University of Alberta

The Lived Experiences of Men Residing in an Inner City Shelter for the Homeless

by

Anne Marie Shand

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Science.

Department of Occupational Therapy

Edmonton, Alberta

Fall 2004

Your file Votre référence
ISBN: 0-612-95850-7
Our file Notre référence
ISBN: 0-612-95850-7

Dedication

To my husband Ken for his support and the pride he took in my personal growth and academic endeavors.

To my children Angie and Wesley and his girl friend Amanda for the support I felt from them.

To my mom (Marie Yeo) who demonstrated to me by having lived her eighty years on her own terms that I can live my life with my own sense of style and humour as she did.

Acknowledgements

To the residents, director, staff and board members at WWH who provided me with an invaluable set of lenses to look beyond my previous limited view of the world.

To Professor Sharon Brintnell, my thesis supervisor who laid the foundation that made the qualitative research process and its rich experience possible for me.

To Dr. Vivien Hollis, my committee member for helping me put my ideas into words.

To Dr. Steven Dennis, my committee member for his enthusiasm and encouragement.

Table of Contents

Page

Table of contents

Table of contents

Page

Table of contents

Table of Contents

Page

Table of Contents

List of Figures

Chapter I - Introduction

Weather Worn Home and People who are "Hard to House"

In 1981, the Weather Worn Home (WWH) Housing Society was established as a cooperative effort by inner city agencies to address the need for a homeless shelter for males in the inner city. The Minister of Social Services and Community Health approved the proposal for a facility licensed to house 69 homeless males 18 years and older. In 1982, staff members were hired, a board of directors was elected to administer WWH and the shelter began operations (Weather Worn Home unpublished brochure).

WWH's mandate encapsulates its intent, "To provide shelter and housing for all in need for whom there is no other facility immediately available or for whom there is no other appropriate facility" (Brinsmenad, Bubel and Devam, circa 2000, p4). These are the hard-to-house individuals who are unable to find suitable housing on their own or have been evicted from many other environments. They have been unable to hold down jobs, are frequently without a steady income and/or require assistance with basic living skills such as cooking, cleaning, personal hygiene etcetera. Their difficulties arise out of unacceptable behaviours and/or the frequent incidents of crises in their lives because of chronic substance abuse and/or mental illnesses.

The objectives of WWH include providing shelter and meals in a safe and secure setting i.e., locked doors at night, 24 hours a day staff supervision and hourly house checks. The staff also acts as a liaison with other inner city agencies in order to provide the necessary medical, legal, financial, employment and social assistance required by the

residents (Brinsmenad, Bubel and Devam, circa 2000). The objectives are carried out in the context of an "environment" conducive to the nature and preferences of the residents.

There are many facilities referred to as "shelters" in the inner city that provide accommodation for indigent persons. Some of these facilities are operated by religious agencies, some by secular ones. WWH differs from other shelters because of its long-term supportive residency option and the application of a harm reduction philosophy that recognizes the reality of the residents' persistent use of substances of abuse. The monitoring of the residents' health and safety and harm reduction strategies such as, having alcohol (locked up on the premises) available for physically fragile residents to help avert life threatening seizures and withdrawal reduce the risk of harm to the residents.

I first came upon WWH in the year 2000 while investigating resources in the inner city for work related reasons. Although WWH is defined as a shelter for government funding and the residents are included in the homeless count as the sheltered homeless there appeared to be more to the facility than a run down structure sheltering homeless individuals from the outside elements. The word "successful" could refer to the effectiveness of WWH in creating an environment within a larger environment (inner city) that addresses the hard-to-house as stated in its mandate. In fact, an indicator attesting to WWH's success in meeting its mandate could be seen as the facility's ability to obtain funding for a new building.

During the data gathering time of the study the shelter was housed in a building originally designed as a warehouse. Since that time the construction of a 2.914 million dollar building to replace the existing facility was approved, funded and completed

(Brinsmenad, Bubel and Devam, circa 2000). The residents and staff have moved to the new facility. Both of these old and new buildings are located in the inner city.

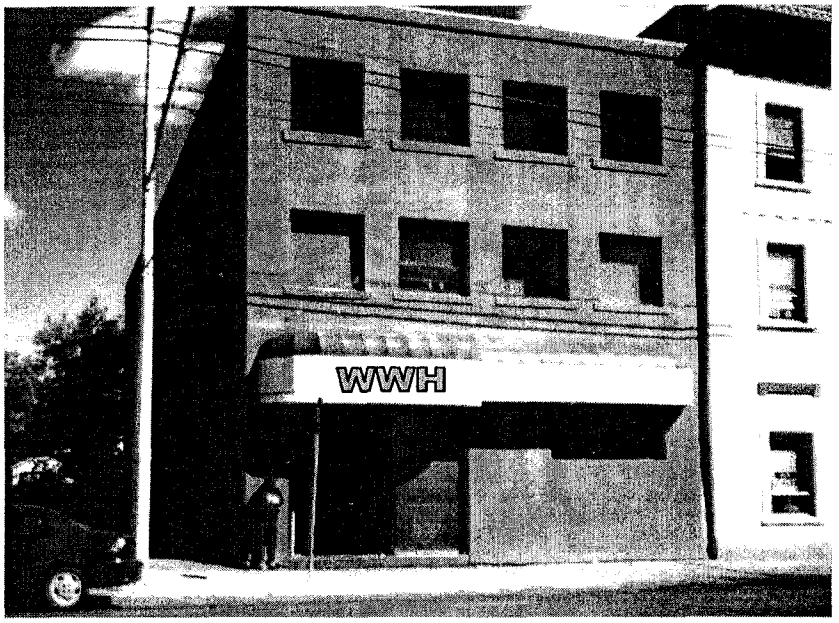

Figure 1-1. Original Weather Worn Home

Figure 1-2. Construction of New Facility

Purpose of the Study

Being successful in engaging the hard-to-house population in treatment and/or stable housing can be defined from several perspectives depending on the values and beliefs of an individual or the organization. WWH operates from a philosophy of non-judgmental acceptance and support, that philosophy in turn creates an environment that appears to nurture a sense of belonging and security for the residents. This philosophy is reflected in the staff's intervention with residents, which is based on validating each resident as an individual, respecting their rights to make choices for themselves, and understanding their struggles and limitations.

The staff's approach to the residents may be seen as contributing to seventy-five percent of the residents being permanent and living at WWH for a minimum of one year to a maximum of fifteen years (Brinsmenad, Bubel and Devam, circa 2000). Many of the residents were previously trapped in a cycle of homelessness punctuated by frequent crisis interventions in the healthcare, legal and social systems. Several of these individuals have been expelled from/or leave other facilities and it is a criterion of success that they remain at WWH. The criterion, however, does not capture the uniqueness of this residence, nor how it creates an atmosphere that is a safe and accepting place for the hard-to-house. Most important of all, it does not capture that appraisal of success which is least often sought but most important for the future of the facility—the appraisal of the clients themselves.

Therefore, the purpose of this study was to understand the residents' experiences of residing in a place that was assumed to address their needs successfully. Because the concept of "success" was not in the collective consciousness of the residents, success was

operationalized through interview questions based on WWH's mandate and objectives. Through the residents' lived experiences of WWH, the meaning of success for WWH as a residence from the residents' perceptions was addressed.

The study used a phenomenological approach to bring meaning to the residents' experiences of living in a setting that meets their criteria for safety and acceptance as a residence. The residents' personnel experiences allow potential readers to step into the reality of the residents' lives and understand the residents' lived experiences that account for their view of WWH's success (van Manen, 2002). By seeing life through the residents' meaning of the phenomenon, insights were gained into how they think and feel about their lives.

> But how can we understand something that we have not experienced ourselves? One useful approach is to employ the theme of sameness and differences. We need to examine how people differ by being attentive to what we share in common, by showing how we are different through sameness. In doing so phenomenology does not offer special theories that explain either being healthy or being disturbed. Rather phenomenology seeks to understand how insights into our ordinary or healthy existence can help us understand in what ways existence can be disturbed and become extraordinary (van Manen, 2002. p.61).

