Service use and recovery among currently and formerly homeless adults with mental illness

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Abstract

Background: A range of health and social services exist to address the many life adversities experienced by people with mental illness. However, the effects of services on their recovery in the context of ongoing homelessness and poverty have been minimally examined.
Aims: This qualitative study sought to better understand the role of health and social services in the recovery processes of people with mental illness and histories of homelessness. Similarities and differences in the perceived impacts of services on recovery between currently and formerly homeless participants were also explored.
Method: In-depth interviews were conducted with 52 currently and formerly homeless people with mental illness. Informed by a recovery framework, qualitative data were analyzed using two cycles of coding.
Results: Services were perceived to affect recovery by (1) finding ways to cope and get by, (2) feeling less alone, (3) giving back, (4) being dehumanized or seen as someone and (5) encountering restrictions when getting help. Experiences of discrimination, fewer opportunities to give back and limited service options were heightened among participants experiencing homelessness compared to the housed group.
Conclusion: Health and social services can promote and hinder recovery among currently and formerly homeless people with mental illness. Despite several differences between the two groups, the relationship between recovery and service use was similar for currently and formerly homeless participants, suggesting that both groups access services to address needs related to social connection, health and functioning and meaningful activities.

Keywords

Recovery, mental illness, homelessness, service use, qualitative research

Introduction

The recovery paradigm has reformed mental health policy around the world over the last 30 years (Pincus et al., 2016). Despite its proliferation as the guiding vision for mental health systems, consensus on the definition of recovery has been elusive (Ellison et al., 2018). The differing conceptualizations have been described as 'recovery from' versus 'recovery in' mental illness (Davidson & Roe, 2007). In the former, recovery involves symptom management and amelioration to a pre-illness state, whereas recovery in mental illness refers to people living their lives and pursuing personal hopes and aspirations despite ongoing illness. Still, for the most marginalized people with mental illness, neither conceptualization may fully capture the recovery process.

Rates of housing instability and unemployment are disproportionally higher among people with mental illness than in the general population (Folsom et al., 2005; Marwaha & Johnson, 2004). Despite this, conceptualizations of recovery have largely neglected how poverty may restrict people from living the lives that they want (Padgett et al., 2016; Sylvestre et al., 2018). For example, research has shown that homelessness and adulthood victimization are detrimental to recovery (Castellow et al., 2015; Karadzhov et al., 2020; Kerman, Sylvestre, et al., 2019; Stumbo et al., 2015). Further, the stability provided by safe and affordable housing, with the necessary supports, can be the foundation to recovery for people with serious mental illness (Kirkpatrick & Byrne, 2009; Padgett, 2007; D. P. Watson & Rollins, 2015). Supported housing may also foster recovery by enabling

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people with mental illness to construct new identities and meaning in life; foster choice and control; and reconnect with families, friends and communities (Piat et al., 2019; J. Watson et al., 2018). As such, housing with supports can be a catalyst for recovery; however, less is known about the recovery processes of people with mental illness during homelessness.

A range of services has been developed to meet the complex and varied needs of people experiencing homelessness. However, past research has minimally examined the effects of service use on recovery among homeless people with mental illness (Kerman et al., 2016). In addition, services may also hinder recovery when people have negative experiences or their needs are not met. People experiencing homelessness commonly encounter a range of barriers to accessing and receiving adequate health care (e.g., lacking identification, feeling stigmatized, being neglected or overlooked; Hwang, 2001; Kerman, Gran-Ruaz, et al., 2019; Martins, 2008; Wise & Phillips, 2013). Negative service experiences and access barriers may further limit the available treatment and care options, thereby impeding recovery. As such, there is a critical need to better understand the role of health and social services in the recovery processes of people with mental illness and histories of homelessness.

This qualitative study investigated how currently and formerly homeless (hereinafter referred to as 'housed') people with mental illness viewed their service use to be helpful or unhelpful to their recovery. Accordingly, two research questions were addressed: (1) How do participants perceive services as affecting their recovery? and (2) Do the perceptions of homeless and housed participants differ on the relationship between service use and recovery? For this study, recovery was conceptualized as an individualized process toward living a full and meaningful life that may or may not involve an improvement in mental health symptoms.

