Cornerstone Apartments: An Innovative Housing Project for People with Concurrent Disorders

FINAL Report

A Research Project by Alberta Health Services

Report by:

Kathleen N. Wright, BA,
Research & Evaluation Assistant
Research and Evaluation,
Information and Evaluation Services,
Addiction and Mental Health,
Alberta Health Services

Shireen Surood, PhD
Supervisor
Research and Evaluation,
Information and Evaluation Services,
Addiction and Mental Health,
Alberta Health Services

Acknowledgements

Investigators

Dr. Shireen Surood, Supervisor, Research and Evaluation, Information and Evaluation Services, Addiction and Mental Health, Alberta Health Services

Dr. Diane McNeil, Manager, Research and Evaluation, Information and Evaluation Services, Addiction and Mental Health, Alberta Health Services

Co-Investigators

Jill Kelland, Director, Cross Level Services and Supports, Addiction and Mental Health, Alberta Health Services

Marcia McKall, Manager, Residential & Housing Supports Initiatives, Cross Level Services and Supports, Addiction and Mental Health, Alberta Health Services

Jim Koning, Supervisor, Residential & Housing Supports Initiatives, Cross Level Services and Supports, Addiction and Mental Health, Alberta Health Services

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Research & Evaluation Assistants:
- Dr. David Gill
- Dylan Lampman
- Lawrence Zalmanowitz
- Viktor Sekowski

Summer Intern:
- Hansen Zhou

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Abstract

The rate of homelessness in Canada, and the proportion of women who are homeless, is increasing; despite this knowledge, there is lack of research regarding the contributing factors for successfully housing women with a history of homelessness.In particular, more needs to be known about women with concurrent disorders who are homeless.

This study aimed to: 1) explore the meaning of independent living as perceived by women living with concurrent disorders; 2) gain an understanding of how community receptivity and support assists in maintaining or gaining independent living; 3) explore the critical factors of success in gaining independent living; and 4) gain an understanding of how the Cornerstone Apartment Program has helped participants in achieving this goal.

Constructivist grounded theory was used to achieve this aim. Semi-structured, in-depth interviews were conducted with eight women experiencing a concurrent disorder diagnosis and who were either living or had lived at Cornerstone Apartments.

The study offered support for the benefits of providing comprehensive wrap-around services within a gender-specific, transitional supported housing program. Participants identified the importance of many facilitators to successfully gain and maintain independent living: safety and security; structure and routine in daily life; daily living skills; awareness of community resources; a support network; confidence and self-esteem.

A larger scale longitudinal study is needed to further explore the long term benefits of being a resident of a supported-independent housing program.

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Executive Summary

Homelessness is a severe, costly and rapidly growing social issue in Canada (Layton, 2000); how to best address this increasingly complex issue is not well understood. Like other major Canadian cities, homelessness is a growing concern in Edmonton (Edmonton Committee to End Homelessness, 2009). Homelessness can no longer be stereotyped as the 'single adult male'; it now includes a significant number of women, families and youth (Intraspec.ca, 2012; Klodawsky, 2006).

The relationship between homelessness and concurrent disorders, i.e., mental illness and substance use disorder (SUD), is well-documented. It is estimated that approximately 30% to 40% of homeless people suffer from severe mental illnesses (SMI) and roughly 50% also have a SUD (Canadian Centre on Substance Abuse, 2010; National GAINS Center for People with Co-occurring Disorders in the Justice System, 2001; Schanzer, Dominguez, Shrout, &Caton, 2007; Tsemberis, Gulcur, &Nakae, 2004; Tsemberis, Moran, Shinn, Asmussen, &Shern, 2003; Vancouver Coastal Health, 2006). Women often have distinct characteristics, vulnerabilities, and treatment needs as compared to men (Brunette & Drake, 1998), and may be increasingly susceptible to homelessness when experiencing a concurrent disorder. However, little is known about what facilitates independent living for this subgroup of women and what independent living means to them.

With this in mind, we sought to bridge the research gap by exploring the barriers and facilitators in achieving and maintaining independent living for women with concurrent disorders who were previously homeless. In addition, we investigated how a supported housing program assisted participants in their journey to independent living.

The objectives of this research project were to:

1. Explore the meaning of independent living as perceived by women living with concurrent disorders.
2. Gain an understanding of how community receptivity and support assists in maintaining or gaining independent living.
3. Explore the critical factors of success in gaining independent living.
4. Gain an understanding of how the Cornerstone Apartment Program has helped participants in achieving this goal.

Method

This research project recruited participants from the Cornerstone Apartment Program. It is a gender-specific, transitional supported independent housing program located in Edmonton, Alberta. Residents are women with mental health and/or addiction issues facing housing issues or homelessness; these women are supported in addressing their needs, goals and challenges in achieving and maintaining independent living.

To be eligible for the research study, participants had to be 18 years of age or older, have a concurrent disorder diagnosis and be a past or current resident of the Cornerstone Apartment Program. Residents interested in being interviewed provided their contact information to the program staff; research staff then contacted the participants. Semi-structured interviews were conducted with eight participants by a trained interviewer and demographic data was collected at the end of each interview. The 20-45 minute

interviews were audio-recorded and transcribed verbatim. To maximize anonymity, participants selected pseudonyms to be used for presentations, reports and publications.

Constructivist grounded theory, a reverse-engineered hypothesis, was used to analyze the transcriptions; coding of the data was done case-by-case, line-by-line, and then compared across participants. Codes were then analyzed and sorted into core-categories and themes. Constant comparison between interviews occurred throughout the stages of analysis.

Findings

The participants were primarily between the ages of 25 to 34 (*n* = 4), 'single (never married)' (*n* = 6) and 'unemployed' (*n* = 7). Their education ranged from 'some high school' to 'post-secondary' and all identified Canadian citizenship by birth. At the time of interview, the length of stay in the program ranged from four weeks to six months.

Independent Living

Participants defined independent living according to several parallel themes: autonomy, minimal support, ownership, freedom and responsibility. Independence and autonomy were synonymous described by all participants. These themes combined to provide a picture of how participants perceived independence and the skills they aimed to acquire. The women provided a balanced view of their future goal: independence was accomplished through minimal support, though the importance of accessing supports when needed was emphasized. In addition, freedom and ownership existed when responsibility was exercised.

The women expressed the importance of independent living skills; these skills ranged from basic to complex. Basic housekeeping skills, such as cleaning and grocery shopping, were widely identified among participants, but also complex skills such as building self-esteem, building confidence, defining boundaries and creating a work-life balance were highlighted.

The main barriers identified by participants included: mental health and addiction issues, a lack of community support for women, a lack of awareness of available community supports, mental barriers (such as fear of the unknown), and financial difficulties. These barriers had a role in preventing them from achieving or maintaining independence in the past, and were reported as potential barriers for the future. However, the participants also noted working on overcoming these barriers through their experience in the housing program (e.g., assistance connecting to financial aid, encouragement in enrolling in community outpatient programs).

The women reported facilitators for achieving and maintaining independent living. Housing programs, structure, life skills, employment/financial support, and a support network were the main facilitators identified. Housing programs, such as the Cornerstone Apartment Program, were praised for providing individuals the opportunity to practice independence with a safety net. Furthermore, participants found they learned many of the necessary skills (e.g., money management) while in the program. Structure in recovery was noted to provide a stable environment in which individuals were able to work towards their goals and further develop skills (e.g., cooking). Participants suggested that securing employment/financial aid would allow them to support and maintain their future independence. Developing a diverse support network, made up of community supports and family/friends, for example, was highlighted by the women as an integral part of maintaining independent living.

Furthermore, participants described elements of transitioning to independent living: determining readiness, concerns, preparation, steps taken, and future steps. Indicators of readiness included self-esteem, self-confidence, and a motivation to move forward. The women reported concerns regarding transitioning to independence, which included safety and security; a lower level of support; and feelings of loneliness. They had prepared for independence by participating in treatment programs, enrolling in housing programs in the past and connecting to community supports. Some participants took steps to acquire employment/self-employment and further their education. The women noted plans for the realities of independent living, such as financial responsibilities (e.g., damage deposit) and residential searches (i.e., safe and secure housing).

Recovery Journey

Participants reflected on their recovery journey; past addiction and/or mental health issues and experience with treatment were discussed, as were triggers and coping strategies. The women noted issues, such as alcoholism and depression, and addressing these issues in the past through hospitalization and treatment programs. Participants identified triggers (e.g., loneliness, nothing to do) and the coping strategies they had developed, such as utilizing a support network, setting a daily routine, and exercise. The participants noted their efforts in planning for their future independence, which included: developing/maintaining daily living skills, learning coping strategies and accessing treatment programs. Many of the participants initially spent their time in Cornerstone as a transitional phase to concentrate on recovery before beginning to prepare for their transition to independent living.

The women had previous experiences in supported and independent living situations. Three main types of supported living were highlighted: hospitalization, group homes, residential treatment centres and shelters. Of the supported living situations listed, all participants reported hospitalization, although being hospitalized met with varying levels of success. For those participants who described past independent living arrangements, living alone or living with family, a partner or roommate(s) were mentioned.

Participant Support

What constituted each participant's support network was explored during the interview. Formal (e.g., social worker) and informal (e.g., family, friends) support types were identified. Formal supports were utilized through both the Cornerstone Apartment Program staff and in the community (e.g., doctor, psychiatrist). Similarly, informal supports were developed in Cornerstone, where participants became friends with co-residents, and in the community, where new, healthy friendships were formed and participants reconnected with family.

Cornerstone Apartment Program

Participants were asked to discuss their experiences in the Cornerstone Apartment Program. Participant responses provided insight into how a gender-specific, transitional supported housing program may assist individuals in achieving independent living. The women explained how they gained awareness of the program, their motivation for choosing this particular housing program and the referral process. A majority of the participants were informed of, and connected to, the Cornerstone program through their hospital social worker. Two primary motivations for enrolling in the program emerged from the interviews; some participants were facing limited housing options after hospital discharge while others felt the housing program addressed their goal of independence.

The participants described Cornerstone in terms of the rules, support, activities, life in the program and treatment/recovery. The rules and regulations, including guest rules (i.e., sign-in sheet) and group responsibilities, allowed participants to feel safe, which in turn provided a healthy environment where they were able to concentrate on their recovery, build confidence, learn life skills, exercise a sense of responsibility, and gain personal insight. Different types of support in the program were credited with participants' feelings of success. Staff, co-residents and the program itself were all highlighted as supportive factors leading to high satisfaction. During the interview, difficulties adjusting to the program were mentioned, such as co-residents breaking rules (e.g., having overnight guests), gossip amongst residents and the need to utilize interpersonal boundaries. Participants enjoyed both the social activities encouraged by the staff and the feeling of independence while living in the program. The participants found they were able to take the time to focus on their recovery while in the program as well as build self-esteem, confidence and daily living skills.

Participants provided insight into challenges with this type of housing program as well as suggestions for improvement. The women identified issues they each experienced within the program, such as the need for better defined and more consistently applied building rules, the need for an emphasis on boundaries, the environment created by a culture of gossip, experiencing stigma, resident rule-breaking and a lack of structure due to no residential manager (at the time). However, when asked to suggest improvements for future housing programs, participants emphasized that the program did not require any major changes. Hiring a residential manager for the building was the main recommendation identified in the interviews. Other suggestions included a place to recycle, increasing recreational activities, more education on boundaries and discouraging gossip.

Discussion and Conclusion

The findings from this study are consistent with the research literature on how independent living is defined, the need for independent living skills, and facilitators and barriers identified for independent living. However, this study also delineated the importance of having a gender-specific program within which women with concurrent disorders could enhance their confidence and self-esteem, and build diverse support networks. A gender-specific program created a physically and psychologically safe environment for women to successfully gain and maintain independent living skills. Future research should aim to explore the long term effects of transitional supportive housing programs with this subgroup of women.

Background

Homelessness is a severe, costly, and rapidly growing social issue in Canada (Layton, 2000), but how to best address this increasingly complex issue is not well understood. Homelessness not only includes people who are 'visibly homeless' such as those living on the streets or in shelters, but it also includes the 'invisible homeless', such as those moving from place to place with no home of their own ("couch surfers") and those who are incarcerated or hospitalized and upon release or discharge do not have housing. The first Canadian homeless count was conducted in 1991 where it was estimated that, from a population of approximately 25 million Canadians, 100,000 were homeless (Rokach, 2004), accounting for 0.40% of the population. Currently, between150,000 and 300,000 people are homeless in a population of 34 million (Government of Canada, 2010; Intraspec.ca, 2012), accounting for approximately 0.44% to 0.88% of the population.

Like other major Canadian cities, homelessness is a growing concern in Edmonton. The number of homeless people in Edmonton tripled within nine years, from the time the first count was conducted in 1999. By 2008 the homeless count was 3,079; if this rate of growth continues it is projected that 6,500 people will be homeless by the year 2018 (Edmonton Committee to End Homelessness, 2009).