Significance of the Study

A preliminary review of the literature revealed that few studies have examined individuals such as WWH's residents who are resistant to conventional residential housing and/or treatment approaches and expectations. I found minimal information on shelters like WWH that use similar management strategies such as harm reduction, long term residency and non-intrusive interventions in addition to promoting an attitude of acceptance and respect (Lamb, 1984). There are few researchers who advocate the value in studying more flexible residential housing and/or treatment programs that support residential stability with expectations adapted to specific subgroups comparable to WWH's residents (Cournos 1987; Goldfinger, Schutt, Tolomiczenko, Seidman, Penk, Turner, Caplan, 1999; Lipton, Siegal, Hannigan, Samuels, Baker, 2000). A study of WWH, a setting that focuses on changing the environment to meet the needs of the residents rather than changing the residents to conform to conventional societal expectations, may provide insight into adaptable and effective management strategies for this often neglected group of inner city occupants.

Understanding the residents' thoughts and feelings about their lives and what is important to them about where they live may lead to the development of new models of care and housing. By asking WWH residents about their perceptions of a successful residency, a partnership between people providing services and those individuals receiving services was being recognized as important in determining future resources and their utilization. Because the majority of residents at WWH are afflicted by chronic substance abuse and/or mental illnesses, they require supports in the social and health care systems (Brinsmenad, Bubel and Devam, circa 2000). Therefore, this study will be

useful both for social and healthcare professionals working in the field and for those who are developing social policy. The insights gained are critical both to the understanding of health and illness behaviours and to the planning and implementation of social and health care programs appropriate to populations similar to the residents at WWH.

Chapter II - Literature Review

The intent of this chapter is to highlight some of the critical issues around homelessness and programming required for the homeless, especially populations similar to Weather Worn Home (WWH) residents. Most of the residents at WWH are between the ages of 46 and 64. Although not all residents have been assessed formally by healthcare professionals, the majority of the residents have substance abuse disorders. They have been referred to WWH from hospitals, police, other agencies and self-referrals (Brinsmenad et al., circa 2000). Because of the residents' recognized dysfunctional behaviours and/or functional impairments, and as there is limited studies of their experiences, the literature review will include studies on populations similar to WWH.

Homelessness

Understanding the Homeless

Canada and the United States are estimated to have a homeless count of 130,000 to 250,000 Canadians and 13.5 million Americans with no solution to this universal struggle in sight (Begin & Saoub, 1991; Link, Susser, Struere, Phelan, Moore, Strueining; 1994). Several researchers have identified homelessness as an escalating problem for those with substance abuse and/or mental illnesses who have difficulties engaging in treatment and remaining in stable housing (Hagen, 1988; Lipton, Nutt, Sabatini, 1988; Carling, 1993; Schutt & Goldfinger, 1996; Goldsmith, 1999). Individuals with mental illnesses such as schizophrenia and co-morbid substance abuse experience serious problems in their ability to maintain stable housing (Hurlburt, Hough, Wood, 1996; Schutt & Goldfinger, 1996). The presences of severe functional deficits add to the

high risk of being homeless (Goldsmith, 1999; Olfson, Mechanic, Hansell, Boyer, Walkup, 1999). Vulnerability to homelessness is also escalated by lack of support from family and friends and social and health care services (Lipton et al., 1988; Bachrach, 1992; Goldsmith, 1999; Olfson et al., 1999; McCabe, Macnee, Anderson, 2001).

Estimates of the proportion of homeless individuals with mental illnesses and/or substance abuse is quite variable with percentages ranging from approximately twenty to eighty percent of a study's participants (Bachrach, 1992; Goldfinger, et al., 1999). Researchers face methodological challenges because of the diverse characteristics of homeless people making it difficult to generalize to the overall homeless population. Biases are inherent in many of these studies because of the sampling techniques used and difficulty tracking transient homeless individuals. For example, studies in specific geographic areas on this population include only homeless sheltered individuals and not individuals living in cars, parks, and river valleys (Bachrach, 1992; Eggins, 2000).

The proportion of mental illnesses in the homeless population can be overestimated by attributing their behaviours to the disabling conditions of substance abuse and/ or mental illnesses rather than as a result of the severe and overwhelming social and internal stressors of being homeless such as residential instability, exposure to harsh environmental elements i.e., street violence and severe weather conditions, and feelings of loneliness and isolation (Bacharach, 1992; Bottomley et al., 2001)

Bottomley et al. (2001) phenomenological study of the elderly homeless provides the reader with an emotional and mental awareness of the stressors and experiences of homelessness. This elderly woman's account of her lived experiences of homelessness illuminates the reality of her existence.

> Staying on the street for over twelve hours a day I sit in the public library and on park benches sometimes. Staying awake with nothing is a special problem. You are not permitted to sleep in the library and I don't dare fall asleep on a park bench for fear that someone will steal my bags or some policeman would arrest me for vagrancy. It's the mornings when I have to leave the shelter that being homeless hits me the hardest. You can't decide what to do because it doesn't matter what you do. You're not needed anywhere, not wanted anywhere, and not expected anywhere. Nobody cares what you do as long as you don't lay down
> (Bottomley et al., 2001. p. 58).

Researchers have attempted to understand the sequence of events leading to substance abuse, mental illnesses, or both at once on the one hand and homelessness on the other hand by looking at what comes first: homelessness as a consequence of job loss and economic hardships contributing to substance abuse and/or mental illnesses or an innate predisposition to substance abuse and/or mental illnesses contributing to homelessness. Retrospective studies have not drawn any definitive conclusions on how people end up homeless. It is difficult for people to retrieve chronological and accurate memories of significant events in their lives that lead to them being homeless (Johson & Freels, 1997; Stuart & Arboleda-Fiorez, 2000). An expansive study on the homeless population in Calgary could not come up with any definitive reasons for why people end up homeless. Instead they found a number of different reasons that were non-linear and intertwining that included shortages of affordable housing, low paying occupational

skills, illnesses and family breakups. These factors contribute to a wide range of social, emotional and financial vulnerabilities that face this population (Stuart & Arboleda-Fiorez, 2000).

Another obstacle to understanding the characteristics of the homeless population is the absence of an accepted definition of homelessness. Terms such as absolute, literal and sheltered homelessness have taken on different meanings depending on the researcher's use of the term (Lipton, Nutt, Sabatini, 1988; Bachrach, 1992). Researchers are also challenged by the evolving changes in the homeless population from "older male skid row alcoholics" to recently identified new cohorts of homeless which include younger people, women with children and individuals with heterogeneous mental illnesses and/or substance abuse (Hagen, 1989; Johson & Freels, 1997). They may not necessarily live in the inner city core or "skid row" (Hagen, 1989; Johson & Freels, 1997).

Studies have shown that the homeless cannot be easily categorized and do not fit into a single stereotypical picture (Bachrach, 1992; Bottomley, Bissonnette, Snekvik, 2001). The stereotypical image of a homeless person is erroneous because it does not account for the diverse characteristics, values and needs of homeless people. Homeless and non-homeless individuals are not discrete groups as both have overlapping issues such as mental illnesses and/or substance abuse. A simplistic view of the homeless is flawed and misleading (Bachrach, 1992; Bottomley et al., 2001). Therefore studies of the characteristics of the homeless and theories on the etiology of homelessness need to be cautiously interpreted when planning residential programs and social policies for the homeless (Bachrach, 1992; Bottomley et al., 2001).

Programs for the Homeless

Residential stability in addition to abstinence from substance abuse were typically identified as successful programming outcomes for the homeless population afflicted with addictions (Conrad, 1988; Hagen, 1988; Lipton et al., 1988; Flanagan, Doyle, Brown, Larkin, O'Callaghan, 2000; Lipton, Siegel, Hannigan, Samuels, Baker, 2000). Although these outcomes were accomplished for several participants in studies of residential treatment programs, there were a significant number of individuals who did not meet traditional program goals. Many persons were either excluded from the residential treatment intervention studied because of attributed lack of motivation for treatment, organic mental illnesses and history of violence or if included relapsed and/or dropped out (Lipton et al., 1988; Hurlburt et al., 1996; Jason, Ferrari, Smith, March, Dvorchak, Groessl, 1997; Nuttbrock, Rahav, Rivera, Ng-Mak, Link, 1998). They became invisible, voiceless and lost. However, society still needs to know, deal and live with this hidden population.