Method

Recruitment and sample

This study used a convenience sample comprising of adults with mental health problems who were homeless or housed. Inclusion criteria were (1) a diagnosis of a mental disorder or acknowledgment of a mental health problem (i.e., self-report), (2) currently or formerly homeless (i.e., one or more nights spent in an emergency shelter or on the street during their lifetime), (3) 18 years or older and (4) fluency in English. Participants were recruited using recruitment posters via an emergency shelter, a supportive housing program, and an intensive case management team located in a large Canadian city.

Of the 54 participants who took part, two were excluded from the analysis (one withdrew and one had poor quality and unreliable data). Data from 52 participants (homeless: $n=26$; housed: $n=26$) were analyzed. All participants provided written informed consent and received a CAD $25 honorarium. The study was approved by the research ethics board of the authors' institution.

Data collection

In-depth interviews using a three-part, semi-structured guide were completed with participants. The first part elicited narratives from participants related to their service use (e.g., 'Can you tell me about a time when you used a service with which you had a very positive experience?'). Part two of the interview explored the impacts of participants' current service use (e.g., 'What do these services allow you to do in life?' 'What parts of your life do the services that you use not help with?'). Using a mental health recovery framework informed by Davidson et al. (2005) and Jacobson and Greenley (2001), the third part of the interview involved a discussion of if and how the services that participants used were helpful to fostering recovery (e.g., 'How do the services that you use help you to feel hopeful about life and things to come?'). A contact summary, as outlined by Miles et al. (2014), was completed after each interview to document salient information related to the study's research questions, unclear parts of the interview and any comments on data quality. On average, interviews were slightly longer than 75 minutes and each was audio-recorded. A survey was also completed with participants to gather information on their gender, age, housing, mental health, substance use and medical conditions.

Data collection occurred in two phases between October 2016 and October 2017. The first phase involved interviews with 15 participants to gain an initial sense of how people perceive the role of services in their lives, as well as how services were linked to components of recovery. The interviews were then transcribed, and the quality and content of the data were evaluated. This process helped to determine whether the study methods were suitable for exploring the research questions and if changes were needed. Small changes were subsequently made to the data collection materials (e.g., minor wording changes, addition of follow-up interview guide questions). The second phase of data collection then commenced with the revised tools. Summaries were also developed for each interview during the second phase of data collection.

Data analysis

All interviews were transcribed verbatim and then uploaded into NVivo 11 for analysis. A start list of deductive, recovery-related codes was then developed based on common components of recovery (Davidson et al., 2005; Jacobson & Greenley, 2001). Data analysis followed the

procedures of first and second cycle coding as outlined by Saldaña (2013). First cycle coding involved line-by-line, descriptive coding of each transcript. Throughout the first cycle, provisional codes were modified and expanded, and additional codes and subcodes were added. Second cycle coding involved pattern coding to reorganize and condense data into a smaller list of broader categories and themes (Miles et al., 2014). All coding was completed by the lead author. To ensure the credibility of the themes and completeness of the findings, these were then compared to the summaries of each interview.

Results

The background characteristics of the sample are displayed in Table 1. Thematic analysis identified five themes related to how participants perceive health and social services as affecting their recovery (see Table 2). Services had mostly positive impacts with regard to several recovery themes, such as finding ways to cope and get by, feeling less alone and giving back. In contrast, the theme of being dehumanized or seen as someone involved polarizing service experiences. The final theme, encountering restrictions when getting help, highlighted how service systems impeded recovery. Each theme was present in the transcripts of homeless and housed participants, though there were a few differences in the prominence of certain subthemes between the two groups. A total of 18 participants are represented in the 25 quotes presented in the results.