In addition to these projections, the profile of who becomes homeless is also disturbing. Homelessness can no longer be stereotyped as the 'single adult male', it now includes a significant number of women, families, and youth (Intraspec.ca, 2012; Klodawsky, 2006). In 2008, although 69% of homeless people in Edmonton were single men, a large proportion were single women (23%) or families with children (8%) (Edmonton Committee to End Homelessness, 2009). Furthermore, certain groups, such as persons with mental illnesses and/or substance use disorders (SUD), are predisposed to housing instability and homelessness (Drake &Mueser, 2000; Tsai, Bond, Salyers, Godfrey, & Davis, 2010). There is considerable evidence that people living with severe mental illnesses (SMI) or concurrent disorders face disproportionately greater challenges in maintaining housing or living independently (Baillargeon, Hoge, & Penn, 2010; Gulcur, Tsemberis, Stefancic, & Greenwood, 2007; Hwang, 2001). Homeless individuals with a concurrent disorder are more likely to remain homeless in comparison to persons without an SMI experiencing homelessness (Bebout, Drake, Xie, McHugo, & Harris, 1997; Serge, Kraus, & Goldberg, 2006).

In view of these trends and projections, considerable attention and planning has been focused on reducing homelessness in Edmonton. These efforts may have contributed to the 21% decrease seen in the homelessness count between 2008 and 2010 (Homeward Trust Edmonton, 2012). This is a step in the right direction, however, further understanding is needed regarding what contributes to successful housing programs.

The need for the Cornerstone Apartments Research Project comes from a significant gap in the body of research related to understanding the factors of success for maintaining independent living for women experiencing concurrent disorders in Canada. Much of the research on independent living and housing programs for homeless individuals with concurrent disorders has focused on specific subgroups such as men (Beijer, Andre´sson, Agren, &Fugelstad, 2007), youth (Hadland, Marshall, Kerr, Montaner, & Wood, 2011), and veterans (Schutt, Weinstein, &Penk, 2005); or have focused on homeless persons with SMI (Hill, Mayes, & McConnell, 2010), or SUD (Rhoades et al., 2011; Torchalla, Strehlau, Li, &Krausz, 2011). These prior studies have not considered the significance of gender effects, but research suggests that women respond differently to traditional SUD treatment programs (Uziel-Miller & Lyons, 2000; Uziel-Miller, Lyons, Kissiel& Love, 1998), benefit from programs for concurrent disorders or SUD that include a

residential component (Uziel-Miller et al., 1998), and that are more comprehensive (Nelson-Zlupko, Kauffman, & Dore, 1995; Uziel-Miller & Lyons, 2000).

The objectives of the Cornerstone Apartments Research Project were to:

1. Explore the meaning of independent living as perceived by women living with concurrent disorders.
2. Gain an understanding of how community receptivity and support assists in maintaining or gaining independent living.
3. Explore the critical factors of success in gaining independent living.
4. Gain an understanding of how the Cornerstone Apartment Program has helped participants in achieving this goal.

This study represented the interests and efforts of Cross Level Services and Supports (CLSS), Addiction and Mental Health (AMH), Alberta Health Services (AHS) in Edmonton. They provide strength-based services to individuals who have mental health and/or addiction disorders. CLSS wants to better address the needs and challenges encountered by persons with concurrent disorders when faced with homelessness or the threat of homelessness. The Cornerstone Apartment Program is a gender-specific, transitional supportive housing program, offered through a partnership between AHS and the Salvation Army in Edmonton. Past and present residents of this program were the focus of this research study.

Constructivist grounded theory was selected to explore and understand the meaning and experience that gaining independent living has for homeless women with SMI or concurrent disorders. There is a lack of theoretical models suitable for exploring this phenomenological question, thus a qualitative methodology was utilized.

Constructivist grounded theory is part of a ‘grounded theory’ family (Charmaz, 1995; Charmaz, 2000; Mills, Bonner, & Francis, 2006). According to Glaser and Strauss (1967, p. 1) grounded theory is “the discovery of theory from data”. In other words, it is an approach to qualitative research that facilitates development of a theory or framework to investigate, explain and understand the phenomenon that is grounded in the experiences of the persons living them. In order to understand the phenomenon, similar and dissimilar meanings attached by the group of individuals to their experiences and the world around them are examined. The analysis of participant perspectives enables researchers to create theoretical generalization. Grounded theory not only helps in capturing the patterns of individual lives through participant voices but also helps researchers uncover and discover other patterns that participants may not understand or may be unaware of (Glaser, 2002).

Literature Review

Homelessness, Mental Illness and Concurrent Disorders

The relationship between homelessness and SMI and/or SUD is well-documented. It is estimated that approximately 30% to 40% of homeless people suffer from SMI, and roughly 50% also have a SUD (Canadian Centre on Substance Abuse, 2010; National GAINS Center for People with Co-occurring Disorders in the Justice System, 2001; Schanzer, Dominguez, Shrout, &Caton, 2007; Tsemberis, Gulcur, &Nakae, 2004; Tsemberis, Moran, Shinn, Asmussen, &Shern, 2003; Vancouver Coastal Health, 2006). A study looking at homeless veterans in the United States found that 66.7% of the sample had mental illness co-morbidity and 82.7% had SUDs (O'Toole, Conde-Martel, Gibbon, Hanusa, & Fine, 2003). In general, North American estimates of concurrent disorders among the homeless are suggested to be around 10% - 20% (O'Campo et al., 2009), though some believe that this is an underestimate (O'Campo et al., 2009; Serge et al., 2006). Although most of the research findings are from the United States, Canadian research findings are similar (Serge et al., 2006). A recent Canadian study across three cities on substance use and predictors of substance dependence among homeless women found that approximately 60% of the sample had a concurrent disorder (Torchalla et al., 2011). In another mid-sized Canadian city study, 22.6% of the single homeless population reported both mental health and substance use problems (Aubry, Klodawsky, &Coulombe, 2012).

Individuals with a concurrent disorder have a greater risk of being exposed to communicable diseases, an increased risk for chronic disease, higher risk of suicide, limited access to health care services and higher unmet health needs compared to the rest of the population (Bebout et al., 1997; Greenberg &Rosenheck, 2008; Klinkenberg et al., 2003; Osher& Steadman, 2007; Prigerson, Desai, Liu-Mares, &Rosenheck, 2003; Reid, Vittinghoff, &Kushel, 2008; Turnbull, Muckle, & Masters, 2007). This population is overrepresented in the criminal justice system (Hartwell, 2004; Reid et al., 2008;Schanzer et al., 2007; Turnbull et al., 2007) and has a higher rate of criminal victimization (Greenberg &Rosenheck, 2008). In addition, social ostracism, loneliness, isolation and disconnection with social support networks are frequently reported (Kaukinen&DeMaris, 2009; Koehler, Puligandia, &Semeniuk, 2007; Rokach, 2004).

Brunette and Drake (1998) reported gender differences among the homeless population with concurrent disorders. They found that women had more children, had more social connections, and had higher rates of sexual and physical victimization. The authors concluded that homeless women with concurrent disorders have distinct characteristics, vulnerabilities, and treatment needs as compared to homeless men (Brunette & Drake, 1998). Contributing factors for women include a lack of employment opportunities and public assistance funding coinciding with increases in poverty levels and home foreclosures (Finfgeld-Connett, Bloom, & Johnson, 2012).

Research shows that homeless individuals with mental illness or concurrent disorders have complex needs compared to those who are not homeless. As a result, clients often encounter difficulties navigating the health system and are frequently excluded or denied treatment; often told to return only when they have their other problems under control (Office of Applied Studies, 2007; Serge et al., 2006). Additionally, engaging this population in treatment is difficult (Reardon, Burns, Preist, Sachs-Ericsson, & Lang, 2003), for they access the system often only when in crisis (Curran et al., 2003). For instance, in the City of Edmonton in 2009, 20% of calls to Emergency Services were from individuals who were experiencing homelessness (Edmonton Committee to End Homelessness, 2009). According to AHS, in Edmonton, during extreme weather conditions a homeless person is 40 times more likely to visit emergency department than the general population (Edmonton Committee to End Homelessness, 2009).

Homeless adults with concurrent disorders have high non-adherence rates with medication and treatment plans, including non-involvement with specialized psychiatric and substance use treatment programs. As a result they are frequently moving in and out of the health care system (Serge et al., 2006). At the same time, homeless adults with mental illness or concurrent disorders have a higher number of hospitalizations and primary health care visits (Villena&Chesla, 2010). According to AHS, the average length of a hospital stay for a homeless person in Edmonton is 28 days compared to 9 days for the general population. Although, if psychiatric hospital days (i.e., Alberta Hospital Edmonton) are included, the average hospital stay of a homeless person exceeds 66 days (Edmonton Committee to End Homelessness, 2009).

Mental Health and Independent Living

Clearly, addressing the issue of homelessness for people with mental health or concurrent disorders is important in terms of client benefit, reduced risks, and cost-effectiveness. One means of addressing homelessness has been through innovative housing models, which enable people to receive community-based care and supports to live independently (Browne & Courtney, 2005; Padgett, Gulcur, &Tsemberis, 2006; Rudman, 1996; Screbnik, Liningston, Gordon, & King, 1995).

There are two predominant housing models for individuals with concurrent disorders (Padgett et. al., 2006; Tsai et. al., 2010): 1) supported housing, and 2) residential continuum housing. In the supported housing model, ongoing mental health support, often on-site, is provided to service users (Leff et al., 2009; Padgett et al., 2006). In the residential continuum model, clients are placed under progressively less restrictive and less intensively staffed accommodation, thus gradually transitioning to community living (Leff et al., 2009; Padgett et al., 2006; Tsai et al., 2010).

Both qualitative and quantitative investigations have sought to identify and understand the critical factors in successfully implementing a housing program and to successfully transition an individual with mental illness or concurrent disorders into the community. Evidence from the evaluation of Housing First implementations in New York and other contexts have demonstrated that the presence of a mental health diagnosis or concurrent diagnoses does not preclude an individual from successfully maintaining housing (Stefancic&Tsemberis, 2007; Tsemberis et al., 2004). Meta-analysis has shown that this capability is not dependent on the specific tenets of Housing First but is evident in any residential support program for individuals with mental health concerns (Leff et al., 2009).

One of the critical qualities related to the effectiveness of a supported housing program is a client's sense of empowerment, choice, or control. In a recent realist synthesis of existing evidence on factors for success in providing community-based services for homeless adults with concurrent disorders, the authors found that an emphasis on client choice contributed to a sense of autonomy and was associated with better mental health outcomes (O'Campo et al., 2009). Evaluative studies of Housing First initiatives demonstrate that a supported housing program that emphasizes consumer choice, particularly about engagement in treatment, has been effective in terms of housing stability compared to linear continuum housing programs (Gulcur, Stefancic, Shinn, Tsemberis, & Fletcher, 2003; Padgett et al., 2006; Tsemberis et al., 2004). There is also a burgeoning qualitative evidence base that client choice and a sense of control are viewed as important aspects of a successful supported housing program (Hill et al., 2010; Kirsh, Gewurtz, &Bakewell, 2011; Tsai et al., 2010). However, it was found that some clients felt that few housing options were explored or that the options offered were very poor (Kirsh et al., 2011; Tsai et al., 2010).

Up to 90% of individuals with mental health concerns prefer living independently rather than in staffed group homes (Browne & Courtney, 2005; Goering, Paduchak, & Durbin, 1990; Holley, Hodges, & Jeffers, 1998; Schutt et al., 2005). In a comparative study looking at veteran and non-veteran homeless people with concurrent disorders, Schutt et al. (2005) found that more veterans preferred to live alone when compared to non-veterans. However, for both cohorts housing preferences were incongruent with clinical recommendations. In a qualitative study conducted by Browne and Courtney (2005), participants affirmed their preference for living in their own homes. They felt that having their own home provided a sense of belonging and enabled them to feel that they were in charge of their lives. Furthermore, it offered them a feeling of safety and provided participants with greater opportunities to form and maintain supportive social relationships. However, Tsai and associates (2010) argued that some individuals who want independent housing may benefit more from an on-site support model and that it is important to balance client preference with client need. Clients can view this balance as a choice between independence and availability of support (Forchuk, Nelson, & Hall, 2006). Clients often prefer more independent accommodations while providers and family members prefer more supervised housing (Piat et al., 2008), but a significant proportion of clients appreciate and desire the potential benefits of supervised housing such as the fostering of a sense of community and social support (Tsai et al., 2010; Kirsh et al., 2011).

Community integration and social support has also been identified as a key aspect of supported independent living. Kirsh et al. (2011) examined this issue through qualitative analysis and found that both residents and service providers identified stable housing as a foundation for community integration. Residents also extolled the importance of social support, for when they know a person who has gone through similar experiences, that person becomes a role model inspiring them to persevere in achieving goals. The necessity of community integration has also been recognized in the development and empirical testing of scattered-site housing models with private landlords that separate housing from treatment (Stefancic&Tsemberis, 2007; Wong, Filoromo& Tennille, 2007).

According to Tsai et al. (2010) there are many barriers to obtaining appropriate housing for clients in supportive housing programs. One such barrier is financial, as clients often have limited options due to income (Tsai et al., 2010). Housing cost is one of the major barriers in obtaining decent and affordable independent accommodations (Human Right and Equal Opportunities, 1993). The relationship between housing affordability and mental health has been established (Evans, Wells, Chan, & Saltzman, 2000; Wells, & Harris, 2007). Housing factors such as quality, location and tenure of affordable dwellings have been found to affect an individual's health (Evans et al., 2000; Wells & Harris, 2007; Windle, Burholt, & Edwards, 2006; Wright &Kloos, 2007).