A significant issue for the homeless population is the lack of individualized services (Hagen, 1989; Bachrach 1992; Hagen, 1993; Goldfinger, 1997). Relevant low cost housing needs to be balanced with other services in order to address the diverse and complex issues of the homeless (Lipton et al., 1988; Goldfinger et al., 1999). The likelihood of continued participation in treatment is reduced when housing is lacking or erratically accessed. Patients with schizophrenia who have difficulties with planning and organizing are at increased risk of homelessness and decompensating mental status if their discharge planning is lacking in residential and other community supports (Olfson et al., 1999).

Innovative approaches to dealing with the diverse issues amongst the homeless are needed. For example, Nuttbrock et al. (1998) addresses the ineffectiveness of historically having two different systems of treatment for individuals with mental illnesses and co-morbid substance abuse. They advocate the need for an effective integrated approach to treating individuals with mental illnesses and co-morbid substance abuse in order to improve their functioning, thereby reducing the risk of homelessness.

Researchers have expressed concerns about the underutilization of social and health care services by the homeless (Lam & Rosenheck, 2000; McCabe et al., 2001). Their concerns are reflected in the serious health problems seen/identified in this population (Kasprow & Rosenheck, 2000). Studies have shown that not all homeless people benefit from the services available and may appear to ignore and reject the offering of services (Cournos, 1987; Lipton et al., 1988; Goldfinger et al., 1999; McCabe et al., 2001). Obstacles to getting support may be the lack of social and healthcare services receptive to the realities of life amongst the homeless. Barriers to servicing this population consist of their fear and/or inability to access and negotiate resources because of cognitive impairments and/or the expectation of being judged (Lipton et al., 1988; Cohen, 1994; Bottomley et al., 2001; McCabe et al., 2001). Researchers need to focus on studying innovative approaches to dealing with the homeless such as promoting services with accepting social attitudes in the environments where the homeless congregate (Cournos, 1987, Lipton et al., 1988). There is a need for research on essential safe, accepting and adaptable programs for the homeless, which means using non-traditional benchmarks of success (Bachrach, 1992). The following reflection by a homeless woman

with schizophrenia epitomizes the need for a flexible and multifaceted service system to address the diverse and complex needs of the homeless.

> In my view the big mistake people make in trying to help the homeless is that they expect, or hope that one single solution will solve the problems of all of us... in fact the solution for one of us can spell disaster for another. Low cost housing for example is a wonderful idea for many of us. Yet that solution would be no more than a sentimental gesture for women who throw rolls of toilet paper down the toilet or, forgetting to take their tranquilizers, tear off refrigerator doors (Bachrach, 1992. p455).

Without an understanding of what community supports are meaningful to the homeless, services become unresponsive to their needs (Lipton et al., 1988; Knisley & Fleming, 1993; Tanzman 1993; Srebnik, Livingston, Gordom, King, 1995). Therefore, it is crucial for service providers to make the extra effort to listen to the individual voices of the homeless. The understanding of homeless individuals, who they are, what their identifying needs are and how they relate to their situation is not well understood. To reduce the pain of their existence and society's care burden there is a need to live their experience vicariously so that more sensitive and meaningful support and programs can be put in place. A phenomenological approach to exploring their lifestyle and attitudes towards support services provides this opportunity as illustrated by the following lived experience of the meaning of homelessness and support to a homeless woman with a mental illness.

> Someone who has been on the streets and is homeless and jobless and who has a disability, who doesn't have a car or a friend and doesn't know what to do with their situation, is in pain. Most people would probably agree that if given a choice they would trade that level of emotional pain for some good old-fashioned physical hurt anytime. But there is no choice. If you talk to someone who has been there, they will tell you they were alone and afraid. So afraid that help doesn't look like help, but like more torture (Bachrach, 1992. p462).

Summary

The literature review suggests that the personal experiences of homeless individuals in the context of their background and environment need to be considered when looking at enhancing their functioning and the meaning and quality of their lives. However, there appears to be limited attention in the literature as to what is meaningful for the hard-to-house that would enhance understanding of what is needed when planning programs. Therefore, it is of interest to study an agency that services the hard-to-house and facilitates cooperation from its clients.

Chapter III – Research Method

Methodology-Phenomenology

The study was designed to uncover the residents' lived experiences of Weather Worn Home (WWH) in meeting their needs as residents. A qualitative research design was selected because it was important to hear the residents' voices. A qualitative study undertaken in a natural setting was used to elicit the residents' experiences.

The phenomenological approach as a philosophy and research study was congruent with the issues and needs of the study. As a philosophy and research approach the uniqueness of each resident's life experiences and his personal meanings of success for WWH as a residency was recognized (Streubert & Carpenter, 1999). This approach to research helped to clarify what was important to a population familiar with being judged and alienated instead of valued for their opinions and knowledge.

Phenomenological Approach

The philosophical perspective of phenomenology is that knowledge can be gained from other people's lived experiences and perceptions of their realities. Because individuals in society are unique they bring personal meanings to their everyday lives. Phenomenology has had wide spread influences as a philosophical perspective on the social sciences (van Manen, 1997).

Distinctions have been made between phenomenology as a pure description of a lived experience and hermeneutics as interpretation of the experience. Sometimes phenomenology is used when the descriptive function is emphasized and hermeneutics when the interpretative function is emphasized (van Manen, 1997). "Often the terms are

used interchangeably because phenomenological description aims at elucidating lived experience and interpretation of the text is required in order to point at something and show itself" (van Manen, 1997. p26).

Hermeneutic phenomenology, as described by van Manen (1997), incorporates phenomenological reflection and thematic analysis. The purpose of phenomenological reflection is to try to grasp the essential meaning of a phenomenon to the participants. Phenomenological reflection involves the participants' first hand account of their lived experiences that contribute to their meaning of a phenomenon and the researcher's reflective process of "pointing out" the meanings of a specific phenomenon to the participants (van Manen, 1997). This reflective process gives insights into the phenomenon of interest (van Manen, 1997; Morse & Richards, 2002).

Phenomenology captures the participants' lived experiences and assumes that there is a structure to the meaning or essence to how people experience phenomena (Patton, 1990; Evans, 1999). "Reflecting on lived experience then becomes reflectively analyzing the structural or thematic aspects of that experience" (van Manen, 1997. p.78). In order to understand the structure of the lived experience, themes are uncovered from the meanings participants give to a phenomenon and integrated into convincing phenomenological descriptions (Patton, 1990; van Manen, 1997; Streubert and Carpenter, 1999). The need for the researcher to be open to new experiences, to be reflective, insightful and sensitive to the participants' language precludes a procedural system (van Manen, 1997). The approach to uncovering themes as they pertain to this study is elaborated on in the data analysis.

Research Design

Van Manen's (1997) approach to phenomenology that attends to both description and interpretation of the data provided an in-depth understanding of the residents' lived experiences of WWH. Twelve residents and seven staff members were interviewed individually at the residence. Five board members were interviewed individually at a place of their choosing. A group interview with participants from inner city community agencies was conducted at the residence. After several informal visits to WWH, I started the research in April 2001 with a two-week period of onsite observation at the residence. Individual interviews were conducted during the period of May until October. The group interview was conducted in June 2001 (see Figure 3-1 for Research Timeline).

Ethical Considerations

The project was submitted to the Health Research Ethics Board, Panel B at the University of Alberta. Participants were informed both verbally and in writing (see Appendixes G and H for Information for Consent Forms) about the study (Creswell, 1998). The reading level had been adjusted on the residents' form to account for the residents who were cognitively too impaired or had some literacy issues. In addition, a taped verbal consent for the residents with cognitive impairments (see Appendix J Script for Taped Verbal Consent) was available as a backup if the staff and I felt it was required.

Those willing to participate and sign a consent form (see Appendix K for Consent Form) were informed that they had a choice to continue in the study or withdraw at any time without negative consequences for them. A major concern was to ensure that the residents at WWH were not exploited or coerced into participating in the study and

special attention was given to this vulnerable population, to ensure they knew that they could withdraw at any time.

Steps were taken to ensure participants' anonymity and confidentiality of information. Codes and pseudonyms for names of individuals and the shelter addressed confidentiality. Data was kept in a locked file cabinet with the thesis supervisor and myself having access.