Theme 1: finding ways to cope and get by

Mental health services had an important role in helping participants to cope with their symptoms and living environments. Having access to medications and learning coping strategies were identified as two ways that services were helpful. Pharmacological interventions were needed for a range of difficulties, including stabilizing mood, managing chronic pain, preventing withdrawal symptoms and sleeping in a communal emergency shelter. Drawbacks were also raised by some participants who described long periods of feeling imprisoned by their medications. Said one housed participant of being on methadone for 25 years, 'It gives you that freedom [to function] but it also takes it away because you're dependent on it. It's like liquid handcuffs'. As for coping, participants reported that they had learned skills in therapy and counseling that were useful for their recovery. Being able to use learned coping skills wherever and whenever was also highlighted as facilitating a sense of control, especially by housed participants: 'To be the one who had the skills and executed them . . . I found that really, really empowering because I didn't have to rely on anyone else to do it once I learned the skills'.

Participants viewed direct service providers as instrumental in fostering hope through encouragement and an orientation toward the future. Words of encouragement from service providers, as well as recognizing progress, were reminders to participants experiencing homelessness that somebody believed in them and made their reality of day-to-day survival slightly more tolerable: 'It gives you that little, tiny bit of hope that, maybe, you'll get through tonight and tomorrow will be a different day'. Housed participants who were receiving ongoing support, such as intensive case management, emphasized the importance of working collaboratively with service providers to discuss future plans and goals: 'It helps feel that one day I am going to get off this stuff [methadone]. You know? One day I'm going to have a job normally again. And, maybe have another kid, I don't know. Just move on'.

Services could also have triggering environments. The availability and visible use of substances at homeless-serving

Table 1. Demographic, housing and health characteristics of sample (*N* = 52).

Characteristic	Homeless (*n* = 26)		Housed (*n* = 26)	
	n/M	*%/SD*	*n/M*	*%/SD*
Gender				
Male	14	53.8	9	34.6
Female	12	46.2	16	61.5
Transgender female	0	0	1	3.9
Age (years)	41.85	8.80	47.62	10.73
Current living situation				
Emergency shelter	26	100.0		
Supported housing			9	34.6
Social housing			8	30.8
Market rent housing			3	11.5
Supportive housing			3	11.5
Living with family or friends			2	7.7
Rooming house			1	3.8
Mental health problem				
Unipolar depressive disorder/problem	12	46.2	11	42.3
Post-traumatic stress disorder	11	42.3	8	30.8
Bipolar disorder	5	19.2	10	38.5
Anxiety disorder/problem	8	30.8	7	26.9
Attention-deficit and hyperactivity disorder	7	26.9	5	19.2
Schizophrenia	3	11.5	4	15.4
Personality disorder	4	15.4	2	7.7
Problematic substance use	17	65.4	15	57.7
Number of chronic medical conditions	1.85	2.31	2.38	3.45

SD: standard deviation.
Supported housing refers to delinked housing and support (i.e., tenants can leave their housing and retain their support services), whereas housing and support were linked in supportive housing.

Table 2. Identified themes and subthemes, and related components of recovery.

Theme	Subthemes	Components of recovery
Finding ways to cope and get by	Having skills or medication to function Being encouraged and looking ahead Abstaining from substance use at and around homeless-serving organizations	Symptom management Hope
Feeling less alone	Finding peers with shared experiences Connecting to family Having at least one person on your side	Connectedness to others Mutual support
Giving back	Helping out at a program as a volunteer or paid employee Informing service delivery and participating in advocacy	Involvement in meaningful activities and social roles
Being dehumanized or seen as someone	Being treated with or without respect Being seen as a person versus defined by a mental illness, substance use problem or living situation	Respect and acceptance Redefined self
Encountering restrictions when getting help	Having limited choice and options of treatment and care Abiding by service rules and requirements Using a service without knowing what else is available	Control and choice over life choices Self-direction

Components of recovery drawn from Ellison et al. (2018).

organizations could create problems for participants who were abstinent or working to reduce their substance use. Because housed participants had more help-seeking options than those experiencing homelessness, they were more able to avoid services that could be triggering. In contrast, some homeless participants described having no choice but to accept support from services that were triggering to them.