Other barriers to obtaining appropriate housing for individuals with mental illness or concurrent disorders include criminal histories (Pogorzelski, Wolff, Pan, & Blitz, 2005), despite evidence that individuals with mental illness and a criminal history are not less likely to maintain housing (Malone, 2009). Another significant barrier to appropriate housing is the quality of housing available. Poor quality housing increases the likelihood of maladaptive behaviours and decreased functioning and quality of life in residents with mental illness (Fakhoury, Murray, Shepherd, &Priebe, 2002; President's New Freedom Commission on Mental Health, 2003). Finally, mental illness related stigma from landlords and neighbours can also be a barrier to maintaining housing (Forchuk et al., 2006; Tsai et al., 2010). However, in a qualitative investigation of the critical characteristics of supportive housing for patients with SMI, Kirsh et al. (2011) found that most communities were very accepting of individuals with mental illness but that this acceptance could degrade if disruptive events occurred. Therefore, it is important for service providers to bridge this barrier and to provide neighbourhood education and support (Kirsh et al., 2011).

Cornerstone Apartment Program

The Cornerstone Apartment Program is a partnership between AHS and the Salvation Army in Edmonton, Alberta. It is a single-site gender-specific, transitional supported housing program that provides housing for women, 18 years of age or older, who are significantly impacted by mental illness and/or concurrent disorders and require holistic support and assistance to gain the skills necessary to live independently. The duration of the program is 12 months, with flexibility to meet individual needs. There are 16 suites ranging from bachelor to two bedrooms. Program referrals come from various sources including probation, parole, Assertive Community Treatment (ACT) teams, inpatient psychiatry, emergency shelters, eating disorders units and residential addiction treatment centers.

Supports include a building supervisor and a residential building manager, employed by Salvation Army as well as a multidisciplinary mental health and addiction team providing wrap-around services employing a wellness recovery action planning approach. This recovery team consists of a social worker, occupational therapist, recreational therapist, nurse and independent living skills worker and is provided by AHS. Both the recovery team and the building staff work closely in providing support and assistance to the program residents.

Wrap-around services include identifying and providing individualized support and assistance to the program participants in any combination of major life areas. This may include education, employment, finances, leisure, relationships, crisis and stress management, addictions, household management and transitioning to market housing. More defined support within each of these areas is identified, all of which is directed towards the highest level of independence, functioning and wellness in a community living setting.

Program residents are also encouraged to participate in Wellness Recovery Action Plan (WRAP) (Copeland, 2011). WRAP is a peer-initiated program offered through CLSS. It is a self-structured plan designed to help individuals with mental illness to monitor, reduce and eliminate uncomfortable and distressing feelings and behaviours (Copeland, 2011). Individuals are encouraged to take responsibility and improve their quality of life.

Method

Drawing on ideas associated with a constructivist grounded theory approach to research, the purpose of this study was to develop a conceptual framework for understanding how community receptivity and support influence women's experience of gaining independent living.

This qualitative method approach is well suited for developing rich, detailed insight into subjective experiences and meaning-making, which are the primary aims of this study. Moreover, this approach was appropriate as little is known about the particular topic: the meaning of independent living, community receptivity and support, and success factors from the perspective of participants. Finally, qualitative methods recognize the participants as experts; the relevance of each person's insight is recognized and validated, which is an important guiding principle of this project.

Participant Recruitment

Following ethics approval from the University of Alberta's Health Research Ethics Board, a purposive sampling strategy was used to select the eight study participants. Eligibility criteria for the study included:

- women aged 18 and older;
- a concurrent disorder diagnosis (addiction and mental illness); and
- current or past participant in the Cornerstone Apartment Program.

In order to recruit participants, a two-step recruitment process was employed. First, the Cornerstone Apartment Program staff identified and contacted eligible participants and provided information regarding the study. It was emphasized that their participation was voluntary and that a refusal to participate would not affect their health and program service access and use. Those who were interested provided their contact information to the program staff (Appendix A). Second, researchers contacted the interested participants. Those who were still interested were given a detailed information sheet and consent form. Participants had the opportunity to have their questions answered and were then asked to sign a consent form (Appendix B). At the time of consent signing, participants were asked to choose a pseudonym for themselves. The pseudonyms were encouraged with the intention of using them during interviews and for reporting and publishing purposes. When only one or two participants existed in a code, or participants with unique information were identifiable, their pseudonyms were not referenced to minimize association or identification. Theoretical saturation principle was used to determine the sample size of the study; as long as new concepts emerged from the data the participant recruitment process continued.

Data Collection and Analysis

Interviews were conducted in 2011. Participants were given the option of being interviewed at the Cornerstone Apartment building or Edmonton Mental Health Clinic (EMHC). Five participants were interviewed in the Cornerstone Apartment building; the remaining three at EMHC. At the beginning of each in-depth, face-to-face interview, participants were encouraged to express their views and share their experiences. The interviews, which lasted approximately 20 to 45 minutes, were audio recorded, transcribed verbatim and supplemented with field notes.

Participants were interviewed by a trained interviewer. A semi-structured interview guide was created to assist the interviewer and provide a clear focus for the interview (Appendix C). However, the exact wording of the questions or their order was not predetermined. After the interview, each participant was invited to complete a demographic data collection form (Appendix D). Each interview also helped researchers in determining areas for further exploration; questions covering those areas were incorporated into subsequent interviews. The interview transcripts were imported into NVivo 9, a qualitative data management program.

Data was analyzed using the constant-comparison method (Glaser,1978). A staged data analysis process was used. In the first stage, the transcribed interviews were openly coded by examining the data on a case-by-case basis and coding the data line-by-line. In stage two, the data was analyzed across participants and collapsed into categories that represented themes occurring across the interviews. The third stage of the analysis involved examining the categories and perceived links, thus creating themes or core-categories under which several categories fit leading to more abstract, higher level categories. However, it is important to point out that the analysis did not occur in a linear sequence; rather at times the three stages were staggered and cyclic in nature. For instance, sometimes two stages of analysis occurred at the same time or a previous stage of analysis was explored again after conducting analysis in later stages.

Participant Demographics

Table 1 presents a summary of participant demographics. Eight women participated in the study. At the time of interviews, one participant had exited the program; the remaining seven were current residents. Pseudonyms were used in the study to represent each participant: Jenni, Jessica, Amanda, #22, Samantha, Rose, Angelina and Jane.

Table 1: Summary of participant demographic (N = 8)

Demographic Factor[1]		# of Participants
Length of Stay[2]	4 weeks	1
	5 weeks	1
	2 months	2
	4 months	1
	6 months	3
Housing Status[3 4]	Homeless	2
	Couch surfing	1
	Group home	1
	Hospitalized	6
	Other (room in community organization)	1
Age	18-24	1
	25-34	4
	35-44	2
	45-54	1
Marital Status	Single (never married)	6
	Separated	1
	Divorced	1
Employment Status	Employed	1
	Unemployed	7
Current Occupation	Unknown	1
Past Occupation[5]	Trade	1
	Food & beverage services	1
	Food services	1
	Office administration	2
	Human services	1
	Custodian	1
Highest Level of Education	Some high school	3
	High school	1
	Some post-secondary	2
	Post-secondary	2
Primary Language	English	8
Fluency	Very good	8
Ethnicity/cultural background	Canadian	3
	French-Canadian	1
	Polish/Czech/Ukrainian	1
	Caucasian	1
	Métis/Cree/White	1
	Métis (Status)	1
Canadian citizenship status	Citizen by birth	8

Notes:[1] Sub-categories with 0 participants are not presented in this table; [2] Length of stay in the program; [3] Housing status prior to entering the program; [4] Participants had the option of selecting more than one housing option; [5] Not applicable for participant currently employed.

Findings

The key objectives of this research were to explore the meaning of independent living, understand formal and informal support structure, identify factors of success/barriers for independent living and understand the Cornerstone Apartment Program's contribution in assisting women with concurrent disorders in achieving their goals of independent living. Five major sets of themes emerged from the interviews related to these objectives, namely independent living, recovery journey, past living situations, participant support, and Cornerstone Apartment Program. These five themes, as well as their accompanying subthemes, are addressed in detail.

Independent Living

Defining independent living

In order to understand what women with concurrent disorders need to live independently, we first addressed their interpretations of the term 'independent living'. The main set of themes that emerged in defining independent living were autonomy, minimal support, ownership, freedom and responsibility.

Autonomy

All participants defined independent living with autonomous descriptions. Interestingly, five participants related the term 'independent living' with the words *"normal"* or *"regular."* Amanda described it as *"moving away from being a part of the mental health society, more into normal society."* Normal or regular activities included employment, participating in community programs, socializing with friends and having dinner with family. Samantha described her new friends as *"…people that like to [do]…regular stuff, you know."*

Minimal support

Almost all interview participants defined 'independent living' as the ability to function in life with minimal assistance and support. This could mean that a person would be able to cook their own food, do their own grocery shopping and manage their own finances. Jessica stated that independent living is to *"…not rely on somebody to make my lunch and…press my blouse."* In addition, Jessica emphasized a person is able to live with others and still lead an independent lifestyle. Amanda identified the *"choice"* of associating, or rather, notassociating with neighbours as a positive aspect of independent living. For those who have been unable to retain privacy in the past, such as living in shelters or group homes, this freedom may be a welcome change. For example one participant stated *"…I just kind of felt like finally, it was just like a huge relief for me."*

Ownership, freedom and responsibility

Ownership was another prevalent idea in the definition of 'independent living'. Two participants voiced similar sentiments, which Jenni put to words: *"It means having my own place, with my own rules."* For participants, independence also equated to 'freedom' and ownership of time; they could do what they wanted, when they wanted, without having to answer to others (such as to co-residents or a residential manager).

Participants tempered freedom with the idea of responsibility. Being independent meant that a person took their medication and attended therapy. Angelina defined 'independent living' as, *"…being able to live*

by yourself…rely upon yourself to be able to take care of yourself…taking care of yourself physically [and] mentally..." Amanda and Angelina stressed the importance of asking for help. As Angelina put it, *"…you are kind of strong enough mentally that, that if you are in a crisis, you know to reach out for help."* A person is able to live independently when they make use of a support system and ask for assistance from the appropriate supports when necessary.

Independent living skills

Participants responded to questions regarding skills for independent living; they illustrated the importance of developing a 'basic' skill set as well as self-esteem, interpersonal boundaries and balance.

The basics

Participants identified a variety of skills needed to achieve and maintain independent living. First, a base set of skills forms the foundation of independence. The ability to cook, clean, manage finances and other tasks were identified by many participants as essential skills for successful independent living. Jenni expressed that independent living required *"good money management skills."* Samantha, Angelina and Jane emphasized that they already possessed many of these skills. Once participants are in a good place mentally, this will allow them to have an internal support system, which moves them forward to independent living. Jane felt that learning to deal with mental health issues would help her to stay well, *"…just learning how to deal with the issues that, that possibly could make me unwell again…. taking care of, number one, my mental health, taking medications…."*

Self-esteem, interpersonal boundaries and balance

Samantha strongly emphasized the need to build self-esteem, *"…that's one of the most important things; if you don't have self-esteem you're not ready to live on your own, you're not."* Setting and maintaining interpersonal boundaries is an important step in maintaining a healthy independent lifestyle. Jenni described her reasons for setting boundaries, *"…because I want to keep out certain kinds of people from coming back in my life and making things worse for me."* Establishing relationships with others is a skill #22 learned in Cornerstone; when living independently it may be beneficial to use this skill to *"...make friends with your neighbours..."* In Cornerstone, participants learn to balance work, therapy and leisure activities to create stability in their lives. Emphasis on balance encourages community engagement and socialization which in turn decreases negative emotions such as loneliness, which, for many, may be a trigger of addiction and/or mental health issues.

Barriers to independent living

When questioned as to what factors may prevent women from achieving independent living, participants identified mental health and addiction issues, lack of community support, fear of the unknown and financial difficulties as major barriers.