Participant Selection

Residents

The participant selection was based on the need for insiders' knowledge of the phenomenon of interest and so the residents were the primary study informants. There were no exclusion criteria for the residents because the director, who has extensive years of experience on the job and around-the-clock close personal contacts with the residents which have resulted in a good understanding of this population, felt that all of the residents were capable of participating and contributing to some aspect of the study. If residents were unable to provide coherent answers to interview questions because of their mental and physical status at the time, they were included in the observational data as part of the overall description of the residents.

Although the individuals at WWH have illnesses, it is not a treatment facility and the residents are considered responsible for themselves. Exclusion criteria for the residents would defeat the purpose of the study because I needed to know about a cross-section of experiences from the residents. It would also undermine the very philosophy of acceptance that WWH employs. A multiple cross-section became the

validation of findings. The cross-section consisted of old and young residents, former residents and those who eventually died on the premises and residents living in the upstairs dorms and those living in the downstairs dorm.

Staff and Board Members

All staff and board members were invited to participate in the study. Although the residents' experiences and perceptions were the most critical, the experiences and perceptions of people connected to WWH in different roles added to the depth of the findings. It also served as another source to capture the phenomena related to acceptance and safety. By understanding the residents', staff's and board members' criteria for WWH's success, comparisons and contrasts were made.

Operatively the staff and board members' beliefs were relevant to the residents' experiences of WWH as they influence the delivery and process associated with operating the residence. A combination of multiple perspectives in a single study was also effective in terms of validating the usefulness of the verbal responses of a group of individuals (the residents) usually seen as too impaired to participate and provide insights into a study. The participants were the residents, staff and board members who shared their experiences and gave meaning, through interviews and/or participant observation, to what makes WWH successful as a residence.

Participants from Community Agencies

During the interviews and participant observation, I recognized a working relationship between WWH and other inner city agencies that seemed significant enough

to explore further. This is an example of how new understandings develop as a result of the research process. Because human responses and where they might lead a study are unpredictable, it is important to let the research design evolve and change continually. It became apparent that a group interview with participants from the community was necessary to ascertain their perceptions of WWH as a residency. Their responses contributed to an understanding of what success was for the facility and how it was achieved.

Participant Recruitment Procedures

The recruitment process began with two orientation meetings for the residents, which were set up in consultation with the director of WWH. Large posters announcing the time of the two orientation meetings were posted in the open areas (see Appendix A for poster). Two orientation meetings were held during the residents' lunchtimes. One meeting was held in the lunchroom upstairs for the younger, mobile residents. The other meeting was held downstairs for the older, chronic residents unable to access the upstairs lunchroom because of their limited mobility. It was agreed that a lunchtime meeting would be informal and more comfortable for the residents and would not interfere in the residents' usual routine.

At the meeting, the residents were informed about the study and invited to participate if they wish (see Appendix B for Orientation Meeting Script). The staff reinforced with the residents that participation was strictly voluntary. During the meeting, they were given the name of a designated staff member who they could inform of their desire to participate in the study. The residents were told that a schedule of the

days I would be at WWH to observe would be posted in the main office for anyone who did not want to be present during that time (see Appendix C for Writer's Schedule).

Data Gathering

The effectiveness of the data gathering was dependent upon my initial access into the field of study, and the building of trust and rapport with the participants. This required a gradual integration into the WWH's physical setting and my ability in conversation to get across to the director, staff and board members the significance of the research. Time was also spent in becoming familiar with an unfamiliar environment in order to comfortably carry out the interviews.

Interviewing

The interview method allowed for sensitivity to the interviewees' feelings and reactions to the questions being asked of them, adding to the understanding of the participants' experiences of WWH as a residence (Marshall & Rossman, 1995). The interviews were an opportunity to seek greater understanding of the observed activity in the setting. A possible disadvantage included the long time commitment and degree of cooperation required of the interviewees who had at their discretion the choice to participate or not to participate.

Residents, staff and board members were interviewed using a semi-structured format. There were two sets of interview guides: one for residents and one for staff/board members (see Appendixes D and E for Interview Guides). The interview guides ensured that the content organized around the phenomenon of interest and salient topics related to

WWH's mandate and its objectives. Unplanned responses regarding the unknown experiences of WWH were elicited by using probes, such as tell me more about what you think, feel or give examples of your experiences. Participants were given time during the interviews to share their own perspectives. As insight and understanding emerged, these were questioned in subsequent interviews.

Unstructured interview format was unsuitable because of the limitations of residents such as expected poor concentration, difficulty with abstract thinking and limited ability to organize thoughts. The semi-structured interview guides provided a solution to dealing with the interviewees' limitations by guiding the conversation to specific topic areas and thus stimulating response in a specific area, which related to the goals of the interview. This approach to interviewing was less threatening and thereby more effective in eliciting responses then asking.the residents to talk generally about their experiences. Prepared interview guides took into consideration the reality of having a one-time opportunity to interview some of the participants because of time limitations and in the case of the residents the fluctuating state of their mental and physical status.

The framework for the interview questions, the experiences of success extrapolated from the residents' interviews could be compared with the findings from the staff and board members' interviews. To meet this objective, the questions in both of the interview guides were congruent and somewhat sequential. The questions within the interview guides provided for a comparability of responses i.e., what is success/not success or difficult/easy about residing in WWH?

If respondents introduced additional material or went in a new direction this was acceptable, as the interviews remained fairly conversational and situational. The new

material was then re-introduced in the original content area at the next opportunity in the process. A distraction-free room was used to conduct the interviews onsite, in order to put the residents and staff at ease and facilitate focus (Morris & Field, 1995). Approximately forty-five minutes were allotted for each interview. During the interviews, the participants' responses were recorded in the interview guides, the interviews were tape recorded and transcribed by the transcript typist in preparation for data analysis. (see Appendix L)

Participant Observation

In the study participant observation involved mainly observations and casual interactions with the residents and staff by shadowing staff in their daily operations related to the care of the residents i.e., serving meals, house checks (Morse & Field, 1995). In order to get details of the day-to-day operations of WWH, I spent the first two weeks of the study following participants (residents and staff) who were willing to participate in this process, for approximately two hours a day. Over the two-week period, different periods of the day and evening were selected for the observation. The plan was to partner with different staff members at different times based on their duties. This contributed to a more accurate description of the overall setting and a greater appreciation of how roles were actualized (Hammell et al., 2000). The observational protocol consisted of descriptive notes on events and life situations and the observational data was presented as a description of key events, incidents and interactions (Patton, 1990).

An advantage of participant observation is the acquisition of experiential knowledge that cannot be gained from interviewing (Marshall & Rossman, 1995).

Because the meaning of a phenomenon is unique to the participants' context, the researcher's observations of what goes on in the participants' environment gives a context to understand the knowledge extrapolated from the data analysis (Barnes, 1996). By using observations nuances in the environment can be noticed and recorded (Spradley, 1979; Bernard, 1995). A disadvantage to participant observation is the reaction of the participants to the presence of a newcomer in their environment (Bernard, 1995). Participant observation without the researcher's careful engagement in the life of the participants may make it difficult for them to behave naturally around the researcher when feeling scrutinized. Overtime, the researcher is less noticed as an outsider and accepted as part of the environment (Spradley, 1979; Marshall & Rossman, 1995).

Group Interview

A group interview was arranged with seven participants from social, healthcare and residential agencies i.e., nurses, social workers etcetera in order to reveal the collective profile and synergies of WWH as a member of the inner city community. An advantage of the group interview was the efficient use of time for both the community participants and myself. The dialogue took place in WWH's basement/recreational area for one and a half hours.

The dialogue questions from the interview guide (see Appendix F for Community Dialogue Interview) focused on the community participants' perceptions and experiences of WWH. The participants were encouraged to express their ideas and opinions about WWH in this semi-open format. Their responses were tape-recorded and transcribed. The

extent of the community involvement and additional themes were verified through the group interview.

Data Analysis

True-to-life narratives of the participants' experiences and perceptions depend on the effectiveness of the researcher as an instrument of data gathering. The development of a rapport between the researcher and participants is important so the latter are less guarded in sharing their life stories (Spradley, 1979; Bernard, 1995). Without sincere and honest responses from the participants about their lived experiences, the data is compromised.