Theme 2: feeling less alone

Social isolation was a prominent concern among both homeless and housed participants who described similar ways in which services were beneficial for promoting connectedness. Visiting services to connect to other people with lived experience (e.g., homelessness, mental illness, problematic substance use) was a way of accessing mutual support and making friends. Self-help groups and group counseling were identified as offering support from peers who were supportive and understanding. The sharing of experiences could serve as a reminder to participants that they were not alone in what they were going through: 'Sometimes it can lift you up a little bit and realize you are not alone anymore; you're not the only one'. Emergency shelters also offered social opportunities, though some participants reported drawbacks of friendships with other people experiencing homelessness, such as risk of theft and exploitation. Further, the importance of focusing on personal issues and goals was raised: 'I try not to make a lot of friends when I come into the shelters and stuff because you have to worry about what you have to do and not what everyone else is trying to do'.

Community services also enabled some participants to connect with family, particularly when services, often libraries, offered computers and internet access. Spiritual and cultural services were another type of service that participants used to connect to family. In some cases, it was accompanying family to church and other faith groups. For others, attending spiritual and cultural services achieved closeness to deceased family: 'I go for my mom. Because my mom's dead and I miss her a lot'.

Relationships between service users and providers could also help people feel less alone. Participants pointed to the value of emotionally supportive relationships with key service providers, such as case workers, doctors or counselors, who were on their side. Said one housed participant of her mental health case manager, 'I knew that I had at least one person in my corner . . . I don't think I would have been able to go to treatment the last time, the one that helped me stay clean, without them'. The reliability of relationships with service providers during tumultuous periods of people's lives, which often involved social support losses, was also discussed: 'The one thing through all of that – my friends bailed, everybody bailed – I had that case worker'.

Theme 3: giving back

Services that offered volunteer or employment opportunities provided a way for current and former service users to give back. Housed participants described helping out at programs that were important to their own recovery: 'I am an employee of the shelter that I used to stay in. I volunteer for a not-for-profit that means something to me'. Because employment was not feasible for all given people's disabilities or work restrictions of disability income programs, some were focused on giving back through volunteering: 'What's important to me is being a part of society. So, if I can't work then I will volunteer'. Another unique way that participants gave back was through their involvement in advocacy and service delivery activities. Involvement in

program development consultations with service providers was perceived 'to strengthen bonds between service provider and recipient'.

There were fewer opportunities to give back for homeless participants due to the instability and unpredictability of daily life. However, some discussed contributing in ways that did not require commitments (e.g., cleaning and tidying up at a shelter) or were planning to give back in the future. Helping out at services during an episode of homelessness could also reinforce a sense of personhood: 'It makes you feel like you're somebody'.

Theme 4: being dehumanized or seen as someone

The interpersonal interactions involved in service use were a key part of participants' experiences that could affect their perceptions of self-worth, as well as their views of health and social services. Participants described polarizing experiences when using services that ranged from being deprived human dignity to being seen as a person and treated fairly and with respect. The verbal and nonverbal communication of service providers contributed to perceptions of the level of respect in treatment and care. Overhearing stigmatizing language and comments (e.g., 'junkie', 'street person', 'you're here again'), being spoken to in a patronizing or belittling way, perceiving favoritism and feeling ignored or dismissed were common experiences of disrespect. Although experiences of discrimination were discussed by both homeless and housed participants, homelessness was an additional and more visible reason for discrimination (e.g., being unable to provide a fixed address when completing paperwork, wearing worn clothing). Fair and respectful treatment experiences were described as an absence of disrespectful communication, being greeted with welcoming comments, the establishment of zero tolerance policies for violence and discrimination and personal care that is the same as other service users.

The importance of being seen for who people are and not being defined by a mental illness, substance use problem or living situation was also discussed. However, almost all participants described past service experiences in which they had experienced discrimination because of their health or poverty. Among participants who currently or formerly used substances, there was an expressed sense of being 'marked' at medical services. Homeless participants also described discrimination in the form of 'half-assed' treatment and care, and experiences of feeling like a number in the shelter system or not being seen as a person at all.

Despite the experiences involving stigma and discrimination, participants also described some service providers as helping them to regain or maintain their sense of personhood. This was achieved when providers knew service users' names, asked questions, were honest and expressed their concerns, made compassionate gestures (e.g., staying late to talk, offering food or a drink when meeting), saw and commented on strengths and used person-first language. Person-centered program policies and approaches, including accommodating people who are intoxicated, were also identified as helping participants to be seen for who they are.