Mental health and addiction issues

Not surprisingly, addiction and/or mental health issues were common barriers identified by participants. For example, the women found complex negative emotions or a lack of self-esteem prevented them from pursuing independence. Jessica described how problems with mental health created a barrier for her, *"…some days I can't even make it through the day without breaking down."*

Lack of community support

As noted by Angelina, a lack of community programs (such as the Cornerstone Apartment Program) for women with addiction and/or mental health disorders prevents women from developing the skills and resources they need to achieve independent living. *"…there's not a lot of support, as far as addictions goes and mental illness for women; I find there's a lot more for men…"* Angelina also noted that she was unaware of supports available in the community until she entered Cornerstone, *"…I've never noticed the supports in the community before; either that or I never searched for them or just never felt like they were there."*

Fear of the unknown and financial difficulties

Amanda noted that fear of others, such as unknown neighbours, may create a mental barrier: *"Just the fear of my neighbours and what they can do…"* In the past, Jane and #22 found financial difficulties prevented them in securing housing to live independently. Succinctly, #22 expressed, "*Money stops me from living independently."*

Facilitators of independent living

The following facilitators for independent living were identified by the study participants:

Housing programs

Most of the participants identified the support received at Cornerstone Apartment Program as a facilitator. In Cornerstone, participants learned debt management, to maintain safety/security and to build confidence. Rose praised, *"And now I have the confidence; because of Cornerstone, because of the staff, I have the confidence in knowing that I can do it [live independently]."* Jessica felt the *"supportive environment"* of the staff and co-residents helped put her in a positive mind frame that would prepare her for independent living. Jane seconded this sentiment, stating *"…just the actual support of their knowledge, you know, and their skills, it's a comfort."* In addition, participants also identified previously accessed housing programs as facilitators in gaining their independence. For instance, Jane indicated *"… I felt independent at a group home but … it's really good when you have your own place, you have a sense of responsibility …"*

Structure and activities of daily living

Participants noted the importance of structure in recovery. Structure may include setting up a daily routine around meals and/or work or ensuring that a resident participates in group activities to reduce isolating behaviour associated with their addiction. A structured lifestyle acquired in a supported living program would assist a person in creating structure for themselves when they transition to fully independent living. Learning the skills needed for basic activities, such as cooking and cleaning, are supportive for those seeking independent living. As Amanda noted, *"…some people need more support on daily living routines like cooking and cleaning…other people need help with getting up in the morning and just maintaining a schedule."* One participant, no longer a resident at the time of the interview, had left the program because she felt it did not provide the structure she needed for achieving independence. She stated,

> *"Alright, you have, I mean if I would've had staff here I probably would've stayed the year, because I would have had the structure and I, you know it would have been different for me, I would've had structure in my life that would have been like a schedule, right."*

Employment and financial support

Employment guidance and support would put participants in a position to earn an income that would support their independent lifestyle. Alternatively, assistance in applying for financial aid would provide clients with a source of income to support independent living. #22 and Jane received assistance from Cornerstone staff in obtaining employment, Jane described how she felt the Cornerstone program helped her,

> *"…the resources for getting me into work and other areas in my life that I'm going to need to have when I have my own place…the encouragement and the atmosphere."*

Support network

In order for participants to maintain independent living, a support system (made up of formal and informal supports) should be in place. Amanda clarifies this, *"…having somebody to connect with, somebody that's able to understand the challenges that I'm facing and that will guide me through the network of what needs to happen to maintain independent living…"* This support system may be more of a preventative measure for some women; the knowledge of availability of resources may be support enough. Jenni commented on the availability of community supports, *"I have lots of places I can go where the people would understand me better [my mental health and addiction issues]."* Another approach, as outlined by Angelina, is to ensure a support system is in place before a woman has transitioned to independent living. Angelina outlined her plans,

> *"I think…taking this next year to build those community supports and get involved with the community…it's really going to build my self-esteem and make me not so afraid to reach out. You carry those, I mean, they're outside of the program so as I move on into my own place I'll still have these connections with these other programs and these people that I've created outside of Cornerstone."*

Transitioning to independent living

Interview participants described transitioning to independent living; including, readiness, concerns, steps taken and plans for the future.

Determining readiness

Participants were asked to identify indicators of transition readiness; that is, how they will know that they are ready to transition to independent living. Confidence, self-esteem and motivation were the dominant indicators. Participants reported a need for confidence to move forward on their own; self-esteem allows individuals to maintain independence and not fall back into detrimental behaviour. Samantha related an indescribable motivation for independence, *"…I just know, when I look at him [my pet] I know I'm ready."*

Participants also indicated that personal grooming and/or paying attention to their visual appearance helped them gain confidence and self-esteem. A participant further elaborated "*I, it look me a long time, I got so much from here, and then when I got my new teeth I got more, when I got my hair cut I got more…Now I'm ready to live independently…"*

Transition concerns

Participants listed a variety of concerns when they discussed plans to transition to independent living. Concerns included safety and security of the residence, leaving the comfort of support, feelings of loneliness and being able to maintain cleanliness. Samantha and Angelina both expressed concern over slipping into isolating behaviour. Angelina related, *"I often get concerned about relapsing into sort of my mental illness…one of the biggest triggers or signs of relapse for me is becoming complacent or starting to isolate."*

Preparing for the transition

The participants discussed their preparation for living independently. Amanda chose to enter the Cornerstone Apartment Program to learn independent living skills; this step suited her as she was able to attempt independence with a safety-net of support to fall back on. One participant indicated using progressively independent living situations as stepping stones; moving from supported living, transitional supported living (Cornerstone) to a family home, she was ready to move on to independent living, *"…I can't wait. I will be the happiest person in the world."* Angelina lined up community supports and programs to assist her in addition to searching for supported-independent living options to continue moving forward. Jane described her process: staying in hospital to treat her mental state then moving to Cornerstone, which she described as *"a chance to do what you need to do for your recovery, get some really good clean time in and eventually move on and not look back."*

Steps taken

To some participants, moving forward into independence meant finding employment or furthering education. With a job already secured, Jenni decided that, in order to compensate for lower efficiency (compared to other workers), she would work long hours; she planned to eventually work a regular eight hour shift once her efficiency increased. This motivation to succeed is echoed by #22, who was also willing to work more hours than the Cornerstone occupational therapist recommended, *"I think she [the occupational therapist] thinks that full time is a bit [much] right now, but I have applied for everything I can..."* Samantha, motivated by her creativity, set up a home business utilizing her skill set. Rose applied for, and was accepted to, a post-secondary institution. With the assistance of Cornerstone staff, Rose developed a plan which would allow her to attend school and stay on track with her goal of one day living independently.

Next steps

Participants discussed their plans and next steps to achieve independent living. Preparing for a damage deposit, securing an income and saving money to cover rent and school fees were expressed. Samantha related, *"…I am not worried about frivolous things; there's things you want and things you need, is what I learned in my budget [lesson]."* Participants' residential preference was determined by their primary concerns; such as, safety for Jenni, group living for #22, autonomy for Samantha, inexpensive accommodation for Rose, and continued supported-independent living for Angelina. The participants and Cornerstone staff took these into consideration when searching for suitable housing.

Recovery Journey

Other major themes that emerged from the interviews centred on participants' recovery journey, in particular, their past issues with concurrent disorders, triggers and coping strategies, and their plans for the future.

Past issues and recovery

Some participants identified past mental health, addiction and physical health issues including: depression, anxiety, alcoholism, drug addiction and viral disease. One participant reported experiencing mental health issues at a young age and described coping with a concurrent disorder for an extended period of time; this led to feelings of *"hopelessness"* with a detrimental effect on her life and informal support system (i.e., family and friends). Another participant reported experiencing helplessness due to past chronic substance use. Individuals identified prior participation in treatment and recovery programs; Jenni noted an intensive therapy program and rehabilitation support group while Jane reported enrolment in treatment programs.

Triggers and coping strategies

Jenni and Jessica identified factors such as *"isolating,""boredom"* and *"idle time"* as probable triggers for mental health and/or addiction issues. Participants described coping strategies learned from past experiences, such as approaching formal and informal supports to avoid feelings of loneliness, *"keep… busy,"* using routine and *"daily habits"* to mitigate *"red zone [trigger]"* situations, avoiding situations and places where triggers may occur, exercising and utilizing coping strategies learned in other therapy/outpatient programs. Jenni noted the importance of engaging in the community as a preventative method for triggers and resulting isolating behaviour. For example, she enrolled in an exercise program that provides a safe and social environment.

Planning for the future

Living skills, coping strategies and treatment

Two participants expressed confidence in their daily living skills, such as taking care of an apartment and punctuality when attending appointments; Jenni and Jessica determined these skills necessary for independent living. Two interview participants described efforts to break unhealthy habits (e.g., isolating behaviour) and actively employing healthy coping strategies. Jenni related two of her coping strategies: engaging in community activities and relaxing (e.g., reading a book). Samantha described avoiding falling into isolation-induced depression by making *"healthy friends"* with whom she has an active social life. Six participants reported accessing therapy programs in addition to Cornerstone Apartment Program supports; these therapy programs addressed their addiction and/or mental health issues formally as well as informally; that is, providing a social aspect that aided in improving their mental health.

Recovery

Participants discussed positive activities beneficial for recovery and maintaining/improving mental health.Cornerstone was identified as a restorative transitional phase between supported living and independent living. At the time of her interview, Jenni had just graduated from an intensive therapy program and was using part of her time in the Cornerstone program as a resting period before pursuing employment. Jessica and #22 were taking their time in the Cornerstone program; these participants had not started planning for independent living. Jane took a very productive approach, as she explained *"I'm in charge of…my recovery,"* using Cornerstone to *"focus on myself,"* identify community supports and

engage formal supports and therapy programs in the community. She noted her motivation and *"open minded[ness]"* as internal facilitators for change.

Two participants illustrated ways in which they took initiative and responsibility for their recovery. For instance, Samantha ensured she secured a stable living situation that would provide structure and promote drug abstinence. With this support she was able to maintain medication adherence as outlined in her treatment plan, and regularly attend therapy. While in Cornerstone, Samantha set up a medication schedule to promote adherence. Samantha highlighted her motivation for the above strategies, *"I wanted to live, I wanted to see what people do, what life is all about, I wanted to open my eyes."*

One participant reflected on her experiences since leaving the Cornerstone Apartment Program. She described her preparation for independent living: building up her self-esteem (improved hygiene, changing her appearance), owning a pet, continued medication adherence, drug abstinence and utilizing formal community support services. At the time of the interview, this participant was in the process of searching for her own apartment.

Past Living Situations

Encouraging discussion with participants about their past independent and supported/dependent living situations helps us understand their views and perceptions of independent living. Participants reported living in multiple cities across Alberta in the past.

Supported living

The three main categories that emerged within the theme of 'Supported Living' were hospitalization, group homes, and residential treatment and shelters.

Hospitalization

All participants had prior experience with hospitalization. Jenni connected to an outpatient program during one of her hospitalizations. Jessica reported an increased number of hospitalizations in the recent past due to declining mental health problems. Her hospitalizations occurred in different cities in Alberta. Rose also reported a history of hospitalizations in different cities in Alberta.

Jane emphasized receiving excellent treatment from individuals in her hospital treatment team. However, she reported experiencing feelings of powerlessness in terms of her control over her treatment options. She stated she was able to take what she needed from her hospital treatment, allowing her to move on to different treatment delivery in a new living situation.

Group homes

Three participants indicated living in group homes. Samantha was provided with a *"little room"* by a community organization where she received help from the organization's formal supports. Jenni emphasized the communal living environment. Unfamiliarity with *"stability"* created issues for Jenni when attempting to maintain independence. Jane reported her family home as her primary home; she did not pursue supported living through group homes, *"…it wasn't working for me in group homes…"*

Residential treatment and shelters

Participants reported experience in residential treatment centres. Jessica, Amanda and Angelina described their experiences: Jessica lived in recovery houses; Amanda in a *"semi-independent living situation";* and Angelina in an addiction treatment centre. Angelina and Jane reported staying in shelters. Jenni described her history with transient living, she would *"float around"* and *"lived on the street,"* similarly, Samantha mentioned couch surfing in the past. Both Jenni and Samantha reported prostitution in the past while living on the streets.

Independent living

Most of the participants described past independent living experiences as either living alone or living with family, a partner, or roommate(s). Jenni and Jessica noted prior experience living alone; however, Jessica noted living with others as a recent trend (*"…past couple years, three years…"*). Participants reported living independently with others: Jessica, Rose and Jane lived with a partner; Rose lived in her family home; and Rose, Angelina, Jessica and Jenni lived with roommates. Jessica went on to clarify that while she may have shared a residence with roommates, she had very little contact with them, *"…I was living in a house with people but alone."*

Jessica noted living in another province, as well as another city in Alberta. Amanda has also lived outside of Edmonton in the past. Prior experience with independence, whether successful at the time or unsuccessful, provided individuals with a learning experience. Amanda, while reflecting on her past experience with independence, asserted her familiarity with seeking assistance when needed. Building on experience, her 'lessons' will be applied when working towards her goal of future independent living.

Participant Support

When asked about what kind of support is needed to live independently most participants answered in a way that highlighted the importance of both formal and informal support.

Formal support

Cornerstone Apartment Program

Participants identified the staff roles that assisted them during recovery at the Cornerstone Apartment Program. The primary support role mentioned during participant interviews was that of the residential manager; a female staff member who would live on site. In addition, the occupational therapist, social worker and recreational therapist roles were identified as important supports.

Participants were very positive about the wrap-around services provided by the Cornerstone staff. The staff members were described as approachable, knowledgeable, informative and *"amazing."* Jane commented on the staff's approachability, *"…they're always just a phone call away…"* Participants felt wholly supported in both mental and physical health; staff members were considerate and caring of participants' physical health issues as well as their mental health issues. Jenni discussed her appreciation for Cornerstone formal supports' understanding; she felt supported in both *"normal, everyday stuff"* as well as her issues with mental illness, something she was unable to receive support for from her informal support system. The Cornerstone staff were described as very knowledgeable and informed about community programs, activities and supports (such as financial aid).

Participants received assistance in many aspects of their lives, including: student loan applications, financial aid applications, resume writing, job searching, community program enrolment and getting to the food bank. #22 noted staff assistance in daily activities, such as cooking. Assistance in building external skills (such as cooking and laundry) as well as internal strengths (such as confidence and coping strategies) set up residents for successful independent lives in the future. Amanda discussed the support of staff not only in daily life in the apartments, but also with personal insight; with their assistance she was able to identify her strengths and areas for improvement. Identifying strengths allows a resident to practice independence; recognizing areas for improvement focuses residents in building that strength and encourages them to ask for help.