Throughout the data gathering and analysis a critical self-examination of my personal beliefs and understandings was acknowledged and consciously set aside (bracketed) in order to ensure as much as possible true-to-life descriptions of the participants' experiences and perceptions (Morse & Richards, 2002). A personal reflective journal was used throughout the study to capture insights into my emotional reactions to the experiences, personal attitudes on homelessness and issues that may afflict the hard-to-house such as mental illnesses and/or substance abuse. I reviewed and made reference to this journal as the themes emerged in order to understand and share my thoughts and feelings with my thesis supervisor. It was important for the themes to arise out of the participants' content rather than being imposed by my beliefs and values. My twenty years of extensive work-related experiences and skills in making observations and interviewing added to the sensitivity and scope of the data gathered and consequently to the effectiveness of the data analysis.

Although a primary literature review was useful in verifying the need for the study, a more comprehensive secondary literature review was delayed until the data analysis was completed in order to assure that the data was grounded in the data gathered (Streubert & Carpenter, 1999). I read through the transcripts cross-checking their accuracy with the interview guides and tape recordings. A detailed reading of sentences and sentence clusters was undertaken by asking myself what the data revealed about the phenomenon. Significant statements and their meanings were highlighted and reviewed on an ongoing basis with the thesis supervisor and at irregular intervals with the director of WWH to ensure the integrity of the data analysis. In addition, I attended to the text as a whole to gain a sense of what was the overarching theme.

By reducing the large amounts of data into non-overlapping formulated meanings of the participants' statements, the common elements of WWH's success were sorted into themes. Themes related to the phenomena of interest were then integrated into narrative descriptions utilizing van Manen's (1997) definition of a phenomenological description. My immersion in the data was an on-going non-linear reflective process. Initially the meanings that were later seen were overlooked due to my newness to the methodology. Through perseverance and time, themes emerged from the data that brought together the meaning of the participants' experience of WWH. Quotes were used to get the participants' point of view and their emotional tone. Because there were four data sets i.e., residents, staff, board members and community dialogue participants each set was handled separately throughout the process of theme-making and narrative descriptions before moving onto the next subset. Once each subset was thoroughly completed, the structure of the meaning or essence of success for WWH was drawn from all four groups.

Evaluating the Quality of a Phenomenological Study

The researcher's role in a phenomenological study is more exposed because the findings are based on the researcher's immersion in the participants' lived stories and the researcher's intuitive and reflective thought processes that bring meaning to the phenomenon of interest (van Manen, 1997). It is imperative that the researcher is open to what emerges from the data.

Sandelowski (1993), judges the best rigor in a qualitative study design as true-to- life meaningful stories that represent the participant's internal reality at the time. In a phenomenological study a true reflection of the participants' lived experiences is dependent on the researcher's openness to their lived experiences. Although objectivity is not the goal, a balance between objectivity and subjectivity requires the researcher's insights into his/her reactions while involved in the research process (van Manen, 1997, Streubert & Carpenter, 1999). The effectiveness of this process is manifested in the emotional responses and new self-awareness of the people interested in and associated with the study, including the researcher (van Manen, 1997, Evans, 1999).

Summary

A phenomenological study was the most effective way to capture WWH's intangible valued atmosphere. The study clarified what the meaning of success was for this residency from the lived experiences of the residents. A narrative description of the residents' shared lived experiences of WWH was used to develop an essential structure of the meaning or essence of "success" for WWH. This understanding was compared to the other participants' responses i.e., staff, board members and the community participants in

order to understand how the facility was perceived as the safe and accepting place that it appeared to be.

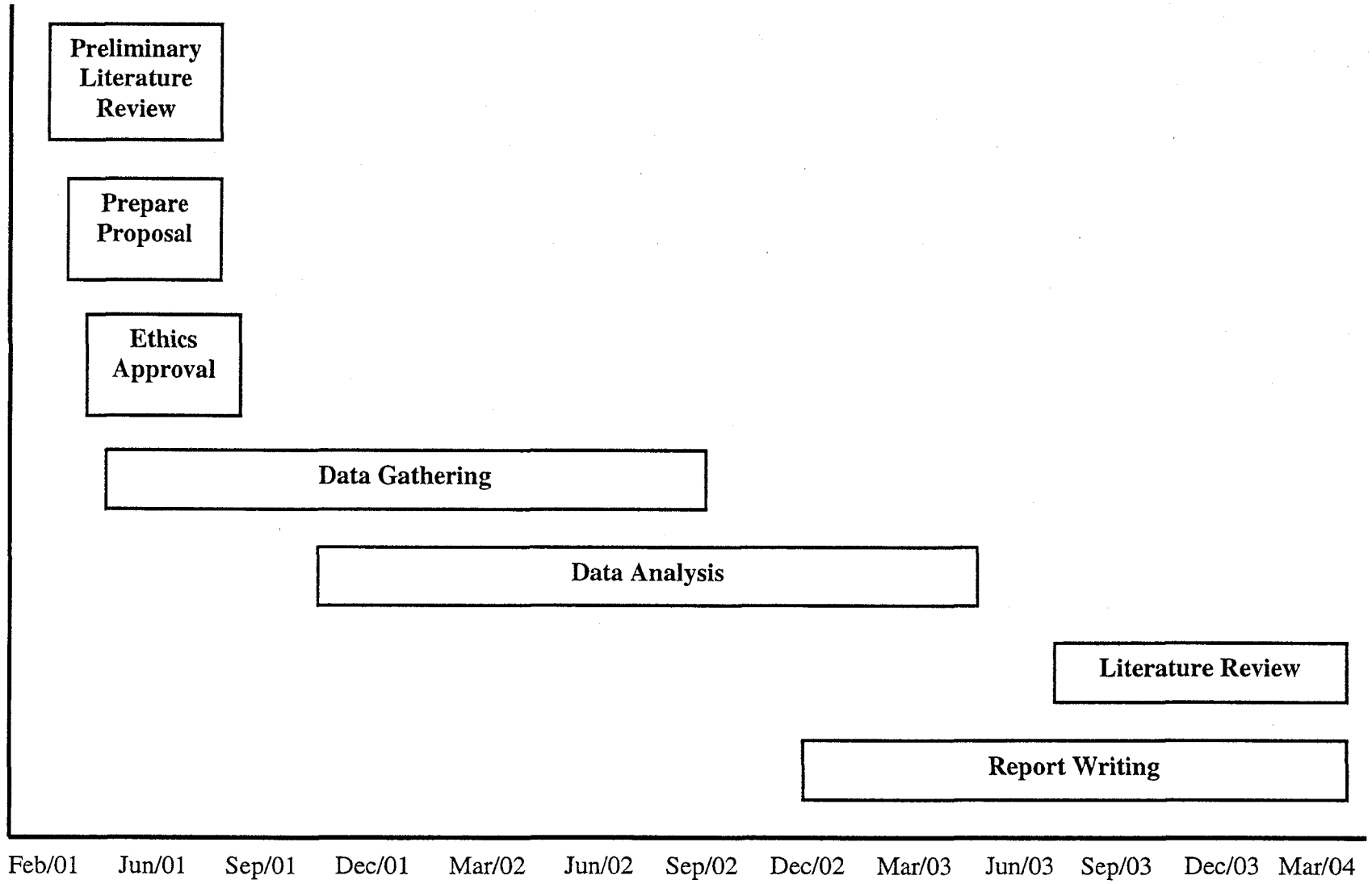

Figure 3-1. Gantt Chart (Research Timeline)

Chapter IV - Findings

This chapter will be presented in two sections: the first includes the profile of the residents and the second will illustrate their meaning of Weather Worn Home as a successful residency. Themes emerging from the residents' interviews are compared to the meaning of WWH as a successful residency from the perceptions of staff, board members and members of the inner city community agencies. All of the findings from the different data sources are synthesized into an over arching theme.

Who are these Residents at Weather Worn Home?

Health Status: Physical/Affective/Cognitive

I observed residents who were disoriented, swearing, mumbling and speaking in two to three word sentences. Many looked emaciated and older than their age with missing teeth and disheveled appearance. A resident with brain damage and impaired vision could become agitated if someone came close or stood behind him. Others were unable to get around without walkers or other assistive devices. This downward spiral of mental and physical health and what it is like to live in these broken bodies and minds were captured in these responses.