Theme 5: encountering restrictions when getting help

Barriers to treatment and care were common experiences that could impede recovery. Participants described limited to no choice, and inflexible program rules and requirements as restrictions they experienced when accessing services. Limited treatment and care options were commonly discussed in the context of opioid substitution therapy, which could lead to a pattern of self-medication with illicit substances: 'They're trying to prescribe me other medications to help the things I'm already helping with the medications that I have chosen'. Service options were more limited for participants experiencing homelessness; however, a lack of choice was also experienced by housed participants as a result of unmet basic needs: 'Poverty line is around $18,000, we make $10,000 [on disability income] . . . I have no choice but to access the food bank or the drop-in center'.

A lack of information and transparency about available services also prevented participants from being able to make choices and achieve a sense of control in treatment and care decisions. This barrier was linked to income support programs and overworked case managers. Some participants reported that they only learned of available options when they pursued the information: 'If you don't know what you're entitled to, they won't tell you'. Uncommunicative service providers forced participants to solve problems on their own: 'You almost have to find your own answers to your own questions'. Some service users also felt unable to speak up because they were uninformed: 'You don't question that because you do not know better. It's his job, he decides'.

Program rules and requirements was another restriction of service use, which were commonly ascribed to homeless-serving organizations. Challenges arose from inflexible hours of operation and requirements for service use (e.g., attending a chapel service to receive a meal at the soup kitchen, taking psychotropic medication to receive a service). Most participants described abiding by rules out of fear of service loss. The greatest concern was being banned from a service, as this would further reduce treatment and care options. This fear could make participants feel powerless and voiceless, especially when they experienced unfair or inadequate treatment: 'If you react, you get kicked out for a day and then you have to go to another

shelter. So, there is no point in reacting to it'. Others believed that they had no right to speak up or that their concerns would be ignored: 'You have nobody to complain to because, if you do start to complain, well, you're just some homeless guy that's just crying about something that he doesn't get for free'.

Discussion

The findings from this qualitative study demonstrate how services can promote and hinder recovery among currently and formerly homeless people with mental illness. Across the themes, the interpersonal interactions between service users and providers were central to recovery. The findings align with research on community mental health service delivery that underscores the importance of positive therapeutic alliances for recovery (Kidd et al., 2017). As such, working relationships that are grounded in trust, respect, fairness and honesty are key to providing recovery-oriented care to currently and formerly homeless people with mental illness. Moreover, as many people with mental illness and histories of homelessness have limited social ties and networks (Hawkins & Abrams, 2007; Karadzhov et al., 2020; Pahwa et al., 2019), the relationships developed in service settings may partially compensate for unmet social needs.

Extending past research on the negative aspects of service delivery for people experiencing mental illness and homelessness (Kerman, Gran-Ruaz, et al., 2019; Voronka et al., 2014), limited choice and control when seeking help was perceived to impede recovery. These findings are consistent with those of other studies that have highlighted the inflexible rules and requirements of homeless sector services, which can be a barrier to accessing adequate support (Ogden & Avades, 2011; Wusinich et al., 2019). However, restrictions were also partially the result of systemic issues related to income support rates being insufficient to meet basic needs without the assistance of services and unaffordability of health care services not covered by insurance. A lack of information and transparency also undermined service users' choice and control in treatment and care. Accordingly, ensuring that service users know and understand what is available to them, as well as their rights and responsibilities, would help to reduce informational barriers. For people experiencing homelessness, service providers can work with them to foster their sense of choice and control in treatment and care by collaboratively identifying needs, helping with system navigation, providing information and discussing available services and addressing concerns related to changing services.

The perspectives of homeless and housed participants were similar, though experiences of discrimination, fewer opportunities to give back and limited service options were heightened among the homeless group. Nevertheless, the perceived ways in which services could foster or impede recovery were alike between the two groups. The findings suggest that participants in this study accessed services to address needs related to social connection, health and functioning and meaningful activities that are not bound to episodes of homelessness. Moreover, as all housed participants were receiving disability income, it is important to recognize that many individuals of this group likely continue to live in poverty – a finding that has also been identified in past research on supported housing (Henwood et al., 2015). As such, aside from housing, the recovery needs of the two groups may be quite similar.