Encouragement for residents to participate in Cornerstone community events and activities, such as potlucks and walks, helped participants feel at ease in the program. This approach allows for residents to feel comfortable in their environment, which in turn assists them to feel comfortable with engaging in the larger community. The person-centered support received by participants was described as a welcome change for Jane, who no longer felt the burden of meeting the high expectations that she felt while in hospital. In addition, Angelina felt truly supported by staff's support style; that is, staff catered their support to each person's needs as opposed to providing each individual with the same, perhaps cookie-cutter, support (which Angelina had experienced in previous recovery). With the support of the Cornerstone staff, Jenni learned how to balance her life and concentrate on her *"well-being,"* all the while ensuring she felt safe. Rose discussed the help she received at Cornerstone,

> *"Just the extra support but at the same time them not like crowding me or like overwhelming me with support, like they're there and I can call them but they're not like hovering over me feeling like I'm useless and can't do it myself."*

Community

In addition to the Cornerstone Apartment Program formal support system, participants identified receiving treatment from a variety of health care providers including social workers, counsellors, recreational therapists and psychiatrists. Participants secured financial aid through organizations such as welfare and Assured Income for the Severely Handicapped (AISH). Formal supports provided services such as addictions counselling and cognitive behavioural therapy. Once she transitioned to independent living, Samantha's community support worker (from a previous supported living situation) would provide assistance in daily activities such as paying bills and furnishing Samantha's new home. At the time of the interview, Samantha's community support worker was encouraging her new home business. One participant pointed out that, occasionally, communication between formal supports (such as an occupational therapist and a hospital nurse) may need prompting. Jane explains how she moderates this issue,

> *"The communication, sometimes it's not so great but, but we're all working together …and if somebody hasn't um, is not in the know about something then I'll go out, gladly let them know."*

Open dialogue between formal supports has many benefits for the resident, including increased quality of care, decreased redundancy of treatment and improved coordination between health care providers.

Informal support

Cornerstone Apartment Program

In Cornerstone, some residents, such as Jenni, would *"buddy up."* Establishing an informal support system within the program would further assist residents on their path to recovery, especially those who are not yet comfortable asking for help from formal supports. Establishing a support system in the program provides residents with an added sense of security in their recovery. Jenni explained her *"buddy up"* system,

> *"When one's not feeling good, she comes down, and if I'm not feeling good, I go up…We sort of have a deal that way. We haven't had to do it very much, but just in case."*

Participants felt secure in approaching other residents for assistance in daily activities, such as baking, as well as more serious issues, such as coping with triggers. However, this support system only works if those providing support are willing and the issues addressed are within reason (e.g., participants noted the issue of being approached by other residents who were engaging in unhealthy behaviour, self-harm behaviour such as cutting).

Community

All participants identified at least one type of informal support; these included family members, long-time friends, support group members and a pet. Some family members formed a constant support system in participants' lives, such as Jessica's, *"…she's [my sister] been through hell with me many times."* Some family members' support was dependent on the degree of a participant's illness, as was Angelina's case,

> *"… they've [my family] always been in my life but not, more like check-up calls kind of thing, like 'ok, you're still alive' …as long as I was using, they wanted kind of not much to do with me."*

However, Cornerstone provided an opportunity to strengthen her bonds with her family,

> *"…since being in Cornerstone I have all of my family back in my life, I mean I haven't seen my brothers in over a year and I've had them both over for dinner…."*

For some women, such as Jenni, informal support provides an anchor. Discussing *"normal"* and *"everyday"* things such as family gossip allow them to escape the worries of a concurrent disorder. Another participant, Samantha, identified new friends, as well as her pet, as her source of increased self-esteem,

> *"I've met friends, healthy friends, so I have support in my life. Friends with vehicles that will come and hang out with me, I got my [pet], I you know, I have a life now, I have people I can go hangout with…"*

For women with a concurrent disorder and poor living conditions (e.g., living on the streets), establishing supportive connections with others could be very difficult. In the past, Jessica was unable to acquire many informal supports due to the difficult living situations imposed on her by her mental health and addiction issues, *"It's just been too rough."* In her interview, she listed two family members as her informal support. Jessica was not alone in possessing limited supportive relationships, #22 only identified a few family members as her informal support system. With the assistance of programs such as Cornerstone, women like Jessica and #22 will learn how to utilize tools such as communication to build healthy, supportive relationships with family and friends.

Maintaining supportive relationships can be difficult for those suffering from addiction and/or mental health issues. As Jenni experienced, it may be difficult to communicate with those who are unable to understand said issues, *"I can't talk to them [my parents] about a lot of the things that happen [with my mental illness] though because they don't understand."* Conversely, Rose identified a risk with relationships that can be too supportive,

> *"Sometimes I feel less independent 'cause they're always there to pick me up when I fall and get groceries or whatever I need when I need it."*

Evident in the interviews, in a hypothetical situation participants were more likely to approach an informal support rather than a formal support. For this reason, it is important for women living with a concurrent disorder to participate in programs such as the Cornerstone Apartment Program. Housing programs provide these women with an opportunity to establish healthy relationships and a support network of both informal and formal supports.

Cornerstone Apartment Program

In relation to questions regarding the Cornerstone Apartment Program, participants described their journey in the program and how the program assisted them in working towards independent living.

Choosing Cornerstone

Discovering the program

Participants described their initial discovery of the Cornerstone Apartment Program and the information regarding the program communicated to them at that time. Jenni, Jessica, #22, Rose, Angelina and Jane were informed of the Cornerstone Apartment Program by their hospital social workers. Angelina was informed that Cornerstone was *"…meant for women such as myself that are dual diagnosis, you know, that suffer from addiction and, and mental disorders, mental illness."* In addition, she was told it was*"…like a transitional program…"* and that it would provide her with *"that transitional time and testing period to make sure that, you know, teaching me to live independently again."*

Deciding on the program

Participants described their reasons for choosing the Cornerstone program. As Amanda explained, Cornerstone meets the needs for those aiming to live independently, *"I chose to go into Cornerstone because it was the best living situation closest to my goal of living independently."* Samantha chose the program based on the experience of a friend, *"…I came to visit her [my friend] and I liked what I saw."* Others had limited housing options after discharge from hospital, such as Angelina and Jane. In addition, #22 reported entering the Cornerstone Apartment Program due to *"…no money and no place to go…"* Jane reported feeling *"absolutely no control"* in hospital living; this lack of control over her life led her to seek an alternative living arrangement (i.e., Cornerstone Apartment Program).

Referral

Jenni, Jessica, #22, Rose, Angelina and Jane were referred by their hospital social workers to the Cornerstone Apartment Program. Amanda explained she was transferred from a program into Cornerstone Apartment Program. As for Samantha, she was supported by a social worker through a community program.

Participants described their experience with the Cornerstone Apartment Program referral process. As described by participants, the process includes an interview and the completion of evaluation instruments to test for living skills and abilities. Jessica's hospital social worker assisted her in navigating the referral requirements. Amanda, #22, Samantha, Angelina and Jane also reported participating in the interview. Angelina remarked on the feelings she experienced during the interview,

> *"It went really good, it was a really casual, I was really nervous at first and then, you know, they just did it right in my suite that I ended up taking and you know we just sat there and there was a couple, not everybody was there, there was only a couple of the, like [the social worker] was there…"*

Angelina described her interview as *"casual"* and she felt *"comfortable," "not judged,"* and emotional, *"…it was just like a huge relief for me…"* Jane explained that, during her interview, she was informed about the program and received material about Cornerstone.

Participants' experience in Cornerstone

Describing Cornerstone

Participants related the rules, conditions and regulations they adhere to while in the Cornerstone Apartment Program. Jenni noted that all guests are required to report their visits via a *"sign-in sheet."* Guests are not permitted to, as #22 put it, *"spend the night."* No children are allowed to live in the building. Jenni noted that *"Most of the people adhere to the rules."* She also reported that some residents may have conditions attached to their contract with the program, such as making an effort to participate in group social events or rehabilitation support group. If these conditions are violated residents run the risk of being terminated from the program. Jenni noted that apartments are inspected once a month, and Amanda pointed out that the Cornerstone contract allows program staff to enter a resident's apartment at any time. Amanda noted that, for the safety of residents, they do not open the entrance door to strangers. Amanda reported, while conditions may be different for each resident, *"…we maintain control of that apartment fully and 100%. This is the contract that you're signing."* Jane felt the program addressed important aspects such as *"structure," "curfew"* and monitoring building guests.

Participants outlined their group responsibilities in the program. Jenni, Amanda and #22 identified a cleaning schedule where residents take shifts cleaning the common areas. However, Jenni remarked, *"…there are a few people who refuse to participate."* Jessica, #22 and Jane noted other group responsibilities such as *"house meetings"* or *"monthly meetings"*.

Participants' positive experiences in the Cornerstone Apartment Program covered a broad spectrum including feeling safe, building confidence, sense of responsibility and gaining personal insight. Jane expressed her feelings regarding the impact Cornerstone has had on her life, *"It means a lot. Since I've been here it's been a breath of fresh air. I mean, it's the first time I've really been independent."* Residents are provided the opportunity to turn over a new leaf in Cornerstone. Angelina exemplified this,

> *"… I've learned a lot about myself already… that I am very capable of leading a normal um healthy happy life …I was so far gone in my mental illness …, I honestly thought shelters was going to be the rest of my life."*

Participants experienced a new way of living where they could learn new skills as well as engage in the community. Jenni had not lived in a safe environment for two decades; Cornerstone allowed her to engage and socialize in the community, *"…I'm trying new things out in my life that I'd normally wouldn't before, and I sort of like having the, the cushion of [the Cornerstone staff] while I do some exploring."* For some participants, it took time for them to adjust to the Cornerstone Apartment Program. Jenni, Jessica and Rose were reluctant to utilize the supports at first. A history of no supports may have contributed to this, as Jenni pointed out, *"I've never had supports before, and I feel really hesitant about calling them because I thought, 'well what are they going to care about my own little thing.'"*

Four participants noted feeling safe in Cornerstone Apartment Program. Jenni disclosed, *"For the first time in probably about 20 years I feel like I have a safe accommodation."* Jenni went on to remark, *"…it was a little scary at first, but because I feel safe here…I felt okay about it."* The following Cornerstone policies were noted to contribute to resident safety: monitoring guests, sign-in sheet, no overnight stays and a residential manager. Due to her *"big fear of men in general,"* Jenni stated that these policies help her feel at ease. Feeling safe provides residents with a base from which they may venture out from, and return to, during new experiences (e.g., engaging in community activities). Amanda cited the *"safe environment"* provided in Cornerstone, *"…I have my basic needs met."* Samantha also commented on safety in Cornerstone, *"…safety here is great… absolutely amazing here, you know, I mean I would never feel safer than here."* Angelina noted safety as one of the most helpful aspects of the program; this was partly made up of the notion of security in that she knew her personal space was secure, *"I remember my first night a Cornerstone just locking the door with like, 'Oh my God, I'm going to go to sleep tonight and I'm going to feel safe."*

Once familiar with the program and staff, Jenni felt comfortable to *"…take advantage of the supports."* Amanda agreed she felt comfortable requesting assistance if needed, though she stated other residents may not share this feeling. Another participant, Jane, similar to Jenni, had to learn how to ask for help,

> *"…it was always a problem to ask for help and just the actual support of their knowledge and their skills, it's a comfort."*

Jane noted that the experience of asking for help is different from asking for help in a hospital living situation, *"in the sense that the attitude of the staff were quite different."*

Formal support

Participants discussed feeling supported by the processes, rules and regulations in place in the Cornerstone program. Jenni described a policy contributing to her feelings of safety, *"…they [Cornerstone staff] monitor who comes in and who doesn't."* In addition, she felt secure with the knowledge that staff would address the issue if residents were ever put in an unsafe situation. Furthermore, Jenni was able to properly pursue addiction recovery due to Cornerstone rules against drugs and alcohol. Jessica and Samantha appreciated the free group activities built into the Cornerstone program. In addition, Samantha felt supported knowing she had a designated apartment while group activities provided socialization and an informal support system. Angelina described her experience feeling supported in Cornerstone,

> *"…so finding Cornerstone, I feel so honoured and lucky that I was able to get into that program and they've just, I don't know, there's just so much support there and yet, like I feel, I feel free and it's my place and I do what I want and I, you know."*

All participants felt supported by Cornerstone staff. Jenni described the team as *"really helpful;"* for this participant, knowledge of accessible support services was enough to make her feel supported. Staff aided her coping with her addiction by providing and suggesting opportunities to occupy her time. Jessica also found the staff a great help, she specifically noted the services of one team member who has worked primarily with her. Jessica found their assistance helped her to pursue activities on her own, such as volunteering and attending appointments. She also noted that while she chose not to participate in religious gatherings held in the building, she did appreciate the *"spiritual support"* she received. Jessica also described assistance in transportation, employment and leisure activities. Amanda noted that the level of support in Cornerstone may be preferable to independent living situations; for example,

> *"…at Cornerstone, if there's a problem, you can complain and hopefully the neighbour will be dealt with, but when you are living independently that may not happen…"*

When asked to identify an aspect of Cornerstone that helped the most, #22 identified the *"support team"* and the assistance they provide. Samantha noted how quickly the staff would respond to resident concerns, both over the phone and in person. She once again noted the importance and value, a *"big asset,"* of having a staff member, a formal support, living on site. In addition, Samantha remarked,

> *"So it's great when you start off here, you got a furnished place and you get to start off slowly, you get staff that comes in to check to make sure…you've cleaned your place or they'll help. That's what I loved about it too…"*

Rose emphasized her appreciation for the level of support she received while in Cornerstone, *"…I know that I could call them anytime with anything. I trust, like I trust all of them, there is no one person that I would go to more than the other but they've been really there for me…"* She described the support team as very approachable, attentive and encouraging. In addition, Rose felt that staff members were approachable when there was anything *"bugging"* residents about the program. Rose illustrated the support team's approach, *"…we have a really amazing team, like you can tell that every member actually cares, they're not just there for a pay check and I think that's really important."* Angelina similarly described the support team, emphasizing their focus on individual client needs. This participant also described the team as *"approachable,"* efficient and accommodating; the support team allowed clients to determine their preferred form of communication (e.g., text messaging). Angelina found that the team worked efficiently to find her a solution for anything that she addressed with them. Jane noted *"…the communication is good…"* with the team and their level of client care, *"… they treat me well here…"* in addition to their knowledgeable expertise. She also noted their *"encouragement"* and *"the way they treat"* the residents.