> Have regrets sometimes break down. [R2-917]

> Well you want to know the truth? Ok, I'll tell you the truth. I just got

kicked out of the G house. You see eh, I couldn't, I was drinking so heavy, I couldn't control my bowel movement, and I went in the bed. I lived there for fifteen months but I got so bad that... I, I can't eat. [R7-256]

The interviewees' sincere and honest comments demonstrated that they have insights into their desperate craving for alcohol and other substances of abuse and were aware of its consequences on their deteriorating physical and mental functioning. They found themselves unable to escape being in an emotional and physical state of limbo or decline. Although the residents did not want to be in this condition and their medical issues were pertinent to them, they did not see abstinence as an option. Living without their substances of abuse and believing that they could get beyond the enormity of their problems was too overwhelming for the residents to even contemplate. The residents were acquiescent, to their familiar methods of coping and facing reality in order to survive day-to-day.

This is a dead end zone for me. I am a chronic alcoholic. I mean, I've been to detox; I've been to treatment; I've gone through all this stuff so many times. Like, I found that it's just quite simply easier to drink. And just forget about it, and I'm an alcoholic; I just drink, that's it. And it takes away so much problems of thinking about things. Like, well, I gotta go to detox, or gotta worry about where I'm at. I'm already here. I don't have to worry about that. But some other people, they come here, and they go well I can't wait to get out here boy, I gotta get out of here and I'm like, well,

go ahead, see you later, fine. Here I am. I'm, I'm not going anywhere. Where else am I going to go? Back in the trees? Underneath the bridge? Have made previous suicidal attempts and depression, if I die tonight don't care. I really don't care about a lot of things anymore but I'm not suicidal. If I die tomorrow, if I die tonight don't care. [R12-802]

My alcoholism got the best of me. [R6-104]

Interviewees made the following comments regarding their perceptions of other residents' state of mind and behaviour. Their empathic comments were a reflection of their awareness of other residents' impairments and the impact of those impairments on emotions and behaviours. The interviewees perceived their fellow residents as lost to their addictions and other illnesses because they have walked or were walking in their shoes.

I know a few here, uh they have been good people in their lives...workin...liquors ruined them. [R7-653]

Well, the first, the first time I ever stayed here, you know it wasn't fairly soon...had a chap...Well, actually he's still here...Had a chap, but at the time his hair was about four feet wide, but, but, four foot long beard, and really...freaky looking, and I woke up in the middle of the night, and this one's standing at the end of my bed. And I waited a second. And all of a

sudden this voice says, "I see you, you're damned. You're gonna die." Well I come off of there, just, what's going on you know. And then I realized who it was, so I just laughed at him. Because he, you know he, he's here because of, uh, they were psychiatric reasons. [R8-848]

Sometimes a resident would go into palliative care in WWH with arrangements made for a visiting home-care nurse, because there were no other facilities that could manage him. According to a staff member, other residents would go into an uproar because they did not want to face their death, or the end result of their very vulnerable and fragile lifestyle by watching another resident dying in their midst. With so many people dying around them the residents buffered themselves from the overwhelming and intense emotions of grieving not only the death of people they have come to care for but also their personal losses of health, significant relationships, etcetera that they were enduring in living. Death took on a new meaning to some of the residents who dulled their senses and emotions and/or denied the consequences of their life style.

Someone dies, have another beer. Another thing that I have found uh, how can I explain it? I don't know if my skin is getting harder or what but uh so many people I know have died since I've been up here. And its ok well so and so died yeah ok. Then the day moves on and you go to the next. Like I never used to be like that. It used to mean more to me if somebody died. Now I up here, I mean there's so many people dying all over the place, it's like, oh well, sorry. And uh, that would be a negative thing I

would uh, that my feelings were changed with uh, cause I respect life I wouldn't even step on a flower. [R12-721]

Families/Personal Connections

The journey that brought many of the residents to WWH was a result of being unable to cope in an environment that could not handle and/or understand the complexities of their lifestyles and behaviours. Past relationships drifted apart and they became estranged from significant people who were part of their lives. I recall seeing a polished well-kept framed picture of a resident's attractive young adult daughter on a well-worn wall by the resident's bedside (a reminder of the bonds that bring us together and a reminder that the bonds can be broken). The reasons for the residents' estrangement from their families and significant others included family members' inability to tolerate their behaviours associated with addictions and/or residents' desires to protect their family members from their own dysfunctional behaviours. The interviewees expressed enduring painful feelings of losing significant people who have faded from their lives.

Drinking was part of the reason, of, uh, of my separation. But then it got worse. The drinking because it broke my heart. [R2-196]

Uh, see mum says I should come home. But she 86 years old, but she can't take care of two sick people (resident and father). [R7-175]

Education/Employment

The residents came from diverse backgrounds and cultures, with variable employment and educational experiences ranging from grade six to post secondary such as university, college courses and trades tickets. Some of the residents have been disabled with minimal skills and/or dysfunctional behaviours all their lives and/or were born into poverty and/or neglect without equal opportunity to survive in mainstream society. Others had fallen a long way from their ability to function, maintain employment and put their lives back together as a result of a number of precipitators. A staff member mentioned a previous resident who was a very capable breadwinner and who was unable to maintain his previous level of functioning after his wife left with their child. Some of the residents felt and expressed pride in their accomplishments and other residents expressed frustration about their difficulties maintaining employment.

> I'm an educated man I've got a degree...I've been working all my life. And now I have problems. I've lost a lot, but what I've lost, it's still higher than a lot of people have. [R12-432]

> Well I, I worked in the oil field there; they wanted me to go drilling, but I couldn't write or, and, my alcohol was my biggest problem. [R7-49]

Overall, the interviewees valued skillfulness and productivity. Their stated accomplishments were variable and included operating industrial equipment, attaining academic papers or learning about animals from growing up on a farm. Memories and the

sharing of the memories of past occupations and related skills connected them to their roots and identities as whole functioning people with dreams, goals and purposes in their lives.

> I operated equipment, lift equipment, high-pressure pumps, raised on a farm you know how to operate just about anything anyway. [R1-226]

> Learn on the farm about animals, worked for another farmer...picking rocks and driving trucks...three dollars a day. Oilrigs, signed on fifteen and a half...grew up quickly or died. [R3-14]

Occupational Performance: Self-Care/Leisure/Productivity

The residents at WWH have functional deficits which impact on their lifestyle and their purposes of occupational performance (OP). OP is a concept in occupational therapy literature, which captures the activities that individuals perform to meet their intrinsic needs for fulfillment of self-maintenance and expression (Law, 1999; Hammell, Carpenter, Dyck, 2000; Towsend, Birch, Langley, Langille, 2000). WWH's residents come from different backgrounds, have encountered different life experiences and have made choices regarding occupations i.e., self-care, leisure and productivity that are unique to them and the situation in which they live. Being in a stabilizing and secure "environment" where their basic needs for nutrition, shelter and healthcare were met gave them the capacity to be involved in social opportunities and productive activities that promoted a healthier well being in a way that was meaningful to them.

Stories and pictures of special events for the residents, such as camping trips and planned holiday celebrations, left me with a lasting impression of the significance of these typical life events to both staff and residents. During these occasions, various residents displayed diverse talents that included being musical, witty and capable of volunteering to get funding for specific events. Enjoyment and pride in the moment were indelibly imprinted on the minds of those involved on these occasions.

> I'm involved with uh, I'm not sure if you know N (outreach social worker). I got involved uh, volunteering for uh certain events, and uh...get very involved in certain events... I was asked to uh, be sort of a spokesman, and uh, I got a thousand dollar grant. It was for a canoe trip eventually. But uh, the canoe trip got cancelled, because uh, we didn't have the proper funding uh, for the canoes. So now uh, we're going on a, a camping trip uh, in replace in June. [R2-299]

The data gathering process made me aware of the residents' involvement in an informal economic structure that included both entrepreneurial pursuits such as collecting and trading saleable items from garbage bins, bottle collecting and casual labour. Some of the residents found meaning in these productive activities in the context of their environment. They prided themselves on the skills, efforts and energies that they put into these endeavours. Interviewees recognized the importance of being productive to their positive self-concept as individuals able to shape healthier functioning for them in the face of adversity. In fact, their identified interests and skills were essential to their

identity as competent and resilient people.