Consistent with past research examining recovery among people with mental illness who have histories of homelessness (e.g., Choy-Brown et al., 2016; Padgett et al., 2012, 2016), participants in this study reported experiencing many adversities beyond their mental health and housing, such as substance use problems, trauma and victimization, chronic medical conditions, incarceration, sex work, social isolation and loneliness and food insecurity. As such, participants often discussed recovery more broadly, holistically considering how services affected their various challenges. Moreover, a single service experience could be linked to multiple adversities (e.g., feeling stigmatized because of substance use and homelessness). These findings would support a conceptualization of complex recovery, as proposed by Padgett et al. (2016), that refers to the cumulative adversities encountered by people with mental illness who have histories of homelessness. This broader framework is necessary for considering the interconnectedness of different adversities and the multiple service systems accessed by this population in their recovery.

The findings have key implications for change at the systems level. As previously asserted by Manning and Greenwood (2018), there is value to using a recovery-oriented approach within the homeless service system. Although housing is a foundation to recovery, homeless services can support the recovery journeys of people with mental illness during the process of finding and obtaining housing. This can be done by providing opportunities for people experiencing homelessness to be heard, emotionally supported and validated. In addition, working with service users who wish to give back and finding ways to include them in service delivery and advocacy work would help to foster meaningful social roles. As readiness for change toward a recovery orientation in the homeless sector service is low (Manning & Greenwood, 2019), mental health systems have an important capacity building role in recovery. After people exit homelessness, providing access to wraparound supports that use a trauma-informed approach, which aligns with a recovery model (Mihelicova et al., 2018), would be beneficial to addressing basic needs associated with poverty that may impede the recovery journeys of people with mental illness.

This study had several limitations. First, because a convenience sample was used and completion of the study took approximately 75–90 minutes, it is possible that participants' level of functioning was above average for this population. Second, the study had a qualitative design, with participants being interviewed only once. As a result, housed participants may have had different service experiences during homelessness than the participants in the homeless group. Third, all homeless participants were recruited from an emergency shelter and few housed participants described past episodes of unsheltered homelessness. Because of this, the findings may be less representative of people with histories of unsheltered homelessness. Fourth, this study did not measure participants' level of recovery. It is likely that participants had different recovery journeys, which may have shaped their perceptions of how services affect recovery. Future research should consider examining the role of services in the lives of adults with mental illness and histories of homelessness who are at different levels of recovery.

Conclusion

Health and social services promoted the recovery of currently and formerly homeless people with mental illness by helping them to find ways of cope and get by, providing opportunities for socialization and connection and making available opportunities to contribute and give back. Although services could also have positive impacts on recovery by seeing service users for who they were, too commonly this was not the case as participants often felt defined by their health conditions or living situations when accessing services. Restrictions related to seeking help also impeded recovery. Findings differed minimally between the two groups, suggesting that formerly homeless participants may continue to live in poverty and have similar service experiences as those who are homeless. Moreover, as participants described experiencing multiple life adversities, a broader conceptualization of recovery is beneficial for understanding the helpfulness of services in promoting recovery for this population.

Funding

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References

Castellow, J., Kloos, B., & Townley, G. (2015). Previous homelessness as a risk factor for recovery from serious mental illness. *Community Mental Health Journal*, *51*, 674–684. https://doi.org/10.1007/s10597-014-9805-9

Choy-Brown, M., Padgett, D. K., Smith, B. T., & Tiderington, E. (2016). Sorting it out: Eliciting consumer priorities for recovery in supportive housing. *American Journal of Psychiatric Rehabilitation*, *19*, 223–234. https://doi.org/10.1080/15487768.2016.1197862

Davidson, L., O'Connell, M. J., Tondora, J., Lawless, M., & Evans, A. C. (2005). Recovery in serious mental illness: A new wine or just a new bottle? *Professional Psychology: Research and Practice*, *36*, 480–487. https://doi.org/10.1037/0735-7028.36.5.480

Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, *16*, 459–470.

Ellison, M. L., Belanger, L. K., Niles, B. L., Evans, L. C., & Bauer, M. S. (2018). Explication and definition of mental health recovery: A systematic review. *Administration and Policy in Mental Health and Mental Health Services Research*, *45*, 91–102. https://doi.org/10.1007/s10488-016-0767-9

Folsom, D. P., Hawthorne, W., Lindamer, L., Gilmer, T., Bailey, A., Golshan, S., . . . Jeste, D. V. (2005). Prevalence and risk factors for homelessness and utilization of mental health services among 10,340 patients with serious mental illness in a large public mental health system. *American Journal of Psychiatry*, *162*, 370–376.

Hawkins, R. L., & Abrams, C. (2007). Disappearing acts: The social networks of formerly homeless individuals with co-occurring disorders. *Social Science & Medicine*, *65*, 2031–2042. https://doi.org/10.1016/j.socscimed.2007.06.019

Henwood, B. F., Derejko, K.-S., Couture, J., & Padgett, D. K. (2015). Maslow and mental health recovery: A comparative study of homeless programs for adults with serious mental illness. *Administration and Policy in Mental Health and Mental Health Services Research*, *42*, 220–228. https://doi.org/10.1007/s10488-014-0542-8

Hwang, S. W. (2001). Homelessness and health. *Canadian Medical Association Journal*, *164*, 229–233.

Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services*, *52*, 482–485. https://doi.org/10.1176/appi.ps.52.4.482

Karadzhov, D., Yuan, Y., & Bond, L. (2020). Coping amidst an assemblage of disadvantage: A qualitative metasynthesis of first-person accounts of managing severe mental illness while homeless. *Journal of Psychiatric and Mental Health Nursing*, *27*, 4–24. https://doi.org/10.1111/jpm.12524

Kerman, N., Gran-Ruaz, S. M., Lawrence, M., & Sylvestre, J. (2019). Perceptions of service use among currently and formerly homeless adults with mental health problems. *Community Mental Health Journal*, *55*, 777–783. https://doi.org/10.1007/s10597-019-00382-z

Kerman, N., Sylvestre, J., Aubry, T., Distasio, J., & Schütz, C. G. (2019). Predictors of mental health recovery in homeless adults with mental illness. *Community Mental Health*

Journal, *55*, 631–640. https://doi.org/10.1007/s10597-018-0356-3

Kerman, N., Sylvestre, J., & Polillo, A. (2016). The study of service use among homeless persons with mental illness: A methodological review. *Health Services and Outcomes Research Methodology*, *16*, 41–57. https://doi.org/10.1007/s10742-016-0147-7

Kidd, S. A., Davidson, L., & McKenzie, K. (2017). Common factors in community mental health intervention: A scoping review. *Community Mental Health Journal*, *53*, 627–637. https://doi.org/10.1007/s10597-017-0117-8

Kirkpatrick, H., & Byrne, C. (2009). A narrative inquiry: Moving on from homelessness for individuals with a major mental illness. *Journal of Psychiatric and Mental Health Nursing*, *16*, 68–76. https://doi.org/10.1111/j.1365-2850.2008.01331.x

Manning, R. M., & Greenwood, R. M. (2018). Microsystems of recovery in homeless services: The influence of service provider values on service users' recovery experiences. *American Journal of Community Psychology*, *61*, 88–103. https://doi.org/10.1002/ajcp.12215

Manning, R. M., & Greenwood, R. M. (2019). Understanding innovation in homeless service provision: A study of front-line providers' values-readiness for change. *Administration and Policy in Mental Health and Mental Health Services Research*, *46*, 649–659. https://doi.org/10.1007/s10488-019-00943-0

Martins, D. C. (2008). Experiences of homeless people in the health care delivery system: A descriptive phenomenological study. *Public Health Nursing*, *25*, 420–430. https://doi.org/10.1111/j.1525-1446.2008.00726.x

Marwaha, S., & Johnson, S. (2004). Schizophrenia and employment: A review. *Social Psychiatry and Psychiatric Epidemiology*, *39*, 337–349. https://doi.org/10.1007/s00127-004-0762-4

Mihelicova, M., Brown, M., & Shuman, V. (2018). Trauma-informed care for individuals with serious mental illness: An avenue for community psychology's involvement in community mental health. *American Journal of Community Psychology*, *61*, 141–152. https://doi.org/10.1002/ajcp.12217

Miles, M. B., Huberman, A. M., & Saldaña, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.). SAGE.