Informal support

Six participants described their experiences with Cornerstone informal support; that is, support from fellow Cornerstone residents. Jenni found that common experiences (such as addiction and/or mental health issues) allowed residents to *"talk to each other and relate."* She noted the supportive environment among co-residents, *"The fact that we are a community and the fact that they try to foster that here…works for me…"* Jessica affirmed this notion stating, *"Like, I don't feel, I don't feel alone, as alone here, because…I literally I can just go to somebody's door…and knock on there, right."* Amanda, too, commented on the support system formed among co-residents in Cornerstone, referring to them as *"friends."* Jane was able to *"relate"* easily with her co-residents due to the all-female population in Cornerstone in addition to having similar experiences. She found that these factors, plus participating in activities with other residents, assisted her in creating a support network within Cornerstone; Jane identified this as one of the

most helpful parts of the program for her. #22 found that resident activities provided her with an opportunity to socialize which prevented, or lessened, isolation. Samantha described feeling very *"welcome"* in Cornerstone, expressing wonder that her co-residents did not have a hidden agenda when they sought her company, an experience she was not expecting due to her past living situations.

Satisfaction

Participants described their satisfaction with their experience in the Cornerstone Apartment Program. Jenni found the conditions and regulations of the program reasonable; she remarked on the suitability of the program to her needs, *"So far it has been a perfect fit."* In addition, she said she would *"…recommend this program for a lot of people."* Jessica, also satisfied with her experience in Cornerstone, credited the program with keeping her *"clean [and] sober."* One participant, despite exiting the program early, also expressed satisfaction with the services offered in the Cornerstone program, *"I loved it because, you know, it was a big apartment, it was nice and clean, and had a lot of support systems."* Rose, Angelina and Jane agreed that the program was working well for them.

Participants expressed hope for the future and a motivation to achieve independent living as a result of being part of the Cornerstone program. Samantha used this motivation to continue building self-esteem and confidence. Rose expressed her hope, *"I'm looking forward to school and the rest of my life. … for a while I kinda felt like it was done for me and I know Cornerstone has helped me have hope."* In addition, Angelina also noted a transformation of outlook and an increasing sense of *"hope"* due to the program.

Living in Cornerstone

Participants discussed difficulties experienced living with, and adjusting to, co-residents. Jessica did not feel comfortable with guests staying the night. She went on to say *"you get a bunch of women together and it's just a nightmare."* Amanda felt uncomfortable bringing up issues at the house meeting, *"…you run the risk of putting yourself as a narc."* In addition, she would have preferred if there was a higher overall level of hygiene among co-residents. Two participants illustrated the need to establish and maintain interpersonal boundaries among Cornerstone residents. As Jenni stated,

> *"I had to set them up because…people were coming to me and talking to me about things that, one, I didn't think it was really my business and, two, I didn't think I was capable handling."*

Furthermore, Amanda stressed the need for residents to take responsibility for their actions (e.g., self-harm and calling for professional help). Two participants discussed sharing information in the program. Jenni's experience was positive, stating that familiarity facilitated residents forming an informal support system. Amanda took issue with co-residents not sharing information, or misrepresenting themselves. She did note that she did know quite a bit of personal information (e.g., birthdays, diagnoses) about her co-residents.

Participants described the group activities available for Cornerstone residents, such as an art group, instruction on money management, monthly group activities and outings, resident-organized activities (e.g., walking group, movie nights), cooking classes, and house meetings with potlucks. Samantha described the sense of community felt as a result of these group activities, *"you feel like you have a family."* Jane related an outcome of the activities organized through Cornerstone, *"they have you know just teaching you how… to have dignity."* Participants described how they engaged in Cornerstone group activities and how they benefitted. Jenni, #22 and Samantha noted the positive social benefit of engaging in the group activities; socializing with co-residents would be important in decreasing feelings of

loneliness. In addition, Angelina found this helpful in overcoming her fear of meeting new people. Jane identified these group activities as *"the most helpful"* aspect of her stay in Cornerstone.

Interview participants commented on their experiences living independently within the Cornerstone Apartment Program. Jessica described herself as independent, with occasional help from a family member. Amanda and Rose provided similar descriptions of independence in Cornerstone. They both reported feeling in control of their lives, personal space and everyday decisions (such as meal planning). In line with Angelina, Rose found the support received from Cornerstone staff fostered resident independence; *"…they're there and I can call them but they're not like hovering over me feeling like I'm useless and can't do it myself."* Jane noted her experience living independently within Cornerstone as *"good practice"* due to a *"sense of responsibility"* that is entrusted to the residents when they are provided with an apartment to care for. Cornerstone provides an opportunity for residents to feel a sense of ownership, perhaps for the first time. Jenni noted, *"…so we take ownership…when we see something's not right in our neighbourhood here, in our Cornerstone, one of us says something because we feel like it's our building."* She went on to describe feelings associated with ownership*, "It made me feel really good to have my own place…to keep clean."* Angelina also noted*, "…it's something I take pride in…"*

Angelina explained how independence and being entrusted with responsibilities aids in recovery,

> *"…something that, that like exactly is yours to take care of and be responsible for and having responsibility is a huge, I think is a huge thing for people with mental illness and drug addiction. Especially mental illness 'cause I think a lot of time people feel that we're not, or at least it's been my experience that, you know, we're not capable enough."*

Further to this statement, Jane adds, *"...it's really good when you have your own place, you have a sense of responsibility to, you know, yeah up keep everything, yeah, so I quite prefer it."*

Recovery

Four participants commented on focusing on their recovery; they are concentrating on moving forward in their health and completing the program, Amanda stated, *"I'm just pushing forward…"* Jane had a similar attitude, *"…I pretty much came in with the 'I'm gonna do this and I'm gonna succeed' [attitude] and so I've been a lot of help in my own treatment."* Participants found coping with addiction issues and triggers mitigated while living in the Cornerstone Apartment Program. Jenni found this made easier as a result of the rules; that is, residents are not allowed to drink alcohol or take drugs. In addition, she and Angelina found the activities and programs organized by Cornerstone staff as coping strategies for cravings and isolating behaviour.

Samantha credited Cornerstone with building her courage and self-esteem. In addition, she took initiative to build on her self-esteem while in the program by taking part in resident group activities and programs. She described the art group, even though she did not participate in creating art, *"it builds your self-esteem…you just feel welcomed, you feel like you belong."* Rose attributed the Cornerstone program and staff members with her confidence in her ability to one day live independently, *"They help me build my confidence and help me see that I can do things on my own."* Angelina related a similar experience in Cornerstone; she learned confidence and self-esteem with the assistance of the staff, *"[The Cornerstone staff member] get me to that first step where I realize 'Oh, ok I'm ok by myself.'"* In addition, Angelina noted that having pride in her home, and therefore the ability to once again involve her family in her life and invite them to her home, *"is a huge self-esteem builder."* Participation in the Cornerstone program facilitated reconnecting and re-establishing a relationship with her family support system. Furthermore, Angelina was able to build her confidence and self-esteem through self-reflection,

> *"…I'm learning about myself and I'm learning that I do love myself, which I never thought I did. And I'm learning that I do have some self-confidence and I'm learning tools to build on that."*

Cornerstone residents' experiences in the program allow them to learn tools and build on confidence and empowerment. For example, Jessica was able to seek out and apply for a volunteer position on her own initiative. Furthermore, Rose gained confidence in her independent living skills, *"Now that I've lived on my own I know that I have that ability."*

In addition, Jane felt she was *"in charge"* and *"more controlled"* in Cornerstone compared to her past living situations. Angelina discussed the personal insight and self-awareness she gained as a result of the Cornerstone program, *"I just really, really lost her [myself] for a long time. I don't even know that I really ever found her until recently…"* Two participants, Rose and Jane, commented on the Cornerstone staff's practice of individualizing treatment plans to the client. Jane commented positively, *"It works really good because I feel my, my needs are being met, yeah."*

Participant advice to new residents

Participants were asked to advise hypothetical new residents of the Cornerstone Apartment Program. This advice reflects lessons learned in the program. One participant emphasized the importance of following the rules and conditions in Cornerstone: keeping in mind their future goals for independent living, new residents should put in the effort to earn a positive landlord's reference from Cornerstone staff. The participants recommended that new residents use their time in the program to work on practicing their independence; although, Jessica cautioned, *"there's always a time when you will need help."* Rose added further caution; new residents must be ready and *"willing"* to further their recovery, *"…willing to put in [your] own work, and if you're not then it's not gonna work for you. "*

Taking advantage of the support provided in Cornerstone was a notion reflected by four participants. Jenni advised, *"Take advantage of everything that they give you here."* Amanda shared a lesson learned in the program, *"The key with Cornerstone is you have to ask for help."* Rose built on this concept, advising an important part of the program is *"Just letting the team in and letting them know when you're having a hard time."* Angelina had similar advice for new residents, *"take advantage of every opportunity that they can in there."* Angelina went on to explain a potential internal barrier for new residents: difficulty asking for help,

> *"If people have mental illness or addiction we don't ask for help… [because we think] we don't need help…. toss your pride aside and ask for help and you'll be amazed at what you'll find."*

Jessica discussed the importance of engaging with the Cornerstone community; that is, socializing with co-residents and avoiding harmful *"isolating"* behaviour patterns. In addition, Samantha's advice to new residents was to participate in the many activities organized within Cornerstone, such as the art group. Jessica and Samantha discussed an important objective of the Cornerstone program: integrating residents into the community. Residents' first step towards this goal would be to engage in the Cornerstone community; Cornerstone staff then encourage residents to engage in the wider community by organizing opportunities such as the Edmonton Leisure Access Pass.

Participants recommended that new residents stay true to their intention of entering the Cornerstone program; that is, as Jessica emphasized, *"…be good to yourself; become good to yourself."* In addition,

participants recommended taking the time to gain personal insight and self-awareness as well as use the time to *"focus on [self]"* (Jane).One participant would have advised new residents to be *"cautious"* with information shared among co-residents. In addition, this participant recommended utilizing appropriate conversation topics with co-residents (i.e., avoiding topics such as addiction issues) and advised against taking part in gossip and rumours.

Participant issues with Cornerstone

Participants provided feedback on aspects of the Cornerstone program that did not work for them. A participant remarked on rules she would define as *"grey area[s],"* such as the sharing of personal information. Ill-defined, or *"grey,"* rules were interpreted differently among residents; this would affect resident actions. This participant warned, *"It can become a very toxic situation."* This participant also expressed concern over the policy of different rules for different residents, which she felt was not a good reflection of an apartment building she may live in once she is independent.

One participant expressed her disagreement with the practice of sharing information among residents (e.g., diagnoses). She felt that some residents were not reciprocating and providing false information. For those who wish to remain in control of the information that is shared with others, or who wish for privacy, this practice negatively affects their experience in Cornerstone. The participant went on to declare their lack of privacy and confidentiality as *"a big issue"* for her.

One participant expressed their concern regarding boundaries of both Cornerstone staff and co-residents. Her issue with the staff concerned the apartment check-ups and entry of maintenance personnel without prior notice and without leaving notice of entry. The participant felt this was a bad example of what to expect and what would happen once she was living independently, *"I should be questioning if my landlord's coming into my apartment without authorization."* As for co-residents, the interview participant felt certain individuals were not approaching the appropriate people for help. For example, she was approached by an individual who then informed her that they were going to self-harm. For residents concentrating on their own recovery, being burdened by a co-resident's mental health and/or addiction issues would cause undue stress. Boundaries are an important aspect of healthy behaviour; respecting resident boundaries allows them to focus on their health in a safe environment. A couple participants conveyed feelings of helplessness when confronted with co-residents' issues (e.g., self-harming). Jenni felt *"alarmed"* when co-residents communicated to her their *"distress"* and Amanda felt like she was *"left in the middle of the situation."*

One participant remarked on her frustration with her co-residents. In her experience, some individuals would attempt to engage her in negative and/or unhealthy conversational topics, such as their addiction or gossip. While she was able to eventually discourage or avoid these topics when in conversation with co-residents, other residents may find it difficult to break this cycle of negative communication on their own. Rumours and gossip may create a toxic environment detrimental to residents' emotional health. Jessica conveyed how *"brutal"* an environment may be when there are only women living in the building, especially when there is gossip. Amanda conveyed her attempts to avoid the gossip and rumours regarding house meetings and residents. It may be difficult for residents to avoid or escape a culture of gossip once it is in place.