> Yeah, I'm working. I got to take a little work home, then you've got a whole bunch around that won't do nothing. [R1-23]

> Uh, it would have been uh, last Thursday, I worked for a guy that I do snow removal with, and we did a spring cleanup. And he's uh, one of the best employers I've ever had. But it's still it's uh, it's very sporadic. Usually after work he grabs his little dog... and he grabs me a beer. Uh, he hasn't dranken for 17 years... I'm going to this park. It's called uh, the Park or something. And uh, we go down there, and you know spend a couple of hours talking. I have my beer.
> We play with uh, his dog. [R2-101]

The residents' subjective expression of their meaning of quality of life translated into individual and unique activities that revealed to me who the residents were and how occupations (self-care, leisure and productivity) were significant to them. The residents' day-to-day activities at WWH gave dignity to their existence by giving them access to showers, washrooms and laundry facilities. A sense of pride and value was evident in the skills they possessed to be productive. The residents' occupational pursuits made prominent the impact of their being in a stabilizing setting where they belong on their desire to carry out activities related to self-care, leisure and productivity. This was evident during meal times when they came together to take care of their nutritional and

some of their socialization needs. Another example of the influence of belonging on carrying out activities was the story of two residents sharing the arduous daily work of collecting bottles together until the death of one of them resulted in a lack of interest and energy in bottle collection by the other. These quotes capture the importance of OP to the residents.

> Well it it is for, for the, the reason,... I I I like the facilities for, well, washing you clothes...[resident was asked why he had lived at WWH for six years] [R1-291]

> Staff are really helpful, caring and understanding, atmosphere reasonable, pretty good. Couple of picnics and couple of parties, Thanksgiving, Christmas, New Years. Get along well with C., D., and E (staff members). I like the staff to be the same because they know what they are doing. Staff are pretty good, knowledgeable, capable and know the people who are here... Who we are and what we're like. Some of the staff a little uncaring, intolerant and lack understanding. [R13-156].

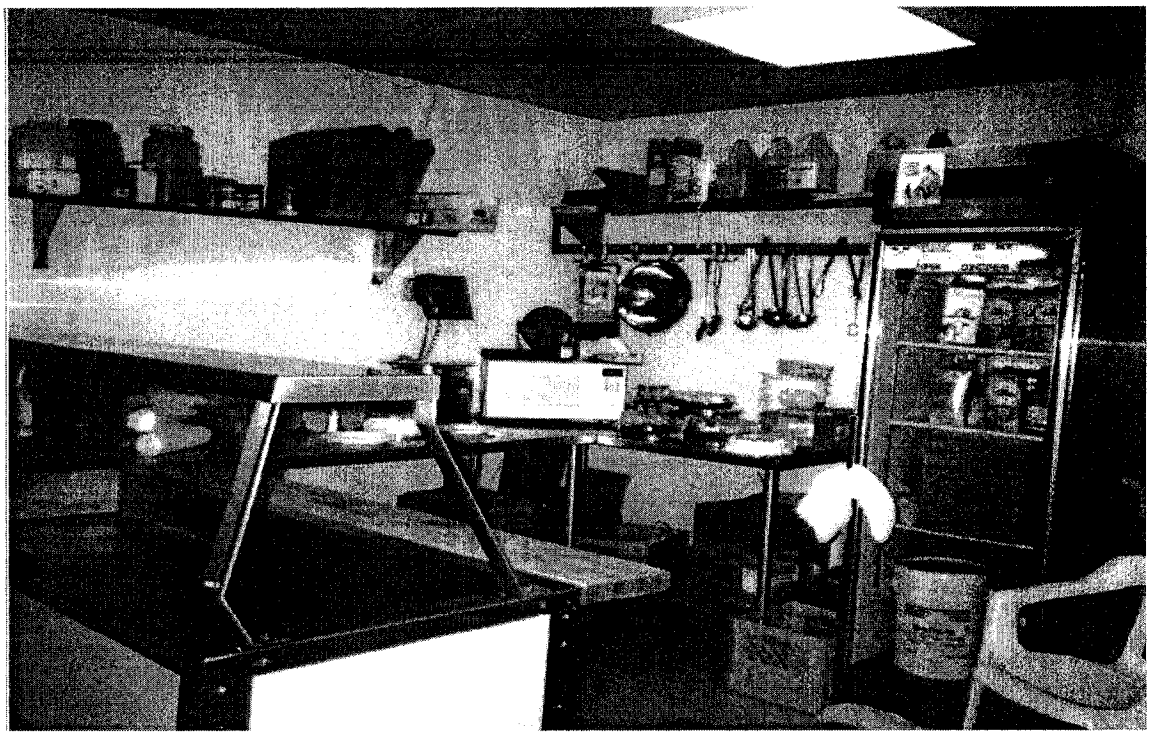

Figure 4-1. Kitchen Where Meals were Served to Residents who Ate in Adjoining Dining area

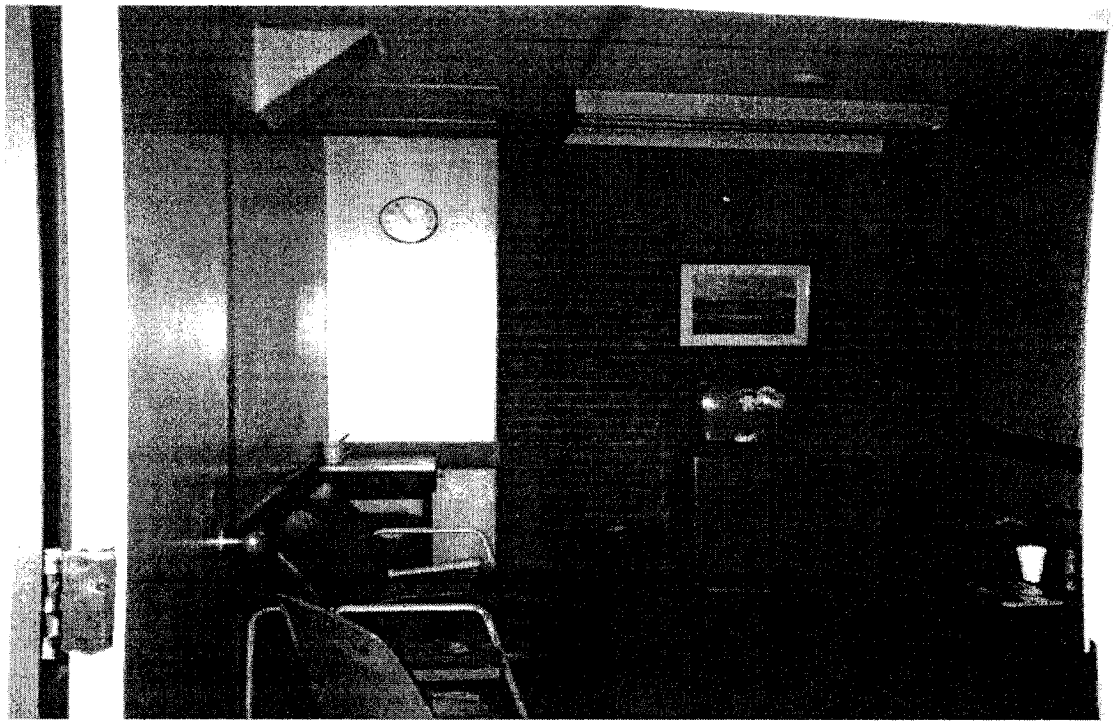

Figure 4-2. Basement Where Social Events Were Held

Residents' Meaning of Weather Worn Home as a Successful Residency

The residents' shared understanding of the essence of WWH's success extended beyond its mandate and objectives to intertwined and enmeshed categories of themes that included security and safety, boundaries and feeling connected. The importance of the residents' experiences of security and safety and boundaries unique to WWH was significant to their experiences of feeling connected through thoughts, feelings and actions to others. Overtime, the residents' connections to those involved with WWH became more secure and significant.

> You got 62 people looking after 62 people not to mention the staff, I mean uh, we are a team. And then that kinda feels good to be part of something. Instead of just wondering around alone and lost and uh, drunk and dirty, stinking, falling off the curb. You know, it, it's different uh, to have a team. If there's anybody laying on the street there, we usually haul them over here, or whatever...make sure you, you know look after each other. You know what I mean. [R2-1262]

Security and Safety

The inner city possesses its own unique culture with a diverse group of individuals with a wide range of values, morals, and backgrounds. Concern and generous individuals as well as destructive, self-serving individuals live in the inner city. In an area with visible poverty and perceived crime, at times basic survival instincts and aggressive impulses can overshadow morals and values. Prostitution, selling drugs, and violence are

part of this environment. Down the street from WWH was a known drug house operating under the facade of a sports bar. A staff member recounted a story of a woman involved in prostitution informing WWH staff of a female passed out on the street being gang raped. Her apparent motivation for requesting help for this woman was her concern over losing potential customers. The staff was able to help in the rescue of the victim. The inner city, despite all its rawness and brutality as shown in this incident, remained the place where the residents were most comfortable and tolerated by society.