Ogden, J., & Avades, T. (2011). Being homeless and the use and nonuse of services: A qualitative study. *Journal of Community Psychology*, *39*, 499–505. https://doi.org/10.1002/jcop.20433

Padgett, D. K. (2007). There's no place like (a) home: Ontological security among persons with serious mental illness in the United States. *Social Science & Medicine*, *64*, 1925–1936. https://doi.org/10.1016/j.socscimed.2007.02.011

Padgett, D. K., Smith, B. T., Henwood, B. F., & Tiderington, E. (2012). Life course adversity in the lives of formerly homeless persons with serious mental illness: Context and meaning. *American Journal of Orthopsychiatry*, *82*, 421–430. https://doi.org/10.1111/j.1939-0025.2012.01159.x

Padgett, D. K., Tiderington, E., Smith, B. T., Derejko, K.-S., & Henwood, B. F. (2016). Complex recovery: Understanding the lives of formerly homeless adults with complex needs.

Journal of Social Distress and the Homeless, *25*, 60–70. https://doi.org/10.1080/10530789.2016.1173817

Pahwa, R., Smith, M. E., Yuan, Y., & Padgett, D. (2019). The ties that bind and unbound ties: Experiences of formerly homeless individuals in recovery from serious mental illness and substance use. *Qualitative Health Research*, *29*, 1313–1323. https://doi.org/10.1177/1049732318814250

Piat, M., Seida, K., & Padgett, D. (2019). Choice and personal recovery for people with serious mental illness living in supported housing. *Journal of Mental Health*. Advance online publication. https://doi.org/10.1080/09638237.2019.1581338

Pincus, H. A., Spaeth-Rublee, B., Sara, G., Goldner, E. M., Prince, P. M., Ramanuj, P., & Patton, L. (2016). A review of mental health recovery programs in selected industrialized countries. *International Journal of Mental Health Systems*, *10*, Article 73. https://doi.org/10.1186/s13033-016-0104-4

Saldaña, J. (2013). *The coding manual for qualitative researchers* (2nd ed.). SAGE.

Stumbo, S. P., Yarborough, B. J. H., Paulson, R. I., & Green, C. A. (2015). The impact of adverse child and adult experiences on recovery from serious mental illness. *Psychiatric Rehabilitation Journal*, *38*, 320–327. https://doi.org/10.1037/prj0000141

Sylvestre, J., Notten, G., Kerman, N., Polillo, A., & Czechowski, K. (2018). Poverty and serious mental illness: Toward action on a seemingly intractable problem. *American Journal of Community Psychology*, *61*, 153–165. https://doi.org/10.1002/ajcp.12211

Voronka, J., Wise Harris, D., Grant, J., Komaroff, J., Boyle, D., & Kennedy, A. (2014). Un/helpful help and its discontents: Peer researchers paying attention to street life narratives to inform social work policy and practice. *Social Work in Mental Health*, *12*, 249–279. https://doi.org/10.1080/15332985.2013.875504

Watson, D. P., & Rollins, A. L. (2015). The meaning of recovery from co-occurring disorder: Views from consumers and staff members living and working in housing first programming. *International Journal of Mental Health and Addiction*, *13*, 635–649. https://doi.org/10.1007/s11469-015-9549-y

Watson, J., Fossey, E., & Harvey, C. (2018). A home but how to connect with others? A qualitative meta-synthesis of experiences of people with mental illness living in supported housing. *Health and Social Care in the Community*, *27*, 546–564. https://doi.org/10.1111/hsc.12615

Wise, C., & Phillips, K. (2013). Hearing the silent voices: Narratives of health care and homelessness. *Issues in Mental Health Nursing*, *34*, 359–367. https://doi.org/10.3109/01612840.2012.757402

Wusinich, C., Bond, L., Nathanson, A., & Padgett, D. K. (2019). 'If you're gonna help me, help me': Barriers to housing among unsheltered homeless adults. *Evaluation and Program Planning*, *76*, 101673. https://doi.org/10.1016/j.evalprogplan.2019.101673