One participant highlighted her issues with stigma in the Cornerstone Apartment Program. She felt staff stigmatized the residents, *"The only problem I had here was staff; they didn't treat people like adults, they thought, 'cause we are mentally ill, that we couldn't think on our own."* She perceived that the staff believed she had no rights, *"I express[ed] my opinion to them, that's when they told me I have no rights*

here." She made a point to emphasize that she has since independently made progress with her mental health issues. She agreed that some residents may need more of a helping hand than others, though she did not feel that she should have been treated as *"a child."* A lack of empathy or awareness among staff will cause residents to feel marginalized, *"They look at you for your illness rather than who you are and that's what they gotta stop doing."* It should be noted that she was still very grateful towards the program and credited it as the starting point of her recovery, such as positive thoughts leading to improved self-esteem.

An interview participant found the curfew rule to be *"frustrating"* and undermined her independence. The curfew imposed on residents does not allow guests to be in the building any later than nine o'clock in the evening. She felt this rule prevented her from pursuing healthy friendships, such as girls' night sleepovers.

Four participants remarked on the issue of co-residents' rule breaking behaviour. This included having guests stay overnight and allowing inappropriate people into the building (e.g., pimps); not participating in group responsibilities, such as cleaning; and engaging in illegal or harmful acts (e.g., drugs, cutting). Jenni felt that rule-breaking was not addressed in sufficient time; this is an issue especially if there are women in the building who have a fear of men due to an unstable past. Samantha and Rose expressed the need for a residential manager to provide structure and discourage residents from breaking rules. Even so, Samantha noted that men were still sneaking into the building – residents' conduct, she observed, were reminiscent of addictive behaviour. In addition, Samantha remarked, *"I just think they need more structure and they need to be firm with everyone."* Samantha would have liked the option to smoke in her apartment; though she noted that this is not a luxury available in all apartment buildings.

Two participants reported instances where they felt unsafe in Cornerstone. For Jenni, it was when residents were allowing strangers in to the apartment building, *"I felt unsafe …because there were pimps."* Amanda was also concerned about strangers, though for a different reason, *"But it is very, can be very emotionally detrimental having people come into your house… because they may not be in a mentally sound position."* She provided examples such as *"self-injuring"* and *"taking drugs."*

Some Cornerstone residents had broken rules or not participated in resident group responsibilities, with no repercussions. Amanda reflected that these individuals would benefit from experiencing consequences for their actions. Samantha reiterated this inequality,

> *"You'd give one tenant chance, after chance, after chance, and you'd watch them get away with everything, and then you would so much [as] sneeze the wrong way and you didn't get away with nothing. And I think everyone should be treated the same."*

One participant noted that, during her time in the Cornerstone Apartment Program when there was no residential manager, the security cameras were not operating; therefore, this participant found that these cameras were not providing the same function as the residential manager (i.e., resident accountability). Jenni noted that some residents may need more support than is intended for the Cornerstone program; she remarked on the program acquiring a more stringent review process not only in the beginning of the referral/interview process but throughout the program. In addition, Amanda noted another aspect for this checking in with residents, *"Some of the people, I don't think have had the opportunity to learn how to ask for [help] if it's necessary."*

One participant discussed her need for increased structure and support when learning basic living skills. #22 discussed her need for more structure in the program: she would have liked assistance in structuring

her day. She noted that a work schedule would solve this issue, though she would need assistance in meal preparation which she could coordinate with Cornerstone staff. One participant noted that she may have stayed the full year in Cornerstone had there been a residential manager to provide increased structure, *"…it would have been different for me, I would've had structure in my life that would have been like a schedule."*

Participant suggestions to Cornerstone and policymakers

Four participants made a point to explain that they did not feel there were any major improvements needed for Cornerstone; if they did recommend anything it was described as a small or minor change. Jenni explained, *"…everything that I need is here."* Two of the participants felt an improved experience in the program was directly related to resident investment in recovery.

Rose's only suggestion to improve the program was to employ a staff to live on-site (i.e., the residential manager). Rose and Jenni noted that, at the time of their interviews, the program was in the process of re-hiring into this position. Samantha expressed her concern regarding the absence of a residential manager role, *"…I truly believe, like, if you don't have a staff member living in here it's not gonna succeed."* A couple participants noted that when there is not a staff member on-site then they will engage in the wrong kind of behaviour and/or break rules. Samantha went on to add, *"…you're not just dealing with normal people, you're dealing with…recovering addicts with illnesses."*

Jane recommended *"tiny things"* such as *"a place to recycle".* One participant recommended more assistance from staff in preparing residents to transition. For example, a notice board listing suitable apartment vacancies (e.g., in a safe neighbourhood) would visually prompt and assist residents in planning their transition from Cornerstone.

Jessica recommended increasing the number of recreational programs. She felt the programs were *"important"* however had not been able to match these activities with her schedule. One participant, #22, found the activity level in Cornerstone too low for those who are not employed. She recommended increasing activities with residents and/or staff to prevent isolation. Activities arranged by both residents and staff would increase both frequency and variety of recreational activities and programs, therefore discouraging negative consequences such as isolating behaviour. She went on to note that encouraging these sessions among residents would create community and respect among Cornerstone residents. Jessica and Amanda felt that discouraging and reducing the amount of gossip among residents would improve their experience in the program; however, Jessica provided a disclaimer, *"that's life."*

Increasing the awareness of, as well as respect for, boundaries among staff and residents was brought up by a couple participants. Amanda recommended being *"proactive"* in handling boundary issues, suggesting all residents attend *"mandatory"* education on the subject. Jenni recommended increasing support for those residents not doing as well in recovery, this would decrease the burden inherently placed on residents, therefore maintaining healthy boundaries among residents. Amanda recommended increased support for new residents. She suggested that their apartments be checked more frequently, *"…you need to be stepping up to checking in."* In addition, Amanda recommended these residents be informed of apartment checks. This approach would increase the accountability expected of new residents. Jenni echoed this sentiment, stating there should be increased awareness and monitoring of residents who are not doing well in the program; these residents should then be referred to a more appropriate (supported) living situation or for Cornerstone staff to *"check on them more."*

Two participants suggested a change in Cornerstone rules. Jenni recommended no men be allowed in to the building; she recognized that this would reflect the concerns of women formerly in the sex trade. Angelina recommended adjusting or making exceptions to the curfew rule. Participants felt that residents should be held accountable for their actions. Jenni recommended staff enforce consequences sooner, *"…before too many people [complain]."* Amanda noted that in her experience, some residents would do very well in the program, some would leave for the wrong reasons and others would stay for the wrong reasons. She felt that increased monitoring of residents would lessen the number of residents who are engaging in unhealthy behaviour while in the program. She felt that some residents should be allowed, and need, to *"hit rock bottom"* or *"given the boot"* so that they may grow from the experience, instead of continuing engaging in unhealthy behaviour.

Two participants noted the need for *"more programs like this out there for people."* Angelina elaborated on this idea, *"I think it's [Cornerstone is] an amazing program, and really the only thing that I would like to see is more of it."* Angelina went on to explain the lack of programs for women, *"I think there is a lot more women suffering from mental illness and addiction than people realize…"*

Discussion

Homelessness in Edmonton and other major cities across Canada is of growing concern. It is recognized that who comprises 'the homeless' is changing, now including more women, youth and families, and it is well known that people with concurrent disorders run a greater risk of becoming and staying homeless. However, what isn't particularly well known is how to support women with concurrent disorders who are, have been, or are at risk of becoming homeless. The current study sought to address this issue through qualitative inquiry. Eight women with concurrent disorders, who were current or past participants in a transitional supported housing program, Cornerstone Apartment Program, were interviewed regarding independent living: their views, needed supports, critical success factors, and how the program helped them achieve their goals.

Regarding what independent living and support means to individuals, the current research study findings are consistent with the literature. The study participants defined independent living as having autonomy, ownership, freedom, and self-reliance with minimal support. Participants' definition of independent living was similar to Brisenden's (1989), "Independence is not linked to the physical or intellectual capacity to care for oneself without assistance; independence is created by having assistance when and how one requires it" (p. 9). Additionally, Brisenden (1986) equated independent living as desiring a place in society, equality, the right to make decisions, and to have control over one's own life. Similarly, Ratzka (2003) equates independent living with self-determination, equal opportunities, self-respect, seeking assistance when needed, and freedom of choice and control in everyday life. In short, most definitions of independent living contain three elements: (1) control/self-direction; (2) choice/options; and (3) freedom/flexibility (Canadian Association of Independent Living, 1991). Women with concurrent disorders, who have been or at risk of being homeless, express similar ideas to what others have expressed regarding what independent living means to them. This supports the notion that although individuals may have different experiences in life, they have common ideals.

Although participants shared a similar concept of independent living, what stage a particular person is at or what is needed from a supported housing program varies from person to person. That is, individuals with different life experiences (e.g., education, pre-existing skills) may have diverse learning and support needs. Therefore, while women with concurrent disorders may enter the same housing program, it is important for each person to have an individualized plan to ensure successful independent living in the future. This was evident in the varying descriptions of what skills participants described as being important to them.

The current study offered support for the benefits of providing women with concurrent disorders a supported housing program with comprehensive wrap-around services. Davis and Kutter (1997) found that women who were homeless had deficits in independent living skills, especially in budgeting and managing their finances. Women in general are reported to have limited financial resources and increased economic vulnerability (Bassuk, 1993; Meschede, Cronin, Sullivan, & Shapiro, 2011) but this is especially true for women who have SMI and are experiencing housing problems (Bassuk, 1993; Manuel, Hinterland, Conover, & Herman, 2011; Rosenheck, Bassuk, &Saloman, 1998). Consistent with the literature, women in the current research study indicated the need to be taught money management and spoke of key lessons learned in budgeting. Training in other independent living skills such as cooking, cleaning, health promotion and disease prevention were also provided in the program. This not only helped women to gain daily living skills but also enhanced their self-confidence and self-esteem. The participants valued the training and supports provided and attributed this to their success.

Education in daily living skills provided these women with a stable base upon which to build complex skills. Learning these skills helped to build confidence and self-esteem which led to an increased motivation to succeed. This in turn promoted engagement in the individual's immediate community (e.g., co-residents, family and friends) as well as in the community-at-large (e.g., volunteering). Encouraging interaction within the community and with informal supports assisted individuals to build a diverse support network. Connecting residents with financial aid or securing employment/education increased chances of maintaining independent living, not only for practical expenses (e.g., rent) but also providing structure and a healthy and productive way to occupy time. Participants also spoke about what a difference positive interactions with program staff members made to enhancing autonomy and self-esteem.

Participants identified a comprehensive range of critical factors that facilitated successful recovery and transition/maintenance of independent living. Lessons in daily living skills (e.g., personal finance management, cooking), structure (i.e., rules, conditions, regulations), increasing awareness of community resources, and a network of support were described as factors facilitating independent living. Participants also reported that engagement in community activities and programs had a social and therapeutic benefit for mental health. This is consistent with the literature where it was found that individuals with a higher level of community engagement had an increased rate of independent living than their more isolated counterparts (Cook, 1994). Connecting residents to employment and/or financial aid was another positive factor highlighted by participants. Interestingly, Cook (1994) discovered a tendency for individuals receiving financial support from family to experience a decreased rate of independent living compared to those who received employment insurance. Building confidence and raising self-esteem was another factor illustrated in the findings. For example, individuals completing a program with improved level of functioning experienced an increased rate of independent living upon follow-up (Cook, 1994). Success factors suggested by participants echo Kiesler's (1991) observation on success "…intermittent, continuing contact with caregivers; some training in the ordinary skills of living; help with independent living; and housing, including some housing that does not require complete independence" (p. 1249).

In addition to the necessary programming and training components described, a critical element was the housing itself. Cornerstone Apartments was described by participants as safe, secure and affordable; the supportive and secure environment fostered feelings of safety in the residents and provided a positive sense of community, thereby enhancing their overall recovery. This notion is supported by a 2008 Canadian Mental Health Association report indicating that mental health is positively affected by safe, secure, affordable housing. The gender-specific nature of the housing also played a considerable role in meeting the safety and security needs of the female residents. This becomes more salient when considering that women living in poverty with mental illness often experience unsafe housing and/or homelessness, thus increasing the odds of becoming victims of crime and violence (Cook, 1994) including physical and sexual assaults (Jacobson & Richardson, 1987). As a result, this subgroup of women likely experienced a high rate of trauma and victimization (Davis &Kutter, 1997) and its unfortunate negative consequences. Results from the present study show that based on women's past experience, having a female-only residential facility enhanced feelings of safety and security.

A consistent finding across interviews was the important role the residential manager (or live-in staff member), played in enhancing feelings of safety and support in the program. The residential manager provided structure and assistance, but also rules and expectations, which held participants accountable for their actions. This led to participants feeling safe and secure in the building, not only in the physical sense (possibly dangerous guests were less likely to be invited into the building) but also in a psychological sense such as having readily-available support, if needed. With their safety and security needs met, participants were able focus more on recovery.

In contrast to these facilitating factors, participants indicated a number of potential barriers such as a lack of community support (and programs), lack of financial support/earnings, a lack of secure and affordable housing and mental health and/or addiction issues. In addition, concerns regarding transition to independent living included safety/security, support, isolation and relapse. Similar to the findings from the current study, Tsemberis and Eisenberg (2000) reported that having a concurrent disorder negatively impacted the ability to maintain housing. Kiesler (1991) and Silverstein (1994) reported economic barriers to independent living for homeless people including financial support, employment and limited affordable housing options. In addition to lack of finances and affordable housing, Silverstein (1994) reported disagreements with family and a history of domestic violence as barriers.

Conclusion

The study findings indicate that a gender-specific, transitional supported housing program was instrumental in assisting women to achieve and/or work towards their goal of independent living. This was accomplished in the context of a gender-specific residence with on-site support; these were key elements in creating a safe and supportive environment.

The program facilitated participants in building basic independent living skills through organized training and peer support. In addition, the acquisition of complex independent living skills was achieved through cultivating confidence and enhancing self-esteem. The residents were also exposed to other possibilities, such as employment and higher education. Furthermore, the program provided the opportunity to develop and maintain meaningful, supportive relationships, thus encouraging community integration and developing stronger social support networks for these women. Increased awareness of existing community supports and being comfortable in asking for help, aided the participants in their recovery journey and road to independence.

Results of this study support the conclusion that more supported housing programs (such as the Cornerstone Apartment Program) are needed for women with concurrent disorders. This population would benefit from a residential program tailored to their specific needs; for example, creating a safe environment for women and addressing mental health and/or addiction issues, in addition to facilitating independence for a successful transition to independent living.

A longitudinal study would be able to further explore the long term benefits of being a resident of a supported housing program. Such a study should examine outcomes for residents who have been in the program for longer periods of time compared to those who exited the program sooner. Furthermore, comparison with a control group of those who have yet to be housed or housed through different housing models would enhance our understanding of supported housing outcomes.

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Appendix A: Participant Recruitment Notice

Alberta Health Services

Recruitment Notice

Research Title: Cornerstone Apartments: An Innovative Housing Project with People with Concurrent Disorders

Principal Investigator(s): Dr. Shireen Surood, Supervisor, Alberta Health Services
Dr. Diane McNeil, Manager, Alberta Health Services

Co-Investigator(s): Jill Kelland, Director, Alberta Health Services
Marcia McKall, Manager, Alberta Health Services
Jim Koning, Supervisor, Alberta Health Services

We are doing a research study with women who have mental health and addiction issues and live in supported housing. We would like to know what helps women to be able to live on their own. This study is important because more needs to be known about what helps the most. We want to hear from people who know what it is like to live in supported housing. Your experiences and views will help to improve housing programs and services. As well, the findings will help us and others understand what helps or hinders women with mental health and addiction issues in achieving their goal of living on their own.

We invite you to help us. If you are a **past or current client of Cornerstone Apartment Program** we would like you to share your experiences, ideas and opinions about achieving your goal of living on your own.

Your personal records related to this study will be kept confidential. No one outside of the research team will know which answers are yours. Any report published as a result of this study will not identify you by name.

This research is being done by Drs. Shireen Surood and Diane McNeil. They are part of Alberta Health Services working in Research and Evaluation for Addiction and Mental Health.

If you are interested in taking part in this study, please provide your contact information to _____ of _____, contact number (____) ___-_____. We will contact you.

Thank You.

Contact Information:

Your Name: _____

Telephone Number or other means of contact: _____

Please contact any of the individuals identified below if you have any questions or concerns:
Dr. Shireen Surood, Telephone: 780-342-7726
Dr. Diane McNeil, Telephone: 780-342-7696

Appendix B: Participant Consent Form

INFORMATION SHEET

<u>Title of Research Study:</u> Cornerstone Apartments: An Innovative Housing Project with People with Concurrent Disorders

Principal Investigator(s): Dr. Shireen Surood, Supervisor, Alberta Health Services
Dr. Diane McNeil, Manager, Alberta Health Services

Co-Investigator(s): Jill Kelland, Director, Alberta Health Services
Marcia McKall, Manager, Alberta Health Services
Jim Koning, Supervisor, Alberta Health Services

<u>Background</u>: We are doing a research study with women who have mental health and addiction issues and want to maintain independent living. Cornerstone Apartments was chosen because it is a new program to help women to live on their own.

<u>Purpose</u>: You are being asked to participate in a research study to find out what helps women to be able to live on their own. This study is important because more needs to be known about what helps the most. We want to hear from people like you who know what it is like to live in supported housing. We would like to hear your ideas and experiences.

<u>Procedures</u>: Participating in this study means that you will be asked to take part in an interview. We will meet for about an hour and a half. I will ask you questions about your living situation. This interview will be tape-recorded. The recording will be used to help us to report your answers correctly. We may need to call you for another meeting to review the information that you gave.

<u>Possible Benefits</u>: A possible benefit to you for being a part of this study is that you may see improvements to the program. The results may help us and others to understand what helps or hinders women with mental health and addiction issues in achieving their goal of living on their own. We hope this will lead to developing better programs and services.

<u>Possible Risks:</u> We do not think there are any risks in being a part of this study. While in our experience it has never been the case, it is possible that talking about some experiences might be upsetting. If you feel upset at any time, please let me know and we can take a break. I will give you a list of mental health contacts that you can call if you would like help.

<u>Confidentiality</u>: Personal records related to this study will be kept confidential. No one outside of the research team will know which answers are yours. Any report published as a result of this study will not identify you by name. In order to report what you said we will ask you to pick a pretend name that we can use instead of your real name. All data collected on paper will be in Dr. Shireen Surood's work area in a locked cabinet for at least 5 years. All electronic data collected will be password protected and also kept for at least 5 years.

<u>Verbal Consent</u>: If you want to be part of the study but do not want to sign the consent form we will tape-record your agreement to be part of the study.

Cornerstone Apartments: An Innovative Housing Project with People with Concurrent Disorders

Voluntary Participation: The decision to take part in the research study is yours. You may change your mind at any time. You are free to leave the meeting at any time. If you decide to leave, the answers you gave before leaving will be used. If you don't want any of your answers used let me know. Your decision to stay or leave the study will not in any way affect where you are living now or any other treatment program you attend. If any knowledge comes from this or any other study which could change your mind about staying in the study, you will be told right away.

If you have concerns about your rights as a study participant, you may contact the Health Research Ethics Board at 780-492-0302.

Please contact any of the individuals identified below if you have any questions or concerns:

Dr. Shireen Surood, Supervisor, Alberta Health Services, Telephone: 780-342-7726

Dr. Diane McNeil, Manager, Alberta Health Services, Telephone: 780-342-7696

CONSENT FORM

Part 1 (to be completed by the Principal Investigator):

Title of Project: Cornerstone Apartments: An Innovative Housing Project with People with Concurrent Disorders

Principal Investigator(s): Dr. Shireen Surood, Alberta Health Services Phone Number(s): 780-342-7726
Dr. Diane McNeil, Alberta Health Services 780-342-7696

Co-Investigator(s): Jill Kelland, Alberta Health Services Phone Number(s): 780-342-7711
Marcia McKall, Alberta Health Services 780-342-7694
Jim Koning, Alberta Health Services 780-342-7695

Contact Name: Dr. Shireen Surood Phone Number: 780-342-7726

Part 2 (to be completed by the research subject):

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to withdraw from the study at any time, without having to give a reason and without affecting your future medical care?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to your study records, including personally identifiable health information?	☐	☐
Do you want the investigator(s) to inform your family doctor that you are participating in this research study? If so, give his/her name _____	☐	☐

Who explained this study to you? _____

I agree to take part in this study: YES ☐ NO ☐

Signature of Research Subject _____

(Printed Name) _____

Date:_____

The pretend name I pick for myself is _____.

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee _____ Date _____

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT

Appendix C: Interview Guide

Interview Guide for Qualitative Face to Face Interview

Thank you for agreeing to participate in this study. We appreciate your willingness to share your time with us. During this interview, we would like to ask you some questions about your living situation. Our purpose is to try to better understand your experience of living on your own, what helps women to be able to live on their own, and how support provided in the community and at Cornerstone Apartments Project has helped (or not helped) you in gaining and maintaining independent living. We are also interested in know how this program or other supported independent housing programs could better meet women's needs who face mental health and addiction issues.

1. **What do you understand by the term 'independent living'?**
    a. Please tell me what does the term 'independent living' mean to you?

2. **Please tell me, what does it mean to you to be able to keep living independently or on your own?**
    Possible probes:
    a. What does this experience mean to you?

    b. What influenced or motivated you to want to live on your own or to live independently?

    c. What influenced or motivated you to become involved or participate in the Cornerstone Apartment Program?

    d. What was your living situation before coming to Cornerstone Apartments?
        (Please Note: Those who were hospitalized or incarcerated ask a follow up question to inquire about their living situation prior to hospitalization or incarceration)

3. **What supports do you think people need to live on their own?**
    (Probe for: sources of informal support, formal support and services)

    Possible probes:
    a. Talking about **informal support**,
        i. What kind of support do you have?

        ii. What kind of support has your family, friends, peers, or other Cornerstone residents provided you?

        iii. Has the nature of informal support changed since coming to the Cornerstone Apartments?

        iv. Reflecting back on your housing situation, what kind of support do you think would have helped you, then?

        v. In your opinion, what kind of support would be useful to you now or once you have completed this program?

    b. Talking about **formal support and services**,
        i. What kind of support have you received since living in the Cornerstone Apartments?

        ii. In your opinion, what other support needs to be provided to help you reach your goal of living independently?

        iii. What kind of formal support or services did you receive before entering Cornerstone Apartments?

        iv. What additional support could have been provided to help you?

c. In your opinion, what kind of informal as well as formal support would women in similar situation as yourself (with mental health and addiction issues) need to live or maintain independent living?

d. During your time with Cornerstone Apartments, what is/was your experience when interacting with the community? Is this interaction different from previous experiences?

4. Based on your experience,

a. How has support provided in the community *(informal and formal support and services mentioned by the participant above)* helped or hindered you to gain independent housing or living?

b. How has support provided in the community *(informal and formal support and services mentioned by the participant above)* helped or hindered you in keeping or maintaining independent living?

5. What (factors) do you think helped you in getting and keeping the ability to live on your own?

a. What helped you in getting to live on your own?

b. What helped you in keeping the ability to live on your own?

6. What (factors) do you think hindered you in getting and keeping the ability to live on your own?

a. What helped you in getting to live on your own?

b. What helped you in keeping the ability to live on your own?

7. Cornerstone Apartment Program

a. How did you learn about this program?

8. Based on your experience with the Cornerstone Apartment Program, how do you think it has helped you in achieving your goal of living on your own or independently?

a. What parts of the Cornerstone Apartments Program do you think have helped you the most?
   i. How were your needs met?

b. What parts of the program do you think did not work for you?

9. What does this experience of living on your own mean to you?
(Please ask this question if not asked already)

10. Based on your experiences, what would you like to tell health professionals and/or policy makers so that they can better understand your situation/experiences/needs?

Possible probes:

a. What words of wisdom do you have to offer to others in a position similar to your own?

b. Do you have anything else that you might like to add that we have not talked about or addressed that you would like to expand on?

11. If you could design a perfect program what would it look like?

Thank you again for your time and willingness to share your thoughts and experiences.

Appendix D: Participant Demographic Data Sheet

Demographic Data Sheet -- (*To be administered only after the interview*)

Name of participant: _____

Date of Interview: _____ Time: _____ to _____ a.m./p.m.

Name of interviewer: _____

A1. How long have you been in this program? _____(months)

A2. How would you describe your housing status before joining this program?
___1.Homeless
___2.Facing Eviction
___3.Couch Surfing
___4.Substandard Housing
___5.Drop-In Shelter
___6.Group Home
___7.Hospitalized
___8.Other (specify) _____

A3. What age category do you belong to?
___1.18-24 ___2.25-34 ___3.35-44 ___4. 45-54
___5.55-64 ___6.65-74 ___7. 75 and above

A4. What is your current marital status?
___1.Single (never married)
___2.Married or living common-law
___3.Separated
___4.Divorced
___5.Widowed

A5. What is your current employment status? _____

A6. What is your current occupation? _____

A7. What is your highest level of education?
___1.No formal education
___2.Elementary school
___3.Some high school/ junior high
___4.Complete high school
___5.Some post-secondary education (please specify): _____
___6.College diploma
___7.University degree
___8.Other (please specify): _____

A8. What language do you mostly speak at home? _____

A9. How would you rate your fluency in English?
___1.Very Poor
___2.Poor
___3.Fair
___4.Good
___5.Very Good

A10. How do you describe your ethnic or cultural background?
_____

A11. What is your citizenship or immigration status?
___1.Canadian citizen by birth
___2.Naturalized Canadian Citizen
___3.Refugee Claimant
___4.Immigrant (Permanent Resident)
___5.Other (please specify) _____

Thanks again for your time and participation in this study