I initially assumed that the residents were overall oblivious to the dangers of the inner city. However, the interviewees were very cognizant of these potential threats to their health and lives. They either knew of someone who had been the victim of street violence or they had been the victim of street violence themselves. The older and more fragile residents felt very vulnerable to the dangerous elements of the inner city. Residents proactively planned their activities around their knowledge of potential threats. They traveled in pairs and/or found safe drinking havens around the WWH building or in a well-managed inner city hotel from where they could return safely to WWH in a taxi.

> It's just... This is our little hive, the inside is safe. Outside is the world. Some people are mean and ugly and not scared of killing. [R12-1305]

> Oh I've been out in skid... I love the skid row. All those native girls, they're easy to pick up you see. Well you said... you wanted to know the truth. Yeah, well I don't love it so much anymore, it's getting too many thieves in... And I hate guys with knives and stuff. A lot of people won't

even go to ... Well I'm too old to go to the bar. Because an old guy, well, they seem to attack them. Like I say, they rob; they can handle them easy. They can grab a hold of the old guys; they can't fight back. [R7-193]

The interviewees were also aware of the risks inside of WWH living with others in similar states of poor reasoning and judgment, many of whom were volatile and desperate. The volatility exposed residents to the threats of harm and the desperation resulted in theft of money and possessions amongst the residents. They slept in their clothes and kept their possessions within their own physical space.

Well like, you know, every once in a while, somebody would be having one of those days. You know, they'll be try' in to find somebody to have a fight with or, you know whatever, you know that sort of nonsense, stuff like that, you know. I don't particularly need (laughs). But you sort of have to just have to grin and put up with it. Cause you know that's why a lot of the clientele, that you know, that's why they're here. [R8-295]

Sometimes too much drinking going on - suppose to be a drink free place, at times seems more drinking going on than at the bar. Uncomfortable when fellows get drunk, get belligerent and antagonistic... looking for a fight. [R13-72]

However, the risks inside WWH did not outweigh the dangers of living alone.

The interviewees felt overall safely maintained and monitored by the staff. They were aware that the staff could make reasonable judgments and choices for them when necessary.

> Like if you go to sleep, you always know the staff is walking around... making sure that you're okay. They come up, and check to make sure that you are okay. They look after you, like, if you don't feel good, they try to uh, get you down... take you to the hospital if they figure it's serious enough. They're all pretty good. [R5-540]

The residents' need for security and safety was relative to their internal state of fear and anxiety as well as to threatening external elements. They lived in a perpetual state of internal crises because of the severity and chronicity of their mental illnesses and/or substance abuse and its frightening consequences, such as losing cognitive and bodily functions. According to the interviewees, although WWH was not always predictable and controlled it met their basic survival needs by providing sufficient protection for them and alleviating their fears of living in isolation and dying helplessly by themselves.

> No I, that's why I come here, because, I can't (laughs), I can't uh live by myself, I gotta drink. Well liquor ruined me. But I'll never tell anyone else that, and they say its ruined me to, well I says, I got big enough problems of my, of my own without telling you about the alcohol. You crave it like

a cigarette. I'm so scared one time that I was gonna run out of alcohol when I am drinking. Wake up three four o'clock in the morning, and when I stayed there in the house, I had to have a few bottles so I could have a drink. Well I couldn't keep walking unless I got up and had two bottles. Then I, couldn't get out of bed; I'd wet myself and the bowel movement. I wish I could take care of myself. Should move where I can eat. Stay more sober when someone to talk to. I can't be by myself. [R7-409]

WWH was the residents last chance for safety and security because they had been repeatedly evicted from other agencies and residences because of their impulsivity and lack of self-control. At WWH they slept in a secure, sheltered bed in a dormitory under the scrutiny of concerned staff, as bed checks were routine. The residents' attachment to their beds provided the grounding point in their chaotic days and gave them the sense of peace and protection they needed to get a good sleep and relax.

Cause we got a bed. Uh, the beds, well I mean some people don't have beds. We can't complain about that; there's not really anything that we should complain about. [R12-1338]

It was interesting to note that the dormitory was significant to the residents as none of them made any comments regarding wanting their own room. It was as if the need for the residents to be aware of the presence of other people was just as important to them as their need for others to be aware of their presence. The dormitory culture of

shared activities and rituals enhanced the human contact and security valued by the residents.

> Get to know guys living in 2 to 3 bedrooms and not as concern about theft. [R3-33]

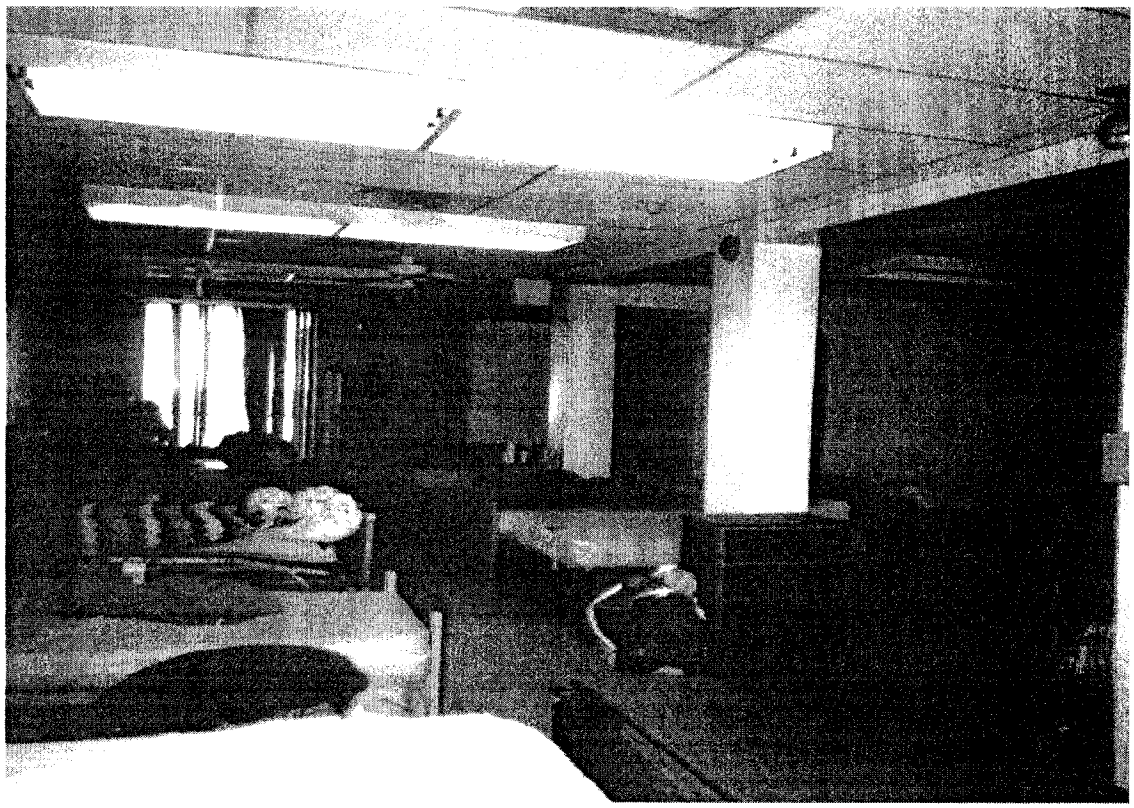

Figure 4-3. Dormitory

Boundaries

All of the interviewees raised issues related to boundaries, an indicator that they have meaning for them. In this context, boundaries emerged as a limit, a point of constraint, and a stop point. The residents lived the experiences of WWH's boundaries

and their comments expressed the significance of this experience for them. Their opinions and stories unmasked and illuminated both the presence and flexibility of boundaries that were significant to them. One of the more elderly and impