone: “*Because when you can't trust them, they'll take the story and they'll go to someone else and tell, but they'll add a little bit to it, and then that person will take it and add a little bit more to it.*” (OAK_001). Interpersonal dynamics and sense of safety play a large role in determining engagement with services (Jones, 2013). Intentional choices that maximize sense of safety and trust between residents at the center may maximize its effectiveness in curbing long-term homelessness.

Residents' Experiences of Employment and Education

Participants discussed how their experiences of homelessness negatively impacted employment and education opportunities. Although most expressed a strong desire to work, they faced various barriers to obtaining and maintaining successful employment. Unemployment is common among individuals currently experiencing homelessness, with estimates ranging between 80-90% (Acuna & Erlenbusch, 2009; Aubry et al., 2011). Participants struggled to conduct appropriate job searches and to secure or create the documents required to do so like making a resume. Moreover, when participants had previous experience in certain fields (e.g., esthetics, carpentry, chef), they stated they were no longer interested in working in that same area, often due to negative experiences they had in that sector such as being treated unfairly by employers. Participants were hopeful that staff members could help facilitate a connection: “*I'm hoping they can help me with getting a resume together and hopefully getting me back into job mode.*” (OAK_006). One participant noted that getting a unit in the center facilitated his job search: “*They got me into an apartment upstairs [at the supported*

housing complex], and that made a big difference in my life. And when I got the apartment upstairs, I was able to go look for work.” (OAK_007).

When asked about barriers to maintaining employment, participants explained that to maintain eligibility for their social assistance funding, they are required to work below a certain number of hours. One participant vocalized his concerns by saying: *“I’m only allowed to make five hundred dollars, right? So, who wants someone that’s gonna be, that’s only certain [number of available] hours, right? So it’s gonna be really difficult for me.” (OAK_005).* Although some participants were motivated and interested in working additional hours, they worried about being able to cover their living expenses without support from the government. Certain supportive housing residents had access to additional services through social assistance (e.g., designated social workers) which they would lose if they were no longer eligible for financial assistance. Moreover, some shelter users explained that their criminal record, mental health history, and substance use precluded them from obtaining or maintaining any job. The listed barriers are consistent with previous research examining difficulties to employment by individuals experiencing homelessness which listed obstacles including: (1) having a criminal record, (2) work-impeding shelter practices, and (3) severe addiction and mental illness (Tiderington et al., 2020). These barriers can influence one another, exacerbating existing difficulties. For example, substance use problems may contribute to criminal activity or exacerbation of mental health symptoms, which can lead to expulsion from employment or shelters (Ferguson et al., 2012; Poremski et al., 2014).

Given the restricted job opportunities and their limited income, some participants explained that people they knew turned to illicit methods to supplement their income:

“He was broke, he was homeless. He started selling a little bit of dope [to] make some money.” (OAK_009). As employment provides an avenue for adaptive social connection, something that is frequently missing in the lives of individuals experiencing homelessness (Tiderginton et al., 2020), it follows that the provision of licit employment opportunities should be embedded within the supportive housing complex.

In a pattern similar to employment, although individuals expressed a desire to increase their level of education, they highlighted barriers in doing so. Some residents cited a lack of ability: *“It’s something I’m totally interested in, but I can’t do it. There’s just no way that I could do the math or the English.” (OAK_005).* Others outlined financial and practical barriers to enrolling in educational or trade-related programs including poor internet connection, difficulty reading and writing, limited access to tutoring or technology. Youth experiencing homelessness tend to have worse academic outcomes compared to their housed peers, even when economic status is controlled (Parrott et al., 2022). Given that education has been shown to be a protective factor for those experiencing homelessness (Mizerek & Heinz, 2004), embedding opportunities for further educational achievement, such as access to a GED program, tutoring services, and learning assessments, are potential areas for intervention. Having residents understand their profile of strengths and weaknesses would inform their career choices and help them identify supports they may require.

Resident-Provided Suggestions for Improvement of Supportive Housing Context

Although participants voiced many issues concerning their current living situation, they were also quick to provide tangible suggestions to address these

problems, including: (1) physical space and the environment, (2) staff changes, (3) tailoring of and appropriate service provision.

Improving the Physical Space and Practical Services. Participants identified a desire to have guests be able to stay overnight, as prohibiting visitors made them feel they lacked ownership of their apartment and made it feel less like a home. This request was especially strong for those trying to find and maintain romantic relationships. One participant said: *“If someone had a boyfriend or girlfriend, you know, we can't really have an overnight guest. I guess that would be something that would be beneficial.”* (OAK_006). Although there are some potential challenges with implementing this change, like setting reasonable limits and ensuring safety of others, allowing overnight guests may make residents feel they have greater control over their living space.

The food services and canteen limitations were another practical concern voiced by participants. Supported housing residents highlighted inconsistency in hours and availability of food on weekends as primary concerns. One participant explained that his early work schedule makes it difficult for him to access food: *“I work and stuff in the morning. I [early and] the kitchen's not open.”* (OAK_007). Residents of the supported housing complex suggested that meal delivery on the weekends, as on weekdays, would make food more accessible.

Because certain participants identified problems with the amenities that are supposed to be included in their rent (e.g., problem connecting to the internet, problems with the toilet, stove tops not working), they requested quicker access to maintenance for their units. Access to technology (e.g., provision of phones, better internet connection) was another prominent request. One participant suggested nominating a

resident advisor for each floor that could act as an advocate for resident concerns.

Allowing residents to nominate a representative to bring forward their concerns to staff members would increase a sense of agency and cooperation between residents. Because complaints and suggestions would be included in a communal document or statement, it may also provide a degree of anonymity and protect individuals against perceived staff retaliation.

Recommendations Concerning Staff. To address commonly voiced concerns around safety and staff availability, participants suggested increased staff presence.

Although some suggested that having someone at the front desk at all times would be ideal, all who spoke about staffing issues stressed that staff coverage on weekends and evenings should be prioritized: *“Especially on the weekends. They need to have more. And there's no staff here in the evenings. That's a bad time to be here.”* (OAK_009).

Interviewees also advocated for more consistency in rule enforcement across staff members. They believed it was unfair to receive contradictory information from different sources, making it challenging to behave according to the rules.

“More training and more communication and more sticking to the rules. Like one person will say one thing one day about [a rule], and you ask a different worker about the rule you get a totally different answer. So, more consistency.” (OAK_010).

Residents expressed a desire for regular resident meetings to voice their concerns to staff members as a group. One participant imagined a staff member introducing the idea like this: *“We're gonna have a meeting on Friday for the third floor. Between this time and this time. If you want to come voice your concerns, come voice your concerns.”*

(OAK_007). Sharing their concerns with staff members collaboratively may have more sway and increase residents' sense of community if they recognize their shared struggles (O'Shaughnessy & Greenwood, 2020). Although shelter residents liked the idea of regular meetings, they did not allude to any initiatives they had started independently. Moreover, to the interviewers' knowledge, they had not presented this idea to staff directly. Multiple factors, including a limited sense of agency, anticipation of negative staff reactions, and reduced belief in the possibility of change, likely contribute to this lack of initiative.

Some participants believed staff should have additional training to help them address residents' unique needs, consistent with research suggesting staff training issues are a common concern among agencies providing services for homelessness (Schiff & Lane, 2021). Interviewees suggested that all staff should receive mandatory first aid training and gain experience with addictions and mental health. In the absence of informed staff, some residents felt obliged to provide information to other residents. For example, one resident vocalized this sentiment: *"They can talk to me, but I'm not [the] one [in] authority. They need somebody with authority they can talk into too, [someone with] a degree in this and that ... because that person will know where to go [to address the need]."* (OAK_001).

Participants believed that staff members can improve a sense of community at the center by facilitating social opportunities for residents. Interviewees suggested that staff could arrange a variety of activities (e.g., bowling, pool night, movie night) that might improve connection between residents. They believed improving social connection between staff and residents should help reduce problematic substance use, as

some research suggests that targeting social networks can be effective in helping individuals reduce their substance use problems (Kennedy et al., 2018). In a similar pattern to the above, participants did not discuss their role in facilitating or initiating social activities among themselves.

Participants reported confusion about the roles of staff members and were unaware of different services offered at the supported housing complex. One participant expressed that individuals living on the second floor are supposed to have access to certain programs: *“All the second floors are supposed to have a program and everybody's saying, what's the program?... Hey, nobody really knows what the program is.”* (OAK_010). Participants expressed a desire to be equipped with more knowledge about the services available and the staff members responsible for them:

“Give a little more information about this place. Have meetings ... if they sit down and have meetings with the floors, give people a chance you know. Three, four staff have [should host] an introductory [session] when you first move in here, okay, this is so-and-so, this is so-and-so. And you can go over [staff] pictures with them and put the job title underneath.” (OAK_007).

Tailoring and Appropriate Support Provision. A common suggestion concerned the provision of extra support on an individual basis. Participants said they would benefit from support for daily living tasks (e.g., grocery shopping, managing bills). Addressing wider support needs of clients facilitates maintenance of long-term housing (Mackie et al., 2019; Kerman et al., 2022; Weightman et al., 2023). Residents expressed that each person’s needs may be different, so flexibility in providing support would be critical:

“Maybe somebody just has a bad foot that day, you know, they need a bit of help. Maybe one person needs to get to Sobeys to get a few things picked up. Somebody like that to help out, I think that would be amazing here.” (OAK_009).

When asked who would serve as ideal support workers, participants suggested university students would be a great population. They believe that working with university students would help students develop personal awareness of homelessness in their community and hopefully fuel their desire to contribute to minimizing its negative impacts: *“I’m thinking tap the students at the university, like the undergrad students at university ... you know ‘cause, you feed the flame ... get students interested early.” (OAK_002).* The proximity between Fredericton’s university and the supported housing complex (about 1.5 kilometers) strengthens the feasibility of this particular suggestion. Participants also suggested that residents may be willing to volunteer their time to provide assistance to those in need, provided they received training to ensure everyone’s safety.

Interviewees suggested having community-based services at the center, including addictions counselling, nursing staff, occupational, and educational training. Although participants wanted services to be available at the supported housing complex, some worried about being provided counselling by the same agency that provides their housing.

Impact of Financial Difficulties

Financial strain is closely linked to homelessness, and past-year economic difficulty is a strong predictor of subsequent experiences of homelessness (Shelton et al., 2009). All participants felt their restricted income negatively impacted their quality of

life. Their limited disposable income shapes every aspect of their lives, as voiced by one participant:

“Nobody got money for nothing. I mean, \$600 you pay off your rent. You know what I mean? I'm left with \$340 a month. What can you do with that? Not a whole lot sweetie. Not when you start with nothing.” (OAK_009).

A recent study highlighted the significant connection between financial strain and homelessness, with Elbogen and colleagues (2021) recommending financial management education as a protective factor. Nevertheless, some financial factors experienced by individuals experiencing homelessness are largely out of their control (e.g., insufficient government support, unstable employment, low wages; Elbogen et al.). Residents in the current study explained many of their choices are driven by their financial status:

And even having a cheque, it's not a whole lot to live off of. So, it kind of led me to [look for] resources out there that can, provide the things that could help me. (OAK_006).

Research suggests that financial strain can lead to difficult decision trade-offs with help-seeking behaviours (Nguyen et al., 2018). Nguyen and colleagues found that individuals experiencing financial hardships prioritized household needs (e.g., food, rent) over medical care, sought cheaper medical alternatives (even those less evidence-based than their physicians' recommendations), and were unwilling to discuss their financial hardships in clinical settings due to embarrassment and shame.

Some residents expressed frustration with how financial constraints complicated compliance with the regulations they must abide by to have appropriate medication

coverage. For example, one participant explained that, without difficult-to-acquire coverage, his medication cost more than he could realistically earn:

“My medications, if [only] I could get off my medications and be well, ‘cause I think they’ve cost me two thousand dollars just for my medications a month. And then if you factor in rent and everything [including] food ... I can’t make enough with being a high school dropout.” (OAK_005).

Patterns of Service Use Among Supportive Housing Complex Residents

An increase in appropriate use of services is likely to lead to the maintenance of housing in the long term, a key factor in preventing reexperiences of homelessness (Boland et al., 2018). Residents of the supported housing complex in the current study identified barriers, facilitators, and service-specific suggestions for change from their perspective, which is often missing in the development of public policy targeting homelessness.

Perceived Barriers to Service Use

Many participants vocalized a need for support in their transitions out of homelessness. They said they struggled with many prerequisite skills for successful housing maintenance including financial management, daily living skills, and mental health challenges. Participants explored several barriers to service engagement, including: (1) access problems, (2) mental health and substance use, (3) negative interactions and beliefs, and (4) transportation.

Access Problems. Participants expressed frustration at having to repeatedly ask for services and explained that this constant demand was as a barrier to engagement. Some individuals reported that asking for help made them feel as though they were

viewed negatively by others. This view is consistent with research suggesting that anticipated discrimination leads to reduced readiness for help-seeking behaviour (Schomerus & Angermeyer, 2008). Interviewees believed that an increase in use would occur if services were offered freely, rather than reserved for those who initiated contact. One participant explained:

“Cause people don't want to reach out. They don't want to be lazy fucks. Yeah, I know, you gotta ask for housing. You really gotta ask for food and you gotta ask for food and you gotta, you know, it's always ask ask ask. It's, it's annoying ... it just feels degrading” (OAK_007).

After garnering the motivation to make an initial contact with service providers, participants were often disappointed at the lack of follow through, as they did not hear back from services, or were enjoined with promises that never materialized. Told she would have an appointment with a service within three months, one interviewee reported waiting seven months without hearing back:

“She had said that she would meet with me in three months and that she would call me, and let me know... I called her the first time in [April] when I called for my intake ... We should have met the third week of June and it's now October, and she hasn't contacted me for a meeting.” (OAK_002).

The lack of follow through contributed to frustration and resentment, and such negative interactions can bolster individuals' beliefs that these services are unable to help them (Parsell et al., 2020; Rizzo et al., 2022). Some participants worried about privacy and confidentiality for services offered at the complex. For example, one participant worried

that information he shared with a service provider would be shared with the John Howard Society and could jeopardize his housing.

Waitlists are a salient issue among this population because the problems they are struggling with can quickly magnify in intensity (Brown et al., 2017). As such, once they finally make it to the top of the waitlist, that service may no longer be appropriate for their needs, or their readiness to engage may wane with delayed access (Rizzo et al., 2022). For example, a participant desiring an inpatient substance use treatment may no longer be interested months later.

Some supported housing residents felt that the breadth of services offered in the community was insufficient. They explained that strict eligibility criteria limit access to existing services that may be helpful and that staff members had discouraged them from seeking these services out:

“I was just trying and to pass time...and I was reading [a handout about a specific community service]. I was like, geez. About 90% of these [criteria] fit me and this was like a Friday evening. So, Monday came, I mentioned it to the workers, and they said oh no, FACT, that's nothing. That's nothing for you. Don't worry about that.” (OAK_006).

Participants uttered statements like this: *“There are no services here. It says there's a lot of services, lots of it on paper. It looks really pretty, but there's nothing here.”*

(OAK_009). Although some participants struggled to identify specific services they would want, they described needing more help with managing their mental health and addictions, finding affordable housing, daily living skills, and increasing recreation opportunities. It is possible that asking participants to identify services they would need

on the spot, rather than giving them time to think about these needs and the questions posed, limited the responses they were able to generate. However, it is also plausible that supported housing residents lacked insight into what skills or knowledge would be most beneficial to them. The implementation of a comprehensive intake evaluation, co-developed by staff and current residents, may help the team identify unique needs for each resident upon their arrival. The evaluation could be repeated at set time intervals (e.g., 3 months, 6 months) to assess changes in needs and progress toward goals.

The most significant access barrier identified by participants was their lack of knowledge about available services (Quinn et al., 2018; Rizzo et al., 2022). Of the ten people interviewed for this phase, seven reported they did not know where to look for services. One participant explained: *“I never really tried to access anything in town really, because I really don't know what services are available to me. That's what I don't know.”* (OAK_008). There is a clear disconnect in how services are being advertised and the methods by which individuals using them had identified those services (Quinn et al., 2018). This discrepancy highlights a need for further outreach and community-based advertisement, as increasing potential users' knowledge of available resources, and the pathways to access, is the first step in ensuring appropriate service use (Parsell et al., 2020).

Mental Health and Substance Use. Consistent with research by Parsell and colleagues (2020), participants in the current study explored how mental health concerns and problematic substance use may impede access to appropriate services. Some participants explicitly stated that their mental health concerns made them unwilling or unable to engage with services. It is likely that substance use problems and mental

health concerns are exacerbated without appropriate access to services (Addorisio et al., 2021; Rizzo et al., 2022). As these concerns escalate in severity, it becomes more difficult to obtain or appropriately engage with services. For example, one participant described how travelling to use services while she is experiencing depression symptoms is very challenging:

“I deal with depression, so sometimes it's hard for me to get motivated to get out and actually go to those places, you know, so probably that would be the biggest thing, you know, getting motivated. If I'm feeling depressed or whatnot, then I don't tend to leave my room, or I'm in bed for a few days.” (OAK_006).

Participants vocalized similar experiences with accessing services when struggling with addiction: *“Some are just too hooked on their drugs that they're just, they're just living on their drugs and don't really care what goes on.” (OAK_010).* When severity of an addiction increases, it becomes more difficult to access and engage with services.

Research comparing service use across three cities in British Columbia—Vancouver, Victoria, and Prince George—found that residents of the smallest city, Prince George, were most likely to report substance use problems (Krausz et al., 2013). These findings align with the results of this dissertation, which also suggests a high prevalence of substance use issues among participants in Fredericton, a city with a population size comparable to that of Prince George.

Negative Interactions and Beliefs. Certain supportive housing residents perceived little utility to services, which contributed to limited motivation for engagement. Consistent with extant qualitative research (Ha et al., 2015), participants in the present study described multiple negative interactions with services. For example,

one participant explained that following an altercation with his psychiatrist, he was no longer able to access any other services through that clinic (e.g., counselling, occupational therapy). Others spoke about avoiding services because of their perceptions of the staff members running them:

“A lot of us don't like coming. They won't even leave their apartment ... because of the miserable face on the two men that work down there, X and Y, nobody wants to approach them, and it puts us in a bad mood.” (OAK_009).

Participants found certain staff members to be unapproachable, dismissive, or rude. One participant expressed how those harmful interactions made her feel: *“It feels like being segregated, being treated differently.” (OAK_002).* These exchanges have created a haze of hesitation about service use generally: *“People won't venture out for fear of embarrassment or ridicule.” (OAK_004).* Some participants feared negative responses or repercussions from engaging with service providers, and as a result, refrained from initiating contact with a service. Barriers to service use are present before an individual even begins to engage with services (Black et al., 2018).

Transportation. Center residents recounted specific practical barriers to service use, which echoed those of shelter residents. For example, although residents are offered free bus passes, they are required to tell staff where they are going, and the transit routes are often inefficient (Sylvestre et al., 2016). One participant expressed how bus travel is especially complicated in the winter:

“You can get bus passes and stuff like that. But I mean, it takes a lot of your time. You need to go someplace. You're gonna spend three hours with transportation. For the bus an hour there, an hour back, an hour waiting.” (OAK_007).

Although participants found the location of the supported housing complex to be relatively convenient for access to certain resources (e.g., grocery stores, banks), they expressed annoyance at the fact that many of the services they would use frequently (e.g., community health clinic, pharmacy) are some distance away. As a result, participants explained that a large part of their day is spent commuting to and from these requisite services. They advocated for a daily shuttle that would do drop-offs from the supported housing complex to popular resources across town. The dispersal of services across cities is a common barrier to access and may be exacerbated in large cities (Murphy, 2019; Sylvestre et al., 2016).

Facilitative Factors and Suggestions for Service Improvement

Interviewees spoke about factors that maximized their engagement with various services. They described engaging with services targeting various areas of functioning including, but not limited to, the provincial housing authority, community mental and physical health clinics, harm reduction services, pharmacies, counsellors, detox, rehab facilities, and food banks. Despite awareness of types of help available, navigating and appropriately engaging with them can be a challenge.

When asked why they use community services, participants said they did when they had no other options, and stressed that using community services was necessary given their limited income: *“It’s really tough getting by with six hundred and thirty dollars a month ... I gotta use the services that are provided to me.”* (OAK_005).

Participants expressed they were more likely to engage actively with a service when they decided to, rather than when they were forced to (e.g., through court mandates, staff member directives).

Maximizing Knowledge and Increasing Self-Advocacy. Participants often struggled with knowing where to find the services they need (Rizzo et al., 2022). In contrast, a minority of participants were equipped with knowledge about what services were available and the pathways to finding them. One participant explained that he spent most of his life trying to learn more about the availability of resources in the city: *“I was a writer pretty well all my life, and I researched everything, and if somebody told me something, I just didn't go “Oh, that's nice,” I go “Why?” or “Tell me more”.* (OAK_001). Participants who were adequately informed were passionate about sharing this information with others.

“I even carry a street survival guide with me, and I've got so many phone numbers and addresses that if somebody talks to me and they mentioned something, I say ‘Oh here, I got a phone number for you or a name for you to get in touch with’” (OAK_001).

As found in other studies (Greenwood et al., 2022; Parsell et al., 2020; Rizzo et al., 2022), participants in the current study felt being equipped with appropriate knowledge is a clear facilitator to service engagement. They explained that because individuals experiencing homelessness have to rely on one another, being able to help others, when possible, ensures that the favour will be returned in the future:

‘Cause when you're homeless, you need to, you can either go by yourself, but at the end of the day, you're gonna have to ask some people for favours. You know what I mean? So, it's best to be nice to other people, and a lot of people help other people out. (OAK_003).

One study by Greenwood and colleagues (2022) found that individuals who persistently advocated for themselves are more likely to get access to resources. In the current sample, one participant explained he made multiple calls over a two-week period to ensure he would have a network of support ready once he left detox services.

“So, I made the phone calls and by the time I was done before I left detox in two weeks, I had a list of 21 people on my list that I could contact if something, if there was a situation.” (OAK_007).

The ability and desire to be able to advocate for oneself is a skill that can be taught and fostered over time. Providing individuals with the tools they need to do so helps increase their self-efficacy (Norman et al., 2015; Parsell et al., 2014). Improving residents’ self-advocacy skills is a tangible area of intervention for staff members at the supported housing complex and at other services in town. As staff members are among those who interact with clients the most, they are well suited to help them identify appropriate services (Greenwood et al., 2022).

Increasing Outreach, Specific Locations, and Environment Changes.

Participants reported they were more hesitant to use services when they had to request them. Interviewees seemed to prefer services that offered a drop-in format, rather than through individual appointments, as it gave them increased freedom in deciding when they used those services (Rice et al., 2023).

Similar to emergency shelter users, center residents spoke about how the service location and environment shapes their likelihood of engaging with them (Nickasch & Marnocha, 2009). Participants indicated they felt more at ease when they could meet

service providers in a familiar environment (Ramirez et al., 2022). One participant said he felt more connected to his social worker when they met at a coffee shop:

“There are coffee shops ... I mean that is so much more, comfortable ... just by going to have a coffee with somebody makes 'em feel you know, like hey man, we're friends a little bit. But going to sit in your office and you're sitting there in your chair, in your desk, you know...it's less comfortable. Sometimes I feel like, oh, okay, I gotta say stuff to the person I don't even wanna talk about anything.”
(OAK_007).

This quote bolsters the rationale that creating a safe and comfortable environment for individuals maximizes the potential benefit of a service (Kertesz et al., 2021). Ensuring adequate staff training and prioritizing environmental safety is an important goal for improving current community services (Peters et al., 2022).

Appropriate Tailoring of Services. As no two experiences of homelessness are identical, the needs of each individual will vary greatly (Kertesz et al., 2021).

Interviewees explained that services are most useful when they can be appropriately tailored and flexible in nature. For example, one participant explained how his stay in detox was extended per his request:

“I went to detox. I stayed an extended period of time. I asked for it for reasons I seen was best for me ... I decided when I was in detox, I was gonna stay sober. And I fought and worked and did the work.” (OAK_007).

Although embedding flexibility within available services allows for greater uptake and engagement, this poses a challenge as programs must be pre-planned when applying for government funding (Parkes et al., 2021).

Maximize Positive Staff Interactions. Staff members have tremendous decision-making power for individuals who are experiencing homelessness (Olivet et al., 2021; Peters et al., 2022) and may act as a positive conduit for change or limit access to services. For example, staff members at the emergency shelter have the power to assign roommate pairings, enforce temporary bans, and control locker access. At the supported housing complex, staff members oversee the approval of guest sign-in, distribute bus passes, create the laundry schedule, and so on. Participants explained that when staff are properly trained and behave with kindness, they can make a huge difference in the lives of their clients (Rice et al., 2023). For example, one explained that a staff member was helping them find employment: *“Yeah, X is printing me off a resumé, and she's gonna help me find a job.” (OAK_005).*

Residents reported that they felt better about services when staff members would follow through on promises they had made. One participant explained that follow-through helped prove that staff members cared about her:

“People listening and caring people giving a shit about each other. Not just saying, walking on but X walks the walk. He talks to talk and if he finds you cold like that jacket's not very warm, he comes in the next day and brings you a damn coat. He cares about people, and he doesn't, that's coming from his money. That's serious. He cares ... that means the world to me. We need the world to give a shit.” (OAK_009).

Given that interviewees often held negative beliefs about themselves and their self-worth, feeling positively about staff members was especially healing. Those

encouraging relationships helped bolster motivation for change. Another participant described an instance when staff members encouraged him to seek addiction services:

“I just continued to drink and drink and drink until the staff [at the emergency shelter] noticed that there was something seriously wrong going on. And I was asked if I wanted to go to detox and I was kind of convinced maybe it was a good idea. I [was] just at the point where I just didn't care if I lived or died. And they were consistent and persistent.” (OAK_007).

Staff members can act as role models for adaptive social relationships for individuals who are isolated and have limited support. Their interactions with staff members and other clients serve to illustrate appropriate conduct and respect for others (Carver et al., 2022).

Protective Factors to Experiences of Homelessness

Participants outlined protective factors that serve as positive buffers in the initiation of homelessness and others that serve as accelerators to housing procurement. They explained that positive community supports provided a safety net, prior to living in a shelter, potentially delaying loss of housing. This pattern is consistent with research highlighting the protective impact of social support, suggesting that bolstering social support predicts well-being over and above housing status alone (Chassman et al., 2023; Cummings et al., 2022; Johnstone et al., 2016; Rea, 2023). Family, friends, and staff members were counted as sources of support, and one resident's family facilitated connection with a substance use program:

“I was going through a really, really tough time. I was at the end of the rope and my cousin paid a thousand dollars for me to get into it ... And it almost saved my life because I was going in and out of the hospital.” (OAK_005).

Staff member support created conditions in which residents could plan and foster hope for their future and increased their self-efficacy. Increasing self-efficacy among individuals experiencing homelessness increases their pursuit of resources (Clark et al., 2024). Embedding appropriate social and emotional supports within services is important, and authentic relationships with staff members are often cherished (Marshall et al., 2022). Interviewees shared planning and forethought that demonstrated secure feelings about support received from staff. One participant planned to move out of the supported housing complex:

“You know, I don't want to stay here forever. This is not my end goal. I have a bigger goal in mind. I want to get back in, in my opinion of a normal life working, you know, contributing to society ... have my own place.” (OAK_006).

Many participants expressed a desire to help others in a similar position, hoping to limit the likelihood others would experience the same hardships they had endured. One participant spoke about how he was motivated to help however he could: *“I'll be of service if I can be. I'll help anyone who needs, who wants to talk to somebody who's not a professional, I'll help them in any way I can.” (OAK_001).* Guiding others may increase individuals' sense of agency and control, helping them maintain motivation to move forward.

Resident Suggestions to Bolster Protective Factors

Participants shared strategies to maximize protective factors and believed that facilitating connection with members of their community was important as it helped challenge negative perceptions and beliefs about individuals experiencing homelessness.

One resident recounted a recent positive interaction:

“I think they should allow us to do more things for the community to help us connect with them because they think we're fucking goose. But when you get up there, and you actually talk to them ... [one guy] had a meeting, came back up hour later, brought us back some smokes.” (OAK_009).

Engaging with community members in various activities can target negative stereotypes and aid in developing agency and self-efficacy. Interviewees yearned for activities that made them feel connected to their communities and able to contribute positively as individuals: *“Things that would help us feel like more independence ... and things that would help bring community together.” (OAK_002).* Research examining how social relationships in an emergency shelter setting found that developing a sense of connection increased self-perceptions of worth (Bell & Walsh, 2015). These relationships protected against the social exclusion they experienced outside the shelter. Research also suggests that individuals who have interpersonal contact with those experiencing homelessness are less likely to endorse individual failure explanations for homelessness (Tsai et al., 2019).

Participants believed that incentives (e.g., gift cards, monetary compensation, recreation memberships) for activities would encourage engagement. This suggestion is consistent with recent research highlighting the effectiveness of financial incentives to maximize service engagement as they provide a source of extrinsic motivation

(Hollenberg et al., 2022). Although there is a risk of coercion by providing financial incentives for engagement, qualitative research with individuals experiencing homelessness suggests that these incentives directly facilitate greater engagement (Reid et al., 2021; Reid et al., 2022). Reid and colleagues (2022) suggest that financial incentives can help ‘hook’ service users, but the quality of the service will determine long-term engagement and facilitate the development of intrinsic motivation.

Participants explained that providing gift cards or money rather than specific items allows them to make decisions about how to allocate their resources. One participant recommended: *“Having the drop-ins where people can go, can come and go, or can come and ask for like, the ten-dollar Sobeys (local grocery store) gift card, you take it and go.”* (OAK_002). Individuals experiencing homelessness have limited agency and are provided with few opportunities to make choices, which are often driven by necessity rather than desire (Greenwood et al., 2022). Although sociological scholars have discussed how agency among individuals experiencing homelessness can be a unique experience (Anderson, 1994; Bourgois & Schonberg, 2009), an in-depth review of this idea falls beyond the scope of the current dissertation. Limited agency contributes to infantilization and perpetuates beliefs that they are incapable of making decisions for themselves. In contrast, personal control over life choices is linked to better psychological wellbeing (Vella-Brodrick et al., 2023), and self-confidence is an important protective factor for mental health (Greenwood et al., 2005). Maximizing agency in the provision of social services to this population is crucial.

One participant felt that expansion of current services rather than adding breadth of services was preferable because a lack of funding for subsidized housing and associated services (e.g., food bank, clothing dispensaries) is critical:

“Well, it’s all manner of money, I guess...just open more facilities, hire more workers, get more funding ‘cause it all boils down to money. You know? If they, if you have the money, you can hire more people, you can get more, get more stuff done. You can build facilities, you can save for, invest in facilities for another homeless shelter, or invest in more money for the food bank.” (OAK_003).

Funding constraints limit service access prior to, during, and following experiences of homelessness (Mackie et al., 2019). Advocating for appropriate funding for resources can minimize the harms associated with homelessness. The value of increased agency for individuals experiencing homelessness includes more community engagement and service use. Fostering self-efficacy allows them to be willing rather than forced participants, and to choose not to access resources or services if they do not need them.

Experiences and Perspectives on Substance Use and Addiction

Substance use was an important topic for interviewees, and research indicates high rates of substance use among individuals experiencing homelessness – almost 40% of individuals experiencing homelessness meet criteria for an alcohol use disorder, and over 25% are dependent on illicit drugs (Stablein et al., 2021). Research suggests that the relationship between problematic substance use and homelessness is bidirectional. Those who meet criteria for a substance use disorder are more likely to experience homelessness and those experiencing homelessness are more likely to engage in problematic substance use (Elmquist et al., 2021; McVicar et al., 2015; Stablein et al.,

2021). Substance use problems increase the risk of homelessness through difficulty maintaining personal and professional obligations and the disruption of social support networks (Stablein et al., 2021). Conversely, experiences of homelessness can lead to substance use problems, as substance use may be a coping mechanism or a way to develop new social relationships (Stablein et al., 2021). Nilsson and colleagues (2024) found that 15% of first-time emergency shelter users without a prior psychiatric disorder received a psychiatric diagnosis within the next year. The bi-directional relationship between substance use disorders and sheltered homelessness may be explained by shared risk factors (e.g., adverse childhood experiences; Nilsson et al., 2024). Residents of the supported housing complex emphasized that because their cohort are especially vulnerable to problematic substance use, services should be more readily available:

“People that are homeless should be a priority ... it should be number one priority right now. I shouldn't have to worry about being on a list for nine months to get addiction services ... you know, it should be automatic. Hey, let's get this guy in there. Should be like alarm bells up.” (OAK_007).

Beliefs About Substance Use

Residents held strong opinions about those with substance use problems and were especially vehement when they were maintaining sobriety. Those maintaining sobriety in the supported housing complex were more likely to express judgment and a sense of superiority towards those still using. For example, two participants expressed similar sentiments:

“I think I've done good though. I don't run around, look[ing] for drugs like half the people here do. Oh, and I'm telling you, they fucking do. They spend their

nights twiddling their thumbs, wondering when they're gonna get their next hit.”
(OAK_004).

“And because they're on drugs a lot, they just think everybody owes them something and somehow somebody has to tell them that they're not owed anything, really.” (OAK_008).

Research suggests that positive expectancies about the future, such as a belief in the achievability of a goal, is related to lower rates of problematic substance use (Gomez et al., 2010). As such, interventions that facilitate the development of adaptive future-oriented goals may help curb problematic substance use.

Residents of the supported housing complex endorsed a hierarchy about substance use, in that alcohol and cannabis were deemed acceptable whereas illicit substances including cocaine and methamphetamines were not. For example, one participant said:

“I'm not a hundred percent away from drugs and alcohol. I smoke weed. I have always smoked weed. Smoking weeds helps... But I mean, it's not something I take my last dollar for. It's not something that's gonna put me in jail and it's not gonna put me homeless, you know what I mean?” (OAK_007).

The rationales for substance use described by participants echoed those highlighted by previous research including helping with mental health concerns, coping with trauma, and a rejection of abstinence-based models (Christiani et al., 2008; Johnson et al., 1997; O'Brien et al., 2015; Stablein et al., 2021) and those voiced by emergency shelter users in Study 2.

Research has examined motivational factors for reducing substance use among youth experiencing homelessness (Battjes et al., 2003; Keys et al., 2006; Miler et al., 2020; Moore & Hardy, 2020). Keys and colleagues (2006) found that motivations for cessation included health, legal, financial, and relational reasons. Overall, they found that individuals who successfully reduced their substance use found it to be causing more problems than the benefits it provided. The youth in their study perceived a positive association between reductions in problematic substance use and improved life circumstance (e.g., increase in stable relationships; Keys et al., 2006). In the current study, some participants felt that reducing their substance use was their only option. For example, one participant vocalized: *“Either I get my ass together, my act together, die, or spend the rest of my life in prison.”* (OAK_007). Another reported that the lifestyle associated with substance use was becoming too difficult to cope with: *“Well, I wanted, I just, I couldn’t keep that up. You know, being a drug user, you know, wanted to get off drugs and kind of, and then also get away from being involved in dealing drugs and, and whatnot.”* (OAK_005). She also outlined how her behaviour transformed her social network: *“I don’t do drugs anymore. I used to be a big addict, so I had to lose a lot of my old friends.”* (OAK_005). These insights illustrate that overcoming addiction, especially in a shelter or supported housing complex, comes with significant social and relational cost (Christiani et al., 2008).

Substance Use in the Supported Housing Complex

Many participants expressed disdain at the availability and prevalence of illicit substances in the supported housing center. For example, one interviewee commented

that the availability of illicit and addictive substances can feel like a trap for those struggling with substance misuse:

“The people who live here, who are trying to get away from doing the harder drugs call this a trap house, like a trap. Because they're trying to get away from it, but it's too accessible.” (OAK_002).

Rampant substance use is frequently named as a reason why individuals avoid using emergency shelters (Kerman et al., 2023; Wusinich et al., 2019). Some participants even highlighted a desire for a living space that imposed abstinence: *“I think if they had a place where there was people like, you know, or a floor... and say. ‘Listen man. You want to come up from this floor here? This floor here. This is no drugs, no alcohol.’” (OAK_007).* Their expressed desire runs counter to academic recommendations emphasizing that requiring abstinence prior to service access can disadvantage individuals experiencing homelessness (Canavan et al., 2012). Although a sobriety pre-requisite can impede access for certain individuals, participants trying to refrain or reduce their substance exposed to illicit substances makes abstinence more difficult, as one participant explained:

“It's hard here for me, trying to stay sober when I see the stuff going on 24/7. I got pictures on my, I got video of on my phone of people filling up needles right in front of my window. So I'm in a dangerous environment.” (OAK_007).

Substance Use Services

Participants frequently discussed their experiences of seeking and using addiction services. Center residents identified multiple resources: (1) AA/NA meetings, (2) faith-based residential facilities (3) detox services, and (4) harm-reduction agencies.

Regardless of service pathway, participants who endorsed using these services found them helpful. One participant reported, “*Because of the drugs and alcohol, um, the Village of Hope just totally re-like, 180ed me*” (OAK_005). Despite numerous services mentioned, participants felt there was room for more services and support, with statements like: “*The services that we have aren't cutting it at all, like, I want to say especially about the services for addiction.*” (OAK_002). Research examining substance use treatment among individuals experiencing homelessness suggests they are more likely to use inpatient or residential treatment services and experience lower rates of treatment retention (Padwa et al., 2022). Researchers believe that substance use treatment that blends contingency management with transitional housing, ensuring access to opioid agonist therapies, and provides education on overdose prevention (e.g., naloxone kits) may help increase effectiveness of substance use treatment among this population (Padwa et al., 2022). Given psychiatric comorbidities are common in this population (Stablein et al., 2021), integrated treatment models that include cognitive-behavioural therapies may be helpful (Padwa et al., 2022). Embedding peer support in substance use treatment among this population may also be helpful (Miler et al., 2020)

Suggestions Specific to Substance Use

Participants offered varying strategies to mitigate treatment access barriers to service use that includes themes of: (1) increasing visibility of the services, (2) providing 2-way transportation, and (3) providing incentives. They advocated for an updated list of daily NA and AA meetings posted in the center, and a shuttle from the center to these available meetings. Providing incentives to increase use was a popular suggestion, like gift cards for attending addictions services, and is consistent with prior

research connecting financial incentives with increased service use (Reid et al., 2022). It was noted that AA meetings typically ended with an outing for coffee afterwards, so provision of money for these activities would be useful:

“People from the AA, they get together after and they go Tim Horton’s or so on ... [so] ‘Here’s a 5-dollar gift card, go meet somebody. Go get sponsored or go talk to somebody.’” (OAK_004).

A study of the effectiveness of substance use treatment found five key factors that facilitated reductions in problematic substance use among the homeless population: (1) compassionate and non-judgmental support, (2) facilitative service environments, (3) flexibility of timing, (4) emphasis on agency, and (5) providing opportunities to (re)learn how to live, with staff related factors (e.g., non-judgmental and compassionate attitudes) most often mentioned (Carver et al., 2020). Thus, ensuring appropriate staff attitudes and behaviours should be a priority for all services geared towards individuals experiencing homelessness.

Resident Perspectives on Mental and Physical Health

Participants vocalized their struggles with a myriad of physical and mental health challenges and experiences of seeking care. Examples include mental health diagnoses of major depression, schizophrenia, and bipolar disorder, and physical health challenges include limited mobility, lupus, arthritis, heart problems, and an emphasis on the impact of suicidality on their lives. Research suggests that tri-morbidity (i.e., chronic physical, mental, and substance use disorders; Addorisio et al., 2021) among individuals experiencing homelessness is common (Carver et al., 2020) and resident interviews

mirror those findings. One participant explained that he required inpatient admissions for both physical and mental health concerns:

“I’ve had to go to the hospital two or three times since I’ve been here because I do have some serious health issues... I was [also] diagnosed with mental health problems...I forget exactly what I had to go to mental health for, but I’ve been in psych wards in different hospitals over the years.” (OAK_001)

One participant noted the personal difficulty of accessing community services:

“My mental health, I don't know what, I just can't get up and get out of my room and go physically do something” (OAK_010). Participants vocalized frustration with the lack of services tailored to mental health, as one recounted: *“They don't really, it seems like they don't, there's not much they do for mental, mental health for the homeless.” (OAK_006).* Many spoke about long waitlists and inappropriate tailoring, and one resident expressed frustration with the one-at-a-time model used by community mental health: *“Cause I'm trying to get a one-on-one counselor, my own counselor. Cause every time I go [to community mental health] I get a different counselor, and it's hard to open up.” (OAK_007).*

Given the limited services available in the community, and lack of match to needs, participants turned to hospital services, often describing negative experiences in the hospital context. Most had been admitted at least once in their lifetime, and one explained that he felt hospital staff provided inappropriate care when admitted for mental health struggles:

“I can't do it when it, when you go to the hospital for mental health issues, they'll stick you in a room for God knows how long until the psych nurse shows

up. It could be an hour; it could be two days. I told him I just can't do it. I'll, I'll break down and lose it because I have before in that situation.” (OAK_010).

Other participants reported they were treated poorly by hospital staff and discharged prematurely. Negative experiences make individuals less likely to seek out services; thus, they seek hospital care as a last resort, missing the benefits of early diagnosis and treatment. Despite qualms with the system, participants expressed a strong desire to access mental health services tailored to their myriad daily challenges, and a belief that appropriate services could improve their quality of life.

Suicidality

All participants described being profoundly impacted by suicidality— having either experienced suicidal ideation, attempted it themselves (40% of the sample), or had friends and family who had attempted or completed experience. Research suggests that incidences of suicidal ideation and attempts are much higher among individuals facing homelessness than among the general population (Ayano et al., 2019). Twenty-two percent of adults experiencing homelessness have attempted suicide compared to estimates between 1.5-4.2% in the general population (Eynan et al., 2002). A recent meta-analysis completed by Ayano and colleagues (2019) found the prevalence of lifetime suicidal ideation among this population to be 41.6%, with the prevalence of lifetime suicide attempts at nearly 30%.

Those who endorsed suicidal ideation in the current study described it as chronic and intense: *“I was at that point for the last five years, more or less. I didn't care if I lived or died.” (OAK_007).* Although participants described various methods and timelines for their attempts, a commonality was a sense of hopelessness. Dichotomous

reactions in response to their suicidality were reported— some felt the services were adequate and helpful, and others felt unfairly or inappropriately serviced. For example, one participant described his positive interactions with a mobile crisis team: *“They’ll listen to what’s on your mind and so on and they help you. Uh, mobile crisis, suicide prevention, and stuff like that are all there for you.”* (OAK_010), whereas another explained that the mobile crisis team made him wait for hours and provided no assistance once they arrived. These opposing experiences are likely due to the intersection of multiple factors including the staff working each shift, the priority level assigned to each case, and the level of distress exhibited by each client. Although client perceptions are important in understanding barriers to service use, it is also valuable to consider systemic constraints (e.g., understaffing) that impact service delivery.

Resident Perceptions of Pandemic Impact

Interviewed in 2022, participants discussed how the COVID pandemic impacted their life and service use, noting that services were less available (e.g., *“It made quite a bit of difference. It made it near impossible to get in anywhere. I mean everything was extremely expensive. So, like everything three, four times price of what it was.”* (OAK_009); however appointments by phone eased access (e.g., *“Then Covid hit and so all my appointments were telephone, so it didn’t really matter.”* OAK_010). For some, the Canadian Emergency Response Benefit (CERB) benefit gave them the financial ability to procure housing: *“I ended up getting one of those COVID checks ... for \$2,000 ... and that is what bounced me into an apartment.”* (OAK_008). Legislation surrounding the intersection of the CERB and income assistance programs varied at the provincial level. Atlantic provinces, including New Brunswick, decided the CERB

benefit would be classified as non-exempt income. Therefore, individuals who chose to claim the CERB benefit became ineligible for other income assistance programs (Petit & Tedds, 2021). However, less than 10% of New Brunswickers who were on income assistance programs were eligible for the CERB.

Mask and vaccine mandates frustrated many, as they complained that policies were challenging to navigate:

“But back then, I would, there were so many times where I didn't have a mask so I couldn't go into [a] business. So, I learned to eventually [to] just find, look around, find a mask that is somewhat clean and put it on and go to the business.” (OAK_003).

And isolation due to COVID infection was challenging:

“When I had Covid, and I was stuck in a room with no food, nobody came and brought me food. Like the, wherever I got the tests, they called me and said, oh my God, you have COVID, you have to stay in ... there was no help for me.” (OAK_008).

Finally, employed respondents saw their work hours negatively impacted, leading them to financial crisis and loss of housing:

“And then Covid hit, and people couldn't come in the door. So, it was just a drive through. So, then I lost a bunch of hours. And then it got even worse ... I had no money to pay rent ... now we're getting closer to the shelter.” (OAK_004).

These findings are consistent with research suggesting that the COVID pandemic compounded existing difficulties for individuals experiencing homelessness (Finnegan, 2022).

Resident Experiences with Police and Incarceration

Residents shared nuanced accounts of positive and negative police interactions and incarceration experiences:

“I’ve had multiple, multiple instances with police both good and bad. Well they’re, they’re all people, right? You’re gonna have, they’re gonna have good days and bad days. And some people are just gonna be assholes, and some people are just gonna be helpful. You know?” (OAK_003).

Some participants described positive interactions with police acting as a connector to community resources like the shelter adjacent to the supportive housing complex:

“I just wandered around for, like, a few nights until a cop ended up helping me and told me there was another shelter up at, up off the top of the hill here ... and I ended up getting, he got me a bed there.” (OAK_003).

And finding a place to be after hospital discharge:

“But when the cops were called to the hospital, I don’t know, for me, standing there and trying to keep warm and I got booted out, they brought me here. And so that’s how I got into the shelter, which I didn’t even know existed here.” (OAK_006).

Positive police interactions centered around assistance securing services, while negative ones were more broadly defined. A salient theme concerned being targeted more frequently for occupying public space, as per previous research (e.g., Fitzpatrick et al., 2011; Herring et al., 2020; Kyprianides et al., 2022; Quirouette, 2016): *“I had a couple, uh, theft charges and a trespass that accumulated over being homeless. Just mistakes, I guess. Whatever, I, I, I got a year’s worth of probation for all this stuff.” (OAK_003).*

Hermer and Fonarev (2020) mapped neo-vagrancy laws (i.e., regulation that penalize people who often occupy public space) across Canada. The city of Fredericton has by-laws that criminalize behaviors commonly associated with homelessness, such as panhandling and loitering. These activities are often unavoidable consequences of living without stable housing, yet the by-laws, which may be enforced by police officers in the city, effectively penalize individuals who are already marginalized and struggling.

Participants also outlined poor police response to a homeless encampment:

“Where are people going to go? They can lay charges against somebody in a tent now. That's stupid. Don't, don't like to put my hand up and down over the bank along the river, they're not allowed to, the police put the run to them. And very often they put the run to them so fast it has to be left behind, or half of their belongings have to be left behind.” (OAK_001).

Solensten and Willits (2019) found that collaboration between police and non-profit community agencies resulted in a more humane, measured dismantling of a tent city with encampment residents alerted beforehand, allowed time to arrange their belongings, and supported in connecting to other community resources prior to moving. Regrettably, residents were not interviewed as part of that study, but a police officer interview conducted two years later indicated that over 80% of the residents of that tent city were either housed or occupying a shelter at the time of the interview (Solensten & Willits, 2019). This case study demonstrates that positive, ongoing collaboration between police and community agencies can lead to more positive outcomes for those experiencing homelessness and should be incorporated into public policy and police protocols.

Perceived Impact of Diversity and Cultural Considerations in Service Uptake

Residents felt that diversity-based discrimination was not an issue, that staff members appropriately acknowledged their cultural backgrounds, and that services were adequately tailored for their cultural needs. One participant said: *“I don't see any racism here or anything like that.”* (OAK_008). Forty percent of the sample spoke about their relationship with their faith and emphasized its positive impact on their life:

“Um, my faith is X, [and I] believe people can believe different things and still worship together. Um, I know, I have friends who are many different faiths again community, like, for me, I go there for the coffee and conversation and singing at the piano after the service. That's my community. I grew up going there.” (OAK_002).

A study of spirituality among youth experiencing homelessness found that connection to their faith helped them cope with adversity in multiple ways (Williams & Lindsey, 2006). Participants in that study expressed that belief in a greater power gave them hope in overcoming difficulties, that God was an important source of support in their lives, that prayer helped them get their needs met, and that their faith fostered the belief that life was worth living (Williams & Lindsey, 2006).

In the current study, participants expressed a desire to have church services available at the center to alleviate transportation barriers (at the time of the interviews the local transit system did not operate on Sundays): *“Maybe, bring in a church service once a week ... just bring in somebody from a church”* (OAK_001).

Conclusion

The third and final study of the current dissertation garnered insights about a supported housing complex from a service user perspective. Centering the lived experience of users was important, as they are best positioned to identify targets for change to maximize the responsiveness between available services and client needs. Participants in the present study contemplated their experiences in the supported housing complex, discussed barriers and facilitators to service use, and reported the impact of other factors on their daily lives (e.g., physical and mental health, the COVID pandemic, cultural identities). Consistent with the perspectives of emergency shelter users (Study 2), supported housing residents highlighted the substantial impact of macro level factors (e.g., lack of service and affordable housing availability) and micro-level factors (e.g., negative interactions with service providers, limiting beliefs) on their experiences of homelessness and service utilization. Although a clear preference for supported housing emerged (compared to the emergency shelter system), participants were critical of existing policies and procedures and provided insightful suggestions for change.

CHAPTER 5: GENERAL DISCUSSION

Based on interviews with service providers and users (at an emergency shelter or living in a supported housing complex), several common themes emerged repeatedly. This section will provide a brief overview of themes that arose across the three studies comprising the current dissertation and the unique insights that emerged in each, before providing targeted recommendations to address staff and service user concerns. Table 6 provides a comparison of themes between studies. Themes listed across columns in non-highlighted font indicate the commonality between studies, and themes which are highlighted in each column represent unique topics discussed by one sample (i.e., yellow for staff members, blue for emergency shelter users, and green for supported housing residents). Within each section below, take-away points and recommendations are ordered from most-to-least perceived positive benefit, accounting for frequency of participant mentions and feasibility of implementation. Many recommendations provided are garnered from service user perspectives. It is important to recognize that their reality is shaped by many factors, and that their perspectives may fall in contrast to those of others involved in care provision. Moreover, it is possible that some of their recommendations were already trialed without their knowledge, or that they have been implemented since data collection concluded.

Table 6

Comparison of themes between dissertation studies

Study 1 themes	Study 2 themes	Study 3 themes
Perspectives on housing	Transitions into homelessness	Transitions into homelessness
Evaluation of shelter environment	Difficulty with housing procurement	Beliefs about homelessness and supported housing
Positives	Desire for a home	
Negatives	Impact of financial insecurity	Perspectives on supported housing
Staff experiences at shelter	Perspectives on shelter environment	Strengths
Challenges staff face	Positives	Weaknesses
Resources advocated for	Negatives	Education and employment
Staff perspectives on service use	Education and employment	Solutions for supported housing
Services used by clients	Solutions for shelter environment	Impact of financial difficulties
Perceived barriers to use	Perspectives on service use	Service use in supportive housing
Perceived facilitators to use	Patterns of current service use	Barriers to service use
Suggestions for service engagement	Barriers to service use	Facilitators to service use
Transitions to permanent housing	Facilitators to service use	Suggestions for change
Staff issues concerning substance use	Community solutions to service use	Protective factors to homelessness
Staff perspectives on COVID pandemic	Perspectives on substance use	Suggestions for protective factors
Staff responses to police intervention	Client physical and mental health	Substance use and addictions
Cultural impact of service engagement	Experiences with police and incarceration	Beliefs about substance use
	Impact of COVID pandemic	Substance use in supported housing
		Substance use services
		Suggestions for substance use
		Physical and mental health perspectives
		COVID pandemic impact
		Experiences of police and incarceration
		Diversity and cultural considerations

Housing Acquisition and Sustaining Tenancy Long-Term

Staff members, emergency shelter users, and supported housing complex residents all highlighted a profound need for housing. Many staff members felt the goal of emergency shelters should be to obviate the need for the shelter, but believed systemic barriers, such as a lack of affordable housing, impeded their ability to achieve that goal. Service users felt that systemic barriers to housing acquisition reduced their self-efficacy and agency by placing extrinsic limits on their choices. Many service users who had acquired housing in the past recounted difficulties with successfully maintaining it (e.g., not paying rent on time, lack of daily living skills). Such factors led service users to experience repetitive cycles of housing procurement followed by eviction.

Recommendations for Housing and Tenancy Sustainment

- 1. Increase availability of affordable housing units.** Participants across housing settings (i.e., emergency shelter, supported housing complex) yearned for a place that was completely their own and emphasized a need for affordable housing. Macro-level factors impeding housing obtainment seemed especially salient, with systemic problems including low vacancy rates, insufficient government subsidies, and deficient unit quality (Elsinga, 2015; Rukmana, 2020; Sylvestre et al., 2018). Interviewees reported feeling frustrated by the negative impact of systemic issues that were largely out of their control. Increasing the availability and provision of affordable housing units, by addressing the systemic barriers, would help address staff and resident frustrations. The Canadian national housing strategy launched in 2017 and pledged over 82 billion dollars to expand

the housing market. Goals include creating 100,000 new units by 2027 and a 50% reduction in chronically homeless shelter users (Government of Canada, 2024). As part of this strategy, three million dollars were recently contributed in March 2024 to build 17 new affordable units in Fredericton (Government of Canada, 2024).

- 2. Maximize the provision of non-housing support needs to enhance likelihood of sustained tenancy.** Emergency shelter users and supported housing residents believed that inadequate development of their daily-living skills was a primary barrier to sustained tenancy, a belief echoed by staff members. The recommendation to provide non-housing support is consistent with literature on the benefit of including non-housing support needs within case management services (Boland et al., 2018; 2021; Weightman et al., 2023). Localizing the provision of non-housing support services for those experiencing homelessness will help ease their transition into long-term housing. For example, a workshop on financial management would be helpful as individuals experiencing homelessness have substantial financial strain (Elbogen et al., 2021) and difficulty accessing financial benefits (Wallace & Quilgars, 2005).
- 3. Target specific factors shown to improve housing sustenance.** Research on supports predictive of successful tenancy maintenance include limiting substance use, ensuring successful employment, and maximizing adaptive social relationships (Boland et al., 2018; Marshall et al., 2022; Marshall, Lysaght, & Krupa, 2018). Individuals who are provided with, and actively engage in, supports of this nature have better educational and employment outcomes (Pierce

et al., 2018). For example, offering training programs at the shelter to help clients develop marketable skills is likely to help them obtain employment (Bretherton & Pleace, 2019).

Shelter Environment Versus Supportive Housing

Interview transcripts from Studies 2 and 3 indicate a strong preference for the supported housing model compared to that of the emergency shelter. Residents of the supported housing complex (Study 3) highlighted greater privacy, more freedom, guaranteed affordability, and positive relationships with other residents and staff as characteristics that made the complex superior to the emergency shelter. Although participants preferred the supported housing environment, they also vocalized dissatisfaction with certain components of the complex, such as the physical environment, staff member behaviours, and certain residents' actions including theft and physical altercations. Proactively addressing these concerns through policies co-developed by staff and residents would help maximize engagement with services offered at the supported housing complex.

Recommendations for Improving Shelter and Supported Housing Environments

- 1. Enhance access to supportive housing and services unique to a supportive-housing approach.** As emergency shelters are not suitable for long-term stays or addressing complex client needs (Gaetz et al., 2016; Gilderbloom et al., 2013; Schmidt et al., 2015; Sylvestre et al., 2016), the development of additional supported housing complexes is recommended. Research suggests that these environments, which are guided by a Housing First approach, are better able to meet the needs of individuals experiencing homelessness (Aubry et al., 2016;

Kerman et al., 2018; Kirst et al., 2015; Nyamathi et al., 2010). Advocacy at the community level, which highlights the evidence supporting this housing approach, may help increase political buy-in for supported housing complexes. For example, civic activism conducted by the Coalition for the Homeless, an advocacy group in New York in the 1980's, demonstrated how grassroots advocacy can lead to tremendous social change (Holtzman, 2019). A more recent example is how the Moms for Housing Collective in Oakland, California leveraged public attention through the media to push for the development and protection of social housing (Overholt, 2022).

2. **Improve acceptability of the emergency shelter environment.** Given that emergency shelters remain a primary intervention for targeting homelessness (Sylvestre et al., 2016), improving the perceived acceptability of the shelter service is important. Staff members and shelter clients' suggestions include:
 - a) **Increase participatory action at the shelter.** Research by Pollock and Tacket (2014) suggests that recognizing the expert opinion of service users, actively challenging the power dynamic between staff and clients, and an ongoing organizational commitment to positive change is required to successfully implement participatory action approaches. Interviewee input supports a recommendation to encourage participatory action by providing shelter residents with a voice concerning shelter policies, possibly: hosting monthly user/staff meetings to share resident concerns; electing a resident representative to attend staff meetings concerning shelter conditions who would get paid for their contribution; and

providing a box for anonymous suggestions. While acknowledging that successful implementation of participatory action requires motivation and commitment from both staff and clients, these approaches are likely to increase effective use of shelter resources.

- b) **Maximize training opportunities and emphasize consistency in rule enforcement.** Staff turnover, limited training, and lack of ongoing supervision create conditions that allow for inconsistencies in staff behaviour (Schiff & Lane, 2021). Prioritizing changes to staff trainings and shelter policies to help limit the inherent power dynamic of service user disadvantage and vulnerability would be beneficial (*see Staff Factors below*). For example, given that boundary negotiation is a common struggle for staff members working with individuals experiencing homelessness (Peters et al., 2022), training and guidance on the management of this topic is warranted. Moreover, improving staff retention may indirectly address these issues. Maximizing organizational supports, providing realistic job previews, increasing compensation for workers, and establishing workforce development strategies may help lessen staff turnover (Voronov et al., 2023).
- c) **Increase client privacy, agency, and self-efficacy.** Self-efficacy is shown to be lower among individuals experiencing homelessness (Maccio & Schuler, 2012), and maximizing agency is an important predictor of service use (Canavan et al., 2012). Increasing self-efficacy among individuals experiencing homelessness increases their pursuit of

resources (Clark et al., 2024) and may help in the transition to stable housing. It follows that fostering self-efficacy and hope in the shelter environment is an important facilitator to quality-of-life improvement (Greenwood et al., 2005). Possible changes include enhancing resident agency by allowing doors to be closed and limiting the frequency of night-time room checks and increasing shelter acceptability by adding flexibility in shelter opening hours and curfew/re-entry policies (e.g., exemptions for late arrival with cause and re-entry after late-evening smoke-breaks).

Influence of Staff Factors on Engagement at Emergency Shelter, Supported Housing Complex, and in Community Resources

The influence of staff members on service engagement cannot be understated. Staff members can positively influence service users (Barile et al., 2020; Black et al., 2018; Pedersen et al., 2016; Peters et al., 2022; Rice et al., 2023) or act as a deterrent to service engagement (Black et al., 2018; Gwadz et al., 2019; Ha et al., 2015; Olivet et al., 2021). In Study 1, staff members spoke about the challenges they face in providing care to emergency shelter users including rule enforcement difficulties, feelings of burnout, staff turnover, and lack of funding and training. In Studies 2 and 3, service users explored how staff members can be instrumental in helping them achieve success by connecting them to resources, acting as a source of practical and emotional support, or facilitating employment opportunities. They also discussed how staff can have a profoundly negative influence on their quality of life through inconsistent rule enforcement, treating them unfairly, and fostering mistrust in the system. Emergency

shelter clients and supportive housing complex residents shared negative experiences interacting with some staff members, feeling infantilized and believing that certain staff members held and acted upon unfair perceptions of them, which made them reportedly less likely to engage with services (Carver et al., 2022; Olivet et al., 2021). Although it is likely that client behaviours may elicit negative staff responses, and that clients who are frustrated with staff behaviours are most likely to criticize them, given the immense impact of staff factors on service engagement (Carver et al., 2020; Marshall et al., 2022; Peters et al., 2022), the following recommendations are issued to maximize their potential positive effects.

Staff-Related Recommendations

- 1. As client engagement with services is maximized when staff attitudes are warm, validating, and accepting, ensure staff members are well equipped to behave in this way.** Positive experiences with staff members increase the likelihood of appropriate service engagement, and clients are more likely to use a service when they have been connected by someone they trust (Parkes et al., 2021). Staff members also act as role models and sources of social support for individuals experiencing homelessness (Armstrong et al., 2021; Bond et al., 2022; Carver et al., 2022). Staff members should be encouraged to embody positive characteristics by teaching them skills like active listening and validation (Bond et al., 2022). Setting up positive reinforcement and accountability systems at the staff level (e.g., performance reviews from management, feedback pathways from clients) would help maximize effective staff behaviour. Skinner's reinforcement theory posits that intrinsic rewards like

feelings of empowerment and extrinsic rewards including an increased salary and benefits can be effective staff motivators (Wei & Yazdanifard, 2014).

Fostering work conditions that provide space for staff to process their own emotional reactions and allow for mentorship and guidance from senior employees would be beneficial in reducing burnout.

2. Increase use of specific strategies to maximize approachability and acceptability of staff members in the emergency shelter, supported housing complex, and community services:

- a) **Maximize consistency in rule enforcement.** Addressing factors related to staff turnover may indirectly improve consistency in rule enforcement (Rogers et al., 2020; Schiff & Lane, 2021; Voronov et al., 2023).

Participants felt that ensuring consistency in staff decisions and better monitoring of how staff treat service users would help limit favoritism.

For example, when staff members from the emergency shelter cover for those in the supported housing complex, specific guidance should be provided to ensure they know the differences in the rules and how they are to be applied.

- b) **Provide specialized staff training.** Because negative staff attitudes and action can be an immense deterrent to service use, it is crucial to provide staff with appropriate training (Planey et al., 2019; Schiff & Lane, 2021). Service users believed that staff training in topics, such as conflict de-escalation, dealing with substance use, mental health, and availability of and access to community services, would increase staff efficacy in

addressing residents' problems. Research with service providers indicates a strong desire for relevant training, including trauma-informed care (Twis et al., 2021). Online training may offer cost-benefits in the long term and be readily available to staff when they are onboarded (Chrysantina et al., 2022).

- c) **Ensure staff can follow through on promises.** Service users felt that relationships with staff members would be strengthened if they trusted that staff would follow through on promised agreements. Importantly, shelter users and supportive housing complex residents understood that organizational policies can impede staff members' agency in following through, but still desired more transparency from staff members on their decision-making processes. Staff's limited ability to adequately address client problems can be partially attributed to a lack of staffing and frequent turnover (Rogers et al., 2020; Schiff & Lane, 2021). Similar to rule enforcement, implementing changes to maximize staff retention would indirectly increase their ability to follow through by enabling staff to enact deep-seated change over time.

- 3. **Given that service provision for individuals experiencing homelessness can have a detrimental impact on staff well-being (Kerman et al., 2022; Kerman et al., 2023; Wagemakers-Schiff & Lane, 2019), it is important to increase organizational support to address these concerns (Voronov et al., 2023).**

Under-staffing and frequent staff turnover inhibit consistency in organizational policy implementation and impede the sharing of institutional wisdom.

Challenging caseloads combined with heightened emotional burden and client complexity can lead to staff burnout and less empathy (Lenzi et al., 2021). Staff members struggle with enforcement of organizational policies that do not align with their personal values, and often feel under-trained to best serve their clients with complex needs. Recommendations from both staff and service users to address these concerns include:

- a) **Prioritize additional staffing.** Under-staffing contributes to staff members feeling ill-equipped to address the needs of their clients (Kerman et al., 2022). Adding more staff in the emergency shelter and supporting housing complex would decrease staff burden and allow for the provision of more tailored care.
- b) **Increase specialized training.** Training in specific domains (e.g., referral processes for community services, conflict resolution, trauma-informed care) may help increase self-efficacy and confidence of staff members in addressing client needs (Twis et al., 2021). As noted above, creation of online modules for training can broaden choice, enhance access, and eliminate the cost and time constraints of in-person training (Chrysantia et al., 2022).
- c) **Ensure front-line staff participation and input for policy development and rule enforcement.** Staff members often experience an incongruence between their personal values and work expectations (Lenzi et al., 2021; Peters et al., 2022; Voronov et al., 2023). Ensuring representation of staff and client perspectives in recurrent examination of

the implementation of these policies may encourage mutual understanding and alleviate some of the front-line staff burdens.

Guarantee that existing shelter and supportive housing complex policies reflect the broader aims of the organization and are consistent with staff values.

Maximizing Service Use Across Settings

Staff and service users were aligned in their suggestions for maximizing service engagement. They spoke about systemic level changes such as increasing funding, providing integrated care, and maximizing availability of services. Staff also provided individual-level suggestions including the provision of financial incentives, increasing storage solutions, and creating a culture of tolerance among staff members. Although the majority of suggestions for change were consistent with existing research (Parsell et al., 2020; Ponce et al., 2018; Rizzo et al., 2022), interviewees provided the following recommendations relevant to their experiences:

1. Increase funding to expand services and address common comorbidities.

Participants emphasized that expansion of current services by extending opening hours and eligibility criteria and providing a greater breadth of services through expanding case management services requires increased funding (Mackie et al., 2019; Olivet et al., 2010; Wusinech et al., 2019). For example, funding specific to the needs of those transitioning to permanent housing, such as furniture and food banks, may help clients sustain tenancy. Increases in funding allocation would address systemic barriers including long waitlists and limited care for clients with complex comorbid presentations.

2. **Increase awareness of available services and access modalities.** A substantial barrier to service use is a lack of awareness of what is available and modes of access (Parsell et al., 2020; Rizzo et al., 2022). Posting available resources in high-traffic areas such as libraries and shelters would help increase service uptake, as being equipped with knowledge is a facilitator to service engagement (Greenwood et al., 2022). Staff members at the emergency shelter, supported housing complex, and community resources can encourage this information exchange and act as a bridge connecting clients to other resources.
3. **Ensure appropriate staffing and encourage positive employee/client interactions.** As noted above, staff members play a crucial role in validating service need, facilitating connections, and as role models for appropriate social relationships (Barile et al., 2020; Black et al., 2018; Bond et al., 2022; Carver et al., 2022; Pedersen et al., 2016; Peters et al., 2022; Rice et al., 2023). Providing staff rewards or incentives to recognize their effort would increase these positive interactions. Enabling activities that promote positive relationship building between staff and users may also be helpful in building a sense of community and common purpose.
4. **Maximize flexibility, tailoring and integration of services.** Flexible policies and tailored services foster greater service use (Kertesz et al., 2021). For example, drop-in models of service provision are often preferred by individuals experiencing homelessness (Parsell et al., 2020; Pedersen et al., 2016). Clients and staff recognized that streamlined access and ‘one-stop-shop’ models of service provision are more effective, less costly in client resources, and more

likely to be used. An integrated model of service delivery, in which different services work in conjunction with each other, would limit the duplication of resources while honoring client preference (Ponce et al., 2018)

5. Increase client agency and participatory nature of services. Increased engagement is most likely to arise when service users play an active role in the development and operation of services more responsive to their needs and foster the agency of service users (Canavan et al., 2012; Greenwood et al., 2022; Maccio & Schuler, 2012). Staff felt under-equipped to provide solutions to specific client requests, and service users expressed a desire to develop methods to help each other and staff improve their living environment and update provision of services. Leveraging the lived experience of service users (e.g., by having resident meetings, providing formal opportunities for idea exchanges) is likely to improve the environment for service users and staff alike.

6. Lower the most pressing practical barriers to service engagement. Supporting transportation through daily shuttles, increasing phone and internet access, and appointment reminders have been shown to facilitate service engagement (Ha et al., 2015; Sylvestre et al., 2016). Staff and clients expressed a strong need for better transportation solutions including dedicated shuttle services and more easily available public transit passes. The implementation of a reminder system which could be enhanced by ensuring clients have access to internet terminals, tablets, and personal phones. Funding these technological enhancements is likely to have a strong positive impact on service engagement by limiting practical barriers.

Staff and Service User Perspectives on Substance Use

Substance use was a prominent theme discussed among staff members, emergency shelter users, and residents of the supported housing complex. All participants emphasized that problematic substance use negatively impacts the lives of those experiencing homelessness, and complicated interactions with both staff and police. Staff members highlighted maladaptive substance use as a prominent barrier to service use (Gonzalez & Rosenheck, 2002; Parsell et al., 2020). Coping motives of substance use are common among individuals experiencing homelessness (Votaw & Witkiewitz, 2021; Wolitzky-Taylor et al., 2018) and were endorsed by many service users. Emergency shelter users also shared how substance use impeded their educational and employment opportunities, consistent with prior research in this area (Poremski et al., 2014). Residents of the supported housing complex stressed the bidirectional relationship between homelessness and substance use (Nilsson et al., 2024; Stablein et al., 2021) and emphasized the need for more extensive addiction services.

Although many participants in Study 2 and Study 3 wished to reduce their substance use, they complained that illicit substances are not well-controlled in the shelter and supportive housing complex. Rampant substance use is frequently named as a reason why individuals avoid using emergency shelters (Kerman et al., 2023; Wusinich et al., 2019). Research suggests that overcoming addiction, especially in a shelter or supported housing complex, comes with significant social and relational cost (Christiani et al., 2008). As such, the following recommendations aim to alleviate some of the burdens associated with substance use reduction:

- 1. There is a strong need for supplemental addictions services.** Existing research highlights the relationship between limited substance use and prolonged housing tenancy (Boland et al., 2018; Marshall et al., 2022). Factors shown to predict substance use reduction include facilitative service environments, accepting staff attitudes, flexibility, increased agency, and opportunities for learning daily living skills (Carver et al., 2020). Initiatives like hosting presentations by addictions counselors, individuals with lived experience, psychologists, and ER doctors, and providing weekly meetings for those wishing to decrease their use can provide tangible methods of support at low cost. Facilitating access to existing addiction services (e.g., AA/NA, detox) by providing transportation and coordinating referrals may also increase engagement. Finally, ensuring staff are non-judgmental and validating of harm-reduction approaches to substance use would decrease the stigma these individuals experience and ease their decision to engage with services.
- 2. Maximize engagement with substance use treatment among individuals experiencing homelessness.** Research suggests that blending contingency management with transitional housing, ensuring access to opioid agonist therapies, and providing education on overdose prevention and harm-reduction approaches (e.g., naloxone kits, rapid drug-testing kits) can be effective tools in minimizing problematic substance use among this population (Padwa et al., 2022). Participants in Study 2 and Study 3 expressed that personal readiness is critical to successful use reduction, consistent with prior research by Moore and Hardy (2020). Embedding peer support in substance use treatment and

motivational enhancement strategies may also be helpful (Battjes et al., 2003; Keys et al., 2006; Miler et al., 2020; Moore & Hardy, 2020). Motivational enhancement strategies that should be taught to staff members include being non-judgmental with clients, supporting client self-efficacy and belief in their ability to change, and reflectively listening to build client motivation for change (Orciari et al., 2022).

- 3. Create abstinence-contingent housing for those determined to reduce substance use.** A systematic review of interventions to reduce homelessness found that abstinence-contingent housing paired with day treatment services, compared to treatment as usual, decreases total number of days spent without housing (Munthe-Kaas et al., 2018). Having both forms of support available (i.e., abstinence-contingent housing and harm-reduction focused housing), and allowing individuals to choose between them, is likely the most successful approach. Moreover, embedding choice within service delivery will also increase agency and self-efficacy.

Perceived Pandemic Impact on Individuals Experiencing Homelessness

Interviews for the three studies occurred in sequential order during the COVID pandemic. Staff members discussed how cleaning and hygiene requirements increased and shelter capacity decreased due to the pandemic (Goodwin et al., 2022). They explained how screening requirements and rule enforcement regarding mask and distancing protocols were added stressors to their workloads (Baral et al., 2021). Staff were unable to offer certain services (e.g., food provision), distancing requirements reduced the capacity of shelters by almost 50%, and enforcing COVID regulations

burdened their already high workload. They perceived the mental and physical state of clients to be deteriorating at a faster rate due to COVID, and specifically, research suggests that these individuals are more likely to have poor outcomes following infection (Tsai & Wilson, 2020). It is likely that the pandemic compounded existing difficulties with physical and mental health, as well as substance use (Finnegan et al., 2022). Staff and service users felt that fewer services were available, and public spaces were more highly monitored. These factors likely contributed to a reduction in overall service engagement (Perri et al., 2020).

Staff interviews were conducted at the beginning of the pandemic, whereas interviews with shelter users and supported housing complex residents happened months later. Interviewees in Study 2 and Study 3 had lived through more of the pandemic at the time of their interviews and, as such, provided extensive coverage of how it impacted their lives. Service users felt that masking requirements and vaccine guidelines limited their freedom, contributing to increased isolation and heightened public stigma. Emergency shelter users felt they were treated worse than before because of public fear that they were carrying the virus. Unique insights from their perspective included the perceived positive benefit of virtual health appointments and the positive impact of the CERB benefit for the few who were eligible (Petit & Tedds, 2021). Importantly, virtual health and psychological appointments and CERB-like direct payments can be extended to provide tangible and effective expansion of service use and encourage the development of client agency.

Perceptions on Police Intervention

Participants across studies held both strong and nuanced beliefs about policing. Staff members felt respected by police officers and relied on them for rule enforcement at the shelter (e.g., escorting clients who were banned away from the premises, enforcing bans); however, some admitted that police officers were sometimes involved in matters beyond their trained-ability or scope of responsibility. This perception is consistent with research indicating that police officers do not believe that policing of homelessness should fall within their mandate (Kyprianides et al., 2021; McNamara et al., 2013), highlighting a lack of police officer training and the need for other trained intervenors like social workers and other types of first responders.

Some emergency shelter users and supported housing residents felt harassed by, and unsafe around police officers. Many recounted negative experiences and believed they were targeted more frequently, treated more harshly, and given less leniency than others due to their housing status. However, a minority of service user participants also recounted positive interactions with police; for example, in situations where police had connected them to community resources.

Across all three studies, interviewees reported that the hypervisibility of individuals experiencing homelessness made them a target of disproportionate police intervention. Research suggests that over-policing and ordinances for minor infractions like occupying public space are common experiences among this population (Gaetz, Gulliver & Richter, 2014; Herring et al., 2020; Laniyonu & Brais, 2023). Research on the use of co-response teams (i.e., a law enforcement officer paired with a mental health professional) in response to behavioural crises has shown increased access to care and cost savings while limiting arrests and repeat calls for service (Kridler et al., 2020).

Participants' histories of police involvement and incarceration complicate current relationships with police, as previous negative experiences make individuals more likely to mistrust the police and less likely to report being victims of a crime (Roy et al., 2016). Up to a third of incarcerated individuals have experienced an episode of homelessness in their lifetime (Forrest & Beckett, 2021). Staff members echoed this sentiment and noted extra reticence from certain service users during interactions with police officers. These interviews yielded two key recommendations:

1. **Increase collaboration between police and community organizations.** Staff members suggested that a social worker present with police officers may help with de-escalation of conflict between police officers and individuals experiencing homelessness. Promising research suggests that collaboration between community organizations and police can help ensure that potentially combative interventions such as dismantling of tent cities can be more cooperative by, for example, ensuring adequate support for the dwelling residents during the transition (Solensten & Willits, 2019). A successful local example of clinician collaboration with the police is the Integrated Mobile Crisis Response Team in Saint John, New Brunswick (Cave, 2023). Modifying traditional policing practices by increasing the use of co-response teams may simultaneously increase service engagement and minimize harm (Batko et al., 2020; Cohen et al., 2019). Funding more robust training for police officers and increased collaboration with community organizations is a recommended target for change.

2. **Modify public policy which leads to the undue criminalization of homelessness.** Research suggests that individuals experiencing homelessness are frequent victims of over-policing (Gaetz, Gulliver & Richter, 2014; Herring et al., 2020; Lanionu & Brais, 2023). Targeting the public policies and biases which underly these experiences (e.g., ordinances which prohibit individuals from occupying public space, policy perceptions of homelessness) through community advocacy and officer training is an important target of change. Furthermore, minimizing unjustifiable policing of individuals experiencing homelessness would increase their trust in the police force and increase the likelihood of them reporting victimization if it occurs (Nilsson et al., 2020).

Perceived Impact of Cultural Factors on Service Use

Staff members considered the impact of diversity inclusion on service use to be more important than did the service users themselves. Staff members suggested culturally relevant resources be made available to service users upon request (e.g., connections to elders, access to language interpreters; Olivet et al., 2021). Although service users believed that staff members acknowledged their cultural backgrounds, they had little input on how services could be made more culturally sensitive. It is possible that cultural considerations are less salient for service users as they prioritize other more pressing needs. Future research should explore service user perspectives on cultural issues impacting engagement.

Religious and faith-based organizations contribute significantly to services aimed at individuals experiencing homelessness (Johnson et al., 2017). A study conducted across 11 American cities found that almost 60% of emergency shelter beds

were provided through faith-based organizations (Johnson et al., 2017). Most shelter and supported housing residents acknowledged using services provided by faith-based organizations (e.g., drop-in centers, AA/NA meetings at churches), many reported a strong relationship with their faith, and found the services they received from churches to be particularly helpful. Research suggests that connection to one's religious faith may help individuals experiencing homelessness cope with the adversity they face (Williams & Lindsey, 2006).

Culturally appropriate service delivery may be sorely lacking for some minority groups. For example, shelters rarely provide culture-based interventions, despite the fact that Indigenous people are overrepresented in the homeless population and display substantially more service use (Baral et al., 2021). Specifically, indigenous populations' shelter use is 8.9 times greater compared to non-Indigenous populations (Duchene et al., 2021); thus, it follows that services should be tailored to Indigenous people (Kidd et al., 2019). In line with the goals of the current dissertation, future research should include interviews with Indigenous clients to learn about specific changes they might welcome, and solicit the input of key partners (e.g., First Nations or Native American leaders).

CHAPTER 6: CONCLUSION

The current dissertation surveyed the lived experience of emergency shelter users, supportive housing complex residents and the staff of both environments. Participants were interviewed about their perspectives on housing, the emergency shelter and supportive housing center, service use, substance use and other selected topics surrounding their life experiences. Participants were also asked to provide insights and suggestions for positive change. Examination of commonalities and discrepancies in the groups' points of view allowed the formulation of key take-away points and tangible recommendations to improve the quality of life of those experiencing homelessness, and to maximize their chances to achieve successful long-term tenancy (see Chapter 5).

Limitations and Future Research

Despite the strengths of the current dissertation, some important limitations must be noted. Because the scope of the project allowed access to only one emergency shelter and one supported housing complex, perspectives surrounding other housing types like tiny home communities and tent cities were not included in the current dissertation. Moreover, only two participants in the current dissertation were interviewed in both the emergency shelter and supported housing environments. Although the other supported housing residents experienced emergency shelters in their lifetime, they had not been interviewed for study 2 of the present dissertation. The perspectives of individuals who actively avoided the shelter or the supported housing complex are also lacking and may have contributed valuable insight into strategies to increase services acceptability for individuals most reticent to engage in service use. Limited extant research on these

unique first-person perspectives suggests that strong negative emotional reactions, fear of violence, and disgust over the physical conditions are linked to avoidance of the shelter environment (Fahnøe, 2018).

Securing interviews with this vulnerable population was made possible by the referrals of outreach workers who held strong, trusted relationships with the client groups. They served as knowledge brokers by facilitating a connection between the researcher and interviewees—critical to the research. This research project does not assume that the questions posed were inherently neutral, nor were they perceived by participants to be that way. Rather, this research is a qualitative synthesis the lived experiences of people in the system, that could have been influenced my own biases as the researcher who interpreted them. In the future, it may be beneficial to increase the authorship of participants in ways that are suggested by Denzin (2016) and Weissman (2017) keeping pace with modern qualitative methods. Future research may be improved by embedding community partners in the data collection process (e.g., having social workers facilitate connections and act as co-interviewers), to facilitate acquisition of more detailed knowledge. Moreover, longitudinal research evaluating the implementation of new policies and procedures is needed. These outcome evaluations would allow for greater insight into the applicability and feasibility of program changes. For example, one study could evaluate the implementation of staff training across different domains including acceptability from staff and clients and fidelity to the training model.

Dissertation data were coded by one researcher, which precluded the use of inter-rater reliability analysis. It is possible that my awareness of the literature on service use

among individuals experiencing homelessness may have skewed my data interpretation, generating themes that were consistent with existing research (Schonfeld & Mazzola, 2013). It is also likely that given the modest N, inter-reliability and cross-tabulated patterns would have been less fruitful than the thick description (Geertz, 2008) embedded in this study. Although it is possible that individual bias influenced the coding process, steps were taken to address this possibility and ensure themes were adequately captured in interview data. Specifically, a preliminary codebook was sent to the Youth and Family lab members along with one de-identified interview, and lab members provided suggestions for revisions before it was used to code the interviews of all three studies. Future research projects would benefit from the use of multiple coders to ensure reliability across the data. Future research interviewing people living in a larger sample of emergency shelters, supported housing complexes and other housing types located in a range of cities would help create a more robust understanding of the barriers and facilitators to service access. A comparison of policies enforced across a larger sample of shelters may highlight specific points of friction and important targets of change. Ideally, should the suggestions from the current dissertation be implemented, follow-up interviews could assess their effectiveness in addressing perceived barriers to service engagement.

Using semi-structured interviews allowed for interviewees to share their unique perspectives and prioritized their agency in choosing the depth to which they discussed certain topics (Adams, 2015; Adeoye-Olatunde & Olenik, 2021; Queirós et al., 2017). However, it is possible that the way questions were posed influenced resulting responses. For example, participants across studies rarely discussed their personal

responsibility in addressing the challenges they face, perhaps because no question explicitly asked them to reflect on this idea. Using qualitative methodology also precluded the use of statistical analyses to evaluate the impact of these factors on service use and is ill-suited to hypothesis testing (Schonfeld & Mazzola, 2012). Qualitative research can provide an important component of hypothesis development to be formally tested with alternative methodologies. For example, although the present dissertation identified the strong perceived impact of staff training on the acceptability of a service, future research could use quantitative research methods (e.g., a prospective survey and service use data with a comparison group of clients with staff trained as usual) to formally assess this hypothesis. Moreover, using mixed-method approaches would be particularly useful to measure objective changes resulting from the implementation of the suggested changes.

Extant research suggests that using mixed methods can facilitate the discovery of novel knowledge (Schonfeld & Mazzola, 2012). When considering how knowledge acquired through the current dissertation may be expanded, a quantitative measure could be used to assess the degree to which the provision of non-housing support needs contributes to longer sustained tenancy. Employing content coding of qualitative interviews could also provide a sense of the relative importance of different non-housing support needs, pointing to those that should be prioritized.

It is important to acknowledge the limitations of generalizability of the current findings. Interviews were conducted during the Covid-19 pandemic, which substantially influenced the service use landscape, and in addition, the city of Fredericton has characteristics that make it different from larger cities in which most of Canadian

homelessness research is conducted (e.g., urban centers with greater resource availability; Schiff et al., 2020). However, reasonable confidence in the generalizability of the findings exists given that many of the findings and recommendations were consistent with a large body of extant research. For example, issues of staff turnover in service sector remain salient despite variation in service availability or city size (Schiff & Lane, 2021; Rogers et al., 2020; Voronov et al., 2023).

Conclusion

The present dissertation offers a comprehensive and balanced examination and comparison of the perspectives of emergency shelter service providers, emergency shelter users, and residents at a supportive housing complex. Interviews garnered personal responses and revealed insights concerning a wide range of topics, including housing types and service use, substance use, mental health, client/staff interaction, rule enforcement, policing implications, social stigma, political policy, funding, housing acquisition and successful tenancy. The results have policy implications at individual and systemic levels. Participants across the three studies provided informed suggestions for change as they highlighted the need for affordable housing, a preference for the supportive housing environment over the emergency shelter and identified numerous practical barriers to service engagement. Focusing on important facilitators to service acceptability and use and addressing these concerns through policy at micro and macro levels, will lead to increased service use and successful long-term housing tenancy. Expanding upon this research will give more voice and agency to a population that has important points of view that need to be heard and acted upon.

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Table 7

Glossary of commonly used terms

Terminology	Definition
Assertive community treatment (ACT)	ACT is a client-centered service delivery model. It has received substantial empirical support for facilitating community living, psychosocial rehabilitation, and recovery for persons who have the most serious mental illnesses, severe symptoms and impairments, and have not benefited from traditional programs.
Adequate housing	Housing that is reported by residents as not requiring any significant repairs. Housing that is inadequate may have excessive mould, inadequate heating or water supply, or considerable damage.
Addictions programs	Programs that consist of self-help residential or outpatient treatment facilities, harm reduction programs, individual or group counselling, and support from community programs.
Affordable housing	Housing that costs less than 30% of before-tax total household income.
At risk of homelessness	People who are not experiencing homelessness, but whose current economic and/or housing situation is precarious or does not meet public health and safety standards
Case management	A collaborative and client-centered approach to service provision for persons experiencing homelessness. In this approach, a case worker assesses the needs of the client (and potentially their families) and when appropriate, arranges, coordinates and advocates for delivery and access to a range of programs and services to address the individual's needs.
Chronic homelessness	Those who are homeless for a long time, usually a year or more.
Continuum of care (CoC)	Developed by the US Department of Housing and Urban Development (HUD), a continuum of care (CoC) is a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximize self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness and has four necessary parts: outreach services, emergency shelter, transitional

Terminology	Definition
Community services	housing, and supportive housing. Any programs delivered through non-profit or faith-based community organizations to assist people experiencing homelessness.
Emergency shelter	Provides a place to stay overnight if you become homeless or otherwise experience a housing issue and have no place to go.
Episodic homelessness or transitional homelessness	Those who move in and out of homelessness for shorter periods of time. Transitional homelessness refers to short-term homelessness usually lasting less than a month.
Family shelter	Facility that provides temporary, short-term accommodation specifically for families.
Group intensive peer support (GIPS)	GIPS is a model of case management developed for veterans experiencing homelessness that is expected to be scalable in nature (Tsai & Rosenheck, 2012).
Homeless Individuals and Families Information System (HIFIS)	Developed by government of Canada in collaboration with communities, the Homeless Individuals and Families Information System (HIFIS) is a comprehensive data collection, reporting and case management system that supports the day-to-day operations of housing and homelessness response service providers.
Harm reduction	Policies, programs, and practices aimed at reducing the risks and negative effects associated with substance use and addictive behaviours for the individual, the community and society as a whole.
Hidden homelessness	Refers specifically to persons who live temporarily with others without the guarantee of continued residency or immediate prospects for accessing permanent housing.
Home	Represents a physical space that emulates safety and a place that fosters fulfillment of a person's fundamental needs.
Housing First	An approach to ending homelessness that centers on quickly moving people experiencing homelessness into housing and then providing additional supports and services as needed.
Low barrier housing	Applicants for this housing do not need to meet any specific requirements to enter a provided facility or housing, especially surrounding the use of substances.
Outreach programs	Services and programs involved in bringing services directly to where people are rather than requiring

Terminology	Definition
	someone to go into an agency.
Point-in-time count	Provides a snapshot of the number of people who are unsheltered during a specific period (usually 24 hours) in a specific city or place.
Prevention programs	Refers to one of the main strategies in addressing homelessness that aims to stop people from becoming homeless in the first place.
Provisional accommodation	Includes individuals who despite having no access to permanent housing, access other forms of accommodation. Provisionally accommodated individuals may have interim housing, live with others (e.g., couch surfing), visit accommodation centers for immigrants and refugees, or live in halfway homes or other institutional care without permanent housing options
Rapid re-housing	An approach to housing that is like Housing First as it has no “readiness requirement.” This approach is best suited for people experiencing episodic and transitional homelessness.
Rent supplement/subsidy	Government-funded payments that bridge the gap between the rent that an individual or family can afford to pay the actual cost of housing. Depending on the program, rent supplements can be used in social and market housing; they can be portable (i.e., move with the tenant from unit to unit) or fixed (i.e., attached to specific housing unit or program).
Service provider	An organization that provides services to individuals and/or families experiencing or at risk of experiencing homelessness.
Severe mental illness	Defined as a serious and persistent mental or emotional disorder (e.g., schizophrenia, mood-disorders, schizo-affective disorders) that interrupts people’s abilities to carry out a range of daily life activities such as self-care, interpersonal relationships, maintaining housing, employment or stay in school.
Shelter users	Individuals or families who use the emergency shelter system.
Social housing	Housing for low- and moderate-income individuals or families, operated and subsidized by the Government and/or a non-profit organization.
Street outreach	Work that involves moving outside the walls of the agency to engage people experiencing homelessness

Terminology	Definition
Substance use disorder	<p>who may be disconnected and alienated not only from mainstream services and supports, but from the services targeting homeless persons as well.</p> <p>According to the <i>Diagnostic and Statistical Manual of Mental Disorders</i> (5th ed., DSM-5; American Psychiatric Association, 2013), an individual meets the criteria for a substance use disorder when they have at least two of the 11 symptom criteria and continue using substances despite substance use related problems or harms. The severity of the disorder is specified based on the total number of symptoms an individual has across four domains: (1) impaired control, (2) social or relational impairment, (3) risky patterns of use, and (4) pharmacological criteria.</p>
Substance use problems	<p>Refers to individuals' perceptions of how substance use affects their lives more broadly. It is a term that allowed participants to more freely conceptualize the impact of substance use, including effects on interpersonal and emotional domains, which are not captured in the DSM-5 criteria.</p>
Supportive housing	<p>Refers to housing that is long term and affordable for individuals experiencing (or at imminent risk of) homelessness. Supportive housing is coupled with embedded support services (i.e., available on-site) that are made generally available and not connected to any individual. The support services and referrals provided through supportive housing include those required to promote, improve, conserve, or restore the mental and/or physical well-being of the participant. Available services can include any combination of clinical and social support programming.</p>
Supported housing	<p>Refers to housing that is long term, independent, and integrated into the community, coupled with support services for individuals experiencing (or at imminent risk of) homelessness. These support services are not embedded within a specific housing; rather, they are connected to the individual. Supported housing can occur all along the housing continuum, and provides assistance with obtaining affordable housing, rental assistance and support services targeted to promote, improve, conserve, or restore the mental and/or physical well-being of the participant.</p>

Terminology	Definition
Thematic analysis (TA)	Thematic analysis (TA) is a method of data analysis that falls within the qualitative research framework and is not tied to any specific theoretical orientation.
Transitional housing	Facilities that provide temporary shelter but can be differentiated from emergency shelters by the longer length of stay and greater intensity of support services offered to clients. Transitional housing can be an intermediate step between emergency shelter and permanent housing. This temporary type of accommodation that is meant to bridge the gap from homelessness to permanent housing by offering structure, supervision, support, life skills, education, etc.
Trauma	An event outside the range of usual human experiences that would be markedly distressing to almost anyone and cause victimization.
Unsheltered individuals	People who lack permanent housing and are not utilizing emergency shelters or accommodation. these individuals often live in spaces without consent or contact (e.g., vacant buildings, public space like parks), or in places not intended for human habitation (e.g., cars or vehicles, tents, or shacks).
Vulnerability Index-Service Decision Assessment Tool (VI-SPDAT)	Standardized self-report assessment tool used to evaluate social, medical, and mental health vulnerabilities of those experiencing homelessness.
Women shelter	Facility that provides temporary, short-term accommodation, specifically for women.
Youth homelessness	Refers to young people between the ages of 13 and 24 who are living independently of parents or caregivers and lack many of the social supports deemed necessary for the transition from childhood to adulthood.



Qualitative Interview Guide (for service providers)

Pre-Interview Instructions for Interviewers:

Explain what the research is about, what it is for, and the interview process.

Outline audio recording, approach to confidentiality, exceptions to confidentiality, voluntary nature of the study, and timing.

Ask if they have any questions.

Give the participant the Consent forms (consent forms may be sent electronically prior to the study) and provide them with sufficient time to read them over.

Ask them to complete the background questionnaire (can be sent by email beforehand or completed during the interview)

Ask if they have any questions.

Sign Consent forms (or record verbal consent).

General capacity of their interactions with individuals experiencing homelessness

To provide some context about your perspective, can you tell us a little about how your current position centers around individuals experiencing homelessness?

Content Prompts:

1. What is your current work position?
2. How long have you held this position?
 - a. Have you held other positions before this one?

3. What kind of interactions do you have with individuals experiencing homelessness?
4. Have you worked with individuals experiencing homelessness in the past?
 - a. If so, are there policies/procedures/practices that are used elsewhere you think would be useful to implement here?

Perspectives on service utilization and access to services

We would like to find out more information about your thoughts on the services people experiencing homeless have access. More generally, what does the low-barrier shelter system look like?

Content Prompts:

1. What are some of the pros and cons about the low-barrier shelter generally?
2. What are some of the pros and cons of the shelter situation given COVID-19?
3. What are some reasons individuals seek services?
 - a. What might play a role in that decision?
4. What might be some of the reasons these individuals are reluctant to use services?
5. What, if any, services do you think are missing from the current shelter system?
 - a. Have you been told about any from service users?
6. What resources, if any, would be helpful for you to have in your current position? What would better help you in helping service users?
7. What barriers have you faced in attempting to provide resources for those experiencing homelessness in Fredericton?

8. What have you found to work well when attempting to provide resources for those experiencing homelessness in Fredericton?
9. Are there any factors that you believe have changed over time that may have impacted resource access?
10. What are your experiences with other agencies and outside service systems regarding those experiencing homelessness?
 - a. E.g., dealing with police, department of social development, medical system/ambulance?
11. Do you have any ideas/suggestions as to how we can enhance services available to individuals experiencing homelessness in Fredericton?
 - a. Have you witnessed any individuals transition from homelessness into a stable housing environment?
 - i. What, if any, obstacles did these individuals experience while making a transition?
12. What, if any, cultural or religious adaptations do you think might be useful to have to enhance service access?
 - a. If applicable, can you identify any situations when an individual experiencing homelessness in Fredericton needed cultural adaptations to access programs or services?
 - b. How have cultural or religious needs been met for individuals when requested?
 - c. Are there any current cultural or religious barriers that you are aware of in the shelters or programs?

After the Interview Instructions for Interviewers:

Thank them for their participation.

Ask if there is anything else they wish to add to the interview that they may have not had the opportunity to discuss.

Give them the debriefing form (or provide them with an electronic link or offer to send them the letter via electronic or postal mail).

Explain that they may contact the researchers if they have any questions or concerns or in the event they wish to continue this discussion in more depth.

Ask if they have any final questions and thank them again for their participation.



Qualitative Interview Guide (for service users)

Pre-Interview Instructions for Interviewers:

Explain what the research is about, what it is for, and the interview process.

Outline audio recording, approach to confidentiality, exceptions to confidentiality, voluntary nature of the study, and timing.

Ask if they have any questions.

Give the participant the Consent forms and provide them with sufficient time to read them over.

Ask them to complete the background questionnaire.

Ask if they have any questions.

Sign Consent forms (or record verbal consent).

Background and experiences with homelessness

To provide some context about your perspective, can you tell us a little about how you came to experience homelessness?

Content Prompts:

1. When did you first experience homelessness?
2. Can you share a little bit about what was happening in your life before you became homeless?
3. What kind of supports do you currently have (e.g., friends, family)?

4. What does it mean to you to be visiting this shelter versus others that have conditions for their use (e.g., like being sober)?
5. Do you have the kind of housing you want? What kind of housing would you want?
6. What's the best thing about the place where you currently stay? The worst part?

Perspectives on service utilization and access to services

We would like to find out more information about your thoughts on the services people experiencing homeless have access to, can you tell us about your experience accessing services?

Content Prompts:

13. How have things changed for you since COVID in terms of being able to use services?
 - a. Has COVID made it easier? Harder? In what ways?
14. Which groups have you come into contact with during your experiences of homelessness?
 - a. Police/legal system
 - b. Department of social development
 - c. Hospital/Mental Health
 - d. Rehab services
 - e. Medical system
 - i. Has contact with these different groups made it easier or harder to access services?
15. What, if anything, do you think is missing from the services available?

16. When are you most likely to use services (e.g., shelters, AIDS New Brunswick, the health clinic)? How did you access them?
- a. What made you come to the decision to use different services?
17. What services have you used? What services have you not?
18. What might make you avoid seeking services/help?
- a. What do you think played a role in the decision to not seek services?
19. How did you learn about this shelter? What have you talked about with others about this shelter?
20. What's good about the services you have access to right now?
21. What could be better about the services you have access to?
22. Are there any cultural, religious or diversity factors that you think might be useful to have (e.g., better access to areas of worship, more diverse staff at the shelters, LGBTQ factors)
- a. Is there anything about the current services that you feel don't meet your cultural needs?

***If client used shelter services before moving into supported housing:*

Has your experience using services changed from when you were in the shelter compared to your current housing?

- *What has stayed the same?*
- *What is different?*
- *In what ways, if at all, is it better or worse than it was before?*

After the Interview Instructions for Interviewers:

Thank them for their participation.

Ask if there is anything else they wish to add to the interview that they may have not had the opportunity to discuss.

Give them the debriefing form

Explain that they may contact the researchers if they have any questions or concerns or in the event they wish to continue this discussion in more depth.

Ask if they have any final questions and thank them again for their participation.



Informed Consent Form

*Moving Beyond Risk and Need: An Evaluation of Service Utilization and Responsivity
Factors Among Service Users and Service Providers.*

You are invited to participate in a qualitative study on the patterns of service utilization among adults currently experiencing homelessness. This study is aimed at understanding the perspectives of professionals who interact with these individuals as well as insight from those currently experiencing homelessness. This project is conducted in partnership with the John Howard Society and the University of New Brunswick. For this study, we are inviting you to participate in an interview that will last approximately 30 to 45 minutes. In exchange, you will receive a \$10 Tim Horton's gift card.

PROCEDURE: First, you will be asked some questions that tells us a bit about yourself (e.g., age, gender identification, general work role). You then will be asked to discuss your experiences with working with individuals experiencing homelessness. We will ask your opinion about what services are useful and ways they could be improved. The interview will be conducted by a trained interviewer and will be audio-recorded so that we can ensure the information you provide is accurately recorded. This recording will be transcribed and all identifying information will be removed. However, if you do not wish to have your interview recorded, then the interviewer will take detailed notes as the interview progresses. To ensure privacy, all interviews will be conducted in person or

will be conducted by telephone or through secure teleconference. In conducting the interview, we request that you have complete privacy wherever you may be physically.

RISKS AND BENEFITS: Although we do not anticipate that you will experience any discomfort during the study, you can choose not to answer any questions that you find uncomfortable or to withdraw from the interview at any time. At the end of the interview, we will provide you with information for the researchers if you have any questions or concerns. You will also receive a \$10 Tim Horton's gift card in exchange for your participation, which will be yours regardless of whether you withdraw from the interview.

CONFIDENTIALITY: Participation in the interview is confidential, and no identifying information will be reported from the results. Your interview will be audio-recorded, and only the researchers and their research assistants will have access to the recording. For those interviews in which detailed notes are taken, those notes will only be accessible to the research team. To protect your identity, you can choose to use pseudonyms for yourself or anyone else you discuss. Your responses will only be summarized in future reports and will not include any personal information. Your responses will not be shared in an identifiable format with your employer in any way to protect your privacy. All physical data will be stored in a locked secure cabinet, and any electronic data will be stored on a secure server in a locked office at the University of New Brunswick.

EXCEPTIONS TO CONFIDENTIALITY: Because of legal and ethical requirements, the research team must break confidentiality if:

- 1) The interviewer becomes aware of child abuse or neglect of someone identified who is currently under the age of 19 years;
- 2) The interviewer becomes aware of sexual abuse perpetrated by a health care professional toward an identified adult or child; or
- 3) The interviewer becomes aware that the participant is threatening harm to oneself or to another identified person.

VOLUNTARY PARTICIPATION: Participation in the study is completely voluntary.

If at any time you do not wish to continue for any reason, you are free to withdraw without penalty.

You may ask that the audio recording and notes taken during the interview be destroyed at any time during or following the interview until the data analysis begins. In the event that you withdraw, you will still receive the \$10 gift card for participation.

QUESTIONS: If you have any questions before, during, or after the interview, please feel free to ask the researcher in person, by telephone, or by email. Contact information is available below and will be provided again at the end of the interview. This project is on file with the University of New Brunswick Research Ethics Board ((REB # 2020-116). If you have any questions or concerns about your rights or treatment as a participant, you may contact the Chair of the Department of Psychology Ethics Committee, **Dr. Lucia O’Sullivan** (osulliv@unb.ca) or the Chair of the Research Ethics Board, **Dr. David Coleman** (ethics@unb.ca). You may also contact Dr. Scott Ronis (sronis@unb.ca or 506-458-7804) or Laura Kabbash (lkabbash@unb.ca) for more information about this study.

Consent to Participate

I, _____, have read the above description and volunteer to participate in this study. I understand that I can decide to discontinue my participation or to not provide any personal information without penalty.

Signature of Participant Signature of Interviewer Date

Consent to Audio-Recording

Do you consent to your interview being audio-recorded? Yes ___ No ___

Signature of Participant Signature of Interviewer Date



Background Questionnaire

Please make the selections that best fit and answer open-ended questions where applicable.

1. To which gender do you identify?
 - Male Female non-binary two-spirited
 - Other (please specify): _____
 - prefer not to say

2. Age (in years): _____

3. Which best describes your race/ethnicity?
 - Caucasian/White/European Black/African
 - Asian/Pacific Islander Aboriginal/Indigenous/First Nations
 - East Indian Hispanic/Latino/Latina
 - Middle Eastern Biracial/Multiracial
 - Other (please specify): _____

4. What is the highest education level you have completed?
 - High School Undergraduate degree
 - Community college diploma Masters
 - Doctorate

5. What is your current academic/employment status (*check all that apply*)?

- In school part-time
- In school full-time
- Employed part-time
- Employed full-time
- Homemaker
- Unemployed
- Currently receiving public assistance
- Leave of absence from work for medical reasons
- Other (please specify): _____

Appendix E – Debriefing Form – Service Providers



Thank you for participating in this study! Your time and effort are greatly appreciated.

Research suggests that individuals who have experienced homelessness have higher rates of physical and mental health difficulties, substance misuse, and are at increased risk of suicide. Although the risk factors and needs of individuals experiencing homelessness have been exhaustively studied, little research has been conducted on the factors affecting how individuals *respond* to available community resources.

Research suggests that potential barriers to service utilization include: a lack of awareness about services, concerns about confidentiality, not wanting to engage with strangers, mistrust of service providers, and lack of perceived need for support. General barriers to mental health service utilization include financial barriers, dissatisfaction with available resources, fear of stigmatization, and substance misuse. We are interested in understanding what factors impact the availability and quality of resources from the perspectives of service users and service providers in the community. Using a qualitative interview approach allows us to highlight nuances in perspectives that could be missed by quantitative analyses.

Gaining insight into the existing gaps and assets of available resources from multiple perspectives will allow us to identify common themes surrounding perceived barriers and facilitators of service uptake and utilization. With a participatory research framework in mind, overall findings from this study will be shared with the John Howard Society to heighten the likelihood that barriers to service utilization for their

service users are minimized in the future. The knowledge mobilization aspect of this project ensures that the voices of service users are amplified and included in public policy discussions.

This study has received ethics clearance through the University of New Brunswick's Research Ethics Board (REB#2020-116). If you have any questions or concerns about your participation in the study, you can contact Laura Kabbash (lkabbash@unb.ca) or Dr. Scott Ronis (sronis@unb.ca; 506-458-5804). If you wish to speak with someone unrelated to the current study, you may contact the Chair of the Department of Psychology Ethics Committee, Dr. Lucia O'Sullivan (osulliv@unb.ca) or the Chair of the Research Ethics Board, Dr. David Coleman (ethics@unb.ca).

The final report will be available online once the study is complete. If you are interested, it will be available at: [**www.scottronis.com/research/completed-ongoing-projects/**](http://www.scottronis.com/research/completed-ongoing-projects/)

Thank you again for participating!



Informed Consent

An Evaluation of Service Utilization and Responsivity Factors Among Service Users.

The current study is looking at how adults (over the age of 19) experiencing homelessness are using social and healthcare services in Fredericton. This project is conducted with the John Howard Society and the University of New Brunswick and should last between 30 to 45 minutes.

HOW IT WILL WORK: First, you will be asked some simple questions about yourself. Second, you will be asked to talk about how you use services in Fredericton. Third, we will ask your opinion about what services you find useful and what difficulties you may have come across. The interview will be recorded so we can make sure we take-in everything you are saying. The recording will then be written out and all personal information will be taken out. If you do not want to have your interview recorded the interviewer will take notes during.

RISKS AND BENEFITS: It is possible that some questions might make you feel embarrassed or cause you to think about times in the past that have upset you. You can choose not to answer any questions or to stop the interview at any time. At the end of the interview, we will give you the researchers' contact information if you have any questions or concerns, and it will also be posted in Marshall house.

PRIVACY: Because the shelter doesn't have many private spaces, we cannot guarantee that we will be completely alone for the interview. That means that other people might hear you talk about your experiences. Your interview will either be recorded, or detailed notes will be taken, and only the researchers will have access to it. Reports that are created from the data will not include any of your personal information. Any physical copies of the data will be stored securely on the UNB campus.

EXCEPTIONS TO CONFIDENTIALITY: The research team might have to tell someone if:

- 1) They become aware of child abuse or neglect of a child under the age of 19 years;
- 2) They become aware of sexual abuse by a health care professional (e.g., a doctor);
- 3) The interviewer learns that the participant is at risk of harming themselves or someone else

PARTICIPATION IS YOUR CHOICE: Participation in this study is completely your choice. If at any time you feel you want to stop, you are free to stop the interview without any consequence. You may ask that the audio recording and/or any notes taken during the interview be destroyed at any time before data analysis begins. When we have finished all the interviews and looking at the data, we will give you a chance to hear us talk about what we found and give you a chance to offer your thoughts.

QUESTIONS: If you have any questions before, during, or after the interview, please feel free to ask the researcher. Contact information is available below, will be given again at the end of the interview, and will be posted in Marshall House. This project is

on file with the University of New Brunswick Research Ethics Board (REB # 2021-039). If you have any questions or concerns about your rights as a participant, you can contact the Chair of the Department of Psychology Ethics Committee, **Dr. Lucia O’Sullivan (osulliv@unb.ca)** or the Chair of the Research Ethics Board, **Dr. David Coleman (ethics@unb.ca)**. You can also contact Dr. Scott Ronis (sronis@unb.ca or 506-458-7804) or Laura Kabbash (lkabbash@unb.ca) for more information about this study.

Consent to Participate

I, _____, have read the above description and chose to participate

in this study. I understand that I can decide to stop my participation or to not provide any personal information without any consequence.

Signature of Participant Signature of Interviewer Date

Consent to Audio-Recording

Do you agree to your interview being audio-recorded? Yes ___ No ___

Signature of Participant Signature of Interviewer Date

Background Information Questionnaire – Service Users



Please make the selections that best fit and answer open-ended questions where applicable.

1. How many times have you been homeless?
2. How much time in total (e.g., months, years) have you been homeless?
 - a. Where did you stay during those times? (e.g., couch-surfing, tent-city, shelters)
3. To which gender do you identify?
 - Male
 - Female
 - non-binary
 - two-spirited
 - Other (please specify): _____
 - prefer not to say
4. Which of the following best describes your sexual orientation?
 - Heterosexual
 - Mostly heterosexual
 - Gay
 - Lesbian
 - Bisexual
 - Asexual
 - Questioning

- Don't know
- No labels preferred
- Other (please specify): _____

5. Age (in years): _____

6. Which best describes your race/ethnicity?

- Caucasian/White/European
- Black/African
- Asian/Pacific Islander
- Aboriginal/Indigenous/First Nations
- East Indian
- Hispanic/Latino/Latina
- Middle Eastern
- Biracial/Multiracial
- Other (please specify): _____

7. What is the highest education level you have completed?

- Less than High School
- Undergraduate degree
- High School
- Masters
- Community college diploma
- Doctorate

8. What is your current academic/employment status (*check all that apply*)?

- In school part-time
- In school full-time
- Employed part-time
- Employed full-time
- Unemployed
- Currently receiving public assistance
- Leave of absence from work for medical reasons
- Other (please specify): _____

Debriefing Form



Thank you for participating in this research study! We really appreciate your time and effort.

- Studies show us that people who have experienced homelessness experience high rates of physical and mental health difficulties and substance misuse.
- We don't know a lot about the factors that impact how people *respond* to community resources.
- Some research shows that these are some of the issues that people who experience homelessness face:
 - Not knowing where to get services
 - Not feeling like the services are private
 - Feeling mistrustful of those who are supposed to help you
 - Feeling no need for extra support
- The goal of this study is to better understand how you access services and how services can be improved
- We are using interviews rather than surveys because they allow us to better understand your unique experience
- This project will help us identify common ideas about the services available and how we can make them better.

- We will share our study findings with you, and with the John Howard Society to help improve services.
- This study has received ethics approval through the University of New Brunswick's Research Ethics Board (REB# 2021-039)
- If you have any questions or concerns about the study, you can contact Laura Kabbash (lkabbash@unb.ca) or Dr. Scott Ronis (sronis@unb.ca; 506-458-5804).
- If you want to talk to someone unrelated to the current study, you can contact the Chair of the Department of Psychology Ethics Committee, Dr. Lucia O'Sullivan (osulliv@unb.ca) or the Chair of the Research Ethics Board, Dr. David Coleman (ethics@unb.ca).

Thank you again for participatin

Curriculum Vitae

Candidate's full name: Laura Kabbash

Universities attended:

- 2018 – 2024 Ph.D., Clinical Psychology
University of New Brunswick (UNB), Fredericton, NB
Dissertation: *Making a shelter a home: insights from service providers, emergency shelter users, and supported housing residents*

(Proposal approved June 2022)
Supervisor: Scott Ronis, Ph.D., L. Psych.
- 2014 – 2018 B.A (Hons.) Psychology
University of British Columbia – Okanagan, Kelowna, BC
Thesis: *Evaluating personality moderator variables in the relationship between child maltreatment and chronic stress and adult outcomes*

Supervisor: Brian O'Connor, Ph.D.

Publications:

- Giberson, E. R., Tracy, B., Kabbash, L., Ronis, S. T., Campbell, M. A., & Gryshchuk, L. (2023). Section 19 Conferencing in the Canadian Youth Criminal Justice System. *Canadian Journal of Criminology and Criminal Justice*, 65(2), 97–118.
- Cassidy, K., Kabbash, L., & Ronis, S. T. (2021). A qualitative content analysis of an online support forum for family members of individuals with reported histories of sexual offences. *The Canadian Journal of Human Sexuality*, 30(2), 232-242.

Kabbash, L., & Ronis, S. T. (2021). Making a dent in human trafficking: Investigating the effects of social institutions and policies across 60 countries. *Crime, Law and Social Change*, 76(3), 321-336.

Ronis, S., & Kabbash, L. (2020). Sexual assault & harassment. In C. Pukall (Ed.), *Human Sexuality: A Contemporary Introduction*, 3rd Edition (pp. 392-419). Toronto, ON: Oxford University Press.

Kabbash, L., & Ronis, S. (2019). What is sexual slavery? In H. Armstrong (Ed.), *Encyclopedia of Sex and Sexuality: Understanding Biology, Psychology, and Culture*. Santa Barbara, CA: ABC-CLIO.

Conference Presentations:

Kabbash, L., & Ronis, S. (2022, March). *Problems with the village raising the child: Issues with case conferencing for youth care and potential directions for change*. Poster presented at the Biennial Meeting of the Society for Research on Adolescence (SRA). (Virtual Presentation)

Kabbash, L., Cassidy, K., & Ronis, S. (2021, September). "He did what?!?": Content analysis of online support groups for family members of sex offenders. Paper presented at the Annual Convention of the Association for the Treatment of Sexual Abusers (ATSA). (Virtual Presentation).

Cassidy, K., & Kabbash, L., & Ronis, S. (2020, October). *Experiences of the family members of individuals with histories of sexual offences: A content analysis*. Poster presented at the Annual Convention of the Association for the Treatment of Sexual Abusers (ATSA). (Virtual Presentation).

Kabbash, L., Cassidy, K., & Ronis, S. (2020, October). *How could you do this?": A*

qualitative exploration of relational stress following an alleged sexual offence.

Data Blitz presented at the Canadian Sex Research Forum (CSRF). (Virtual Presentation).

Cassidy, K., & Kabbash, L., & Ronis, S. (2020, October). *Understanding the consequences of registry laws on non-offending family members of individuals with histories of sexual offences.* Poster presented at the Canadian Sex Research Forum (CSRF), Waterloo, ON, Canada.

Miller, D. A. A., Kabbash, L., Ronis, S., & Gallagher, A. (2019, October). *Indirect supports and validation as enablers for mental health service access.* Paper presented at the 5th International Conference on Youth Mental Health (IAYMH), Brisbane, Australia.

Miller, D. A. A., Kabbash, L., & Ronis, S. (2019, October). *“Out of control”:* *Complications of access to youth mental health services.* Poster presented at the 5th International Conference on Youth Mental Health (IAYMH), Brisbane, Australia.

Kabbash, L., & Ronis, S. (2019, October). *Getting a handle on child sexual exploitation: Investigating macro and micro predictors of child sex trafficking.* Paper presented at the 5th International Conference on Youth Mental Health (IAYMH), Brisbane, Australia.

Kabbash, L., Ronis, S., & Vander Molen, L. (2019, October). *Exploring factors related to child sexual exploitation: Predictors of global child sex trafficking.* Poster presented at the Canadian Sex Research Forum (CSRF), Victoria, BC

Kabbash, L., Ronis, S., & Garceau, C. (2019, June). *What might have happened: Initial sexual experiences and evolving conceptualizations of sexual consent*. Poster presented at the International Health Research Day Conference, Saint John, NB.

Kabbash, L., Ronis, S., & Garceau, C. (2019, June). *If I would have known: Initial sexual experiences and evolving conceptualizations of consent*. Poster presented at the 4th North American Correctional & Criminal Justice Psychology Conference, Halifax, NS.

Kabbash, L., & Ronis, S. (2018, October). *Making a dent in commercial sexual exploitation of children: Investigating the potential effects of prostitution laws and policies across six countries*. Poster presented at the Canadian Sex Research Forum, Toronto, ON.

Academic Awards:

2020 – 2023 **Joseph Armand Bombardier Canada Graduate Scholarship – Doctoral (CGS-D)** Social Sciences and Humanities Research Council of Canada (SSHRC)

2019 – 2020 **Joseph Armand Bombardier Canada Graduate Scholarship – Master's (CGS-M)**, Social Sciences and Humanities Research Council of Canada (SSHRC)

2020 **CPA Student Research Grant**, Canadian Psychological Association

2020 **Student Award for Best Data Blitz Presentation**, Canadian Sex Research Forum

2019 – 2020 **Magee Third-Century Merit Award**, UNB

2019 – 2020 **Snodgrass Prize for Graduate Statistics**, UNB

- 2019 – 2020 **Student Award for Best Conference Poster**, International Health
Research Day, St. John, NB.
- 2019 **New Brunswick Innovation Fund Award**, UNB
- 2018 – 2019 **Faculty of Arts Graduate Assistantship**, UNB
- 2018 **New Brunswick Innovation Fund Award**, UNB
- 2015 – 2017 **Scholarship for Continuing Students**, UBC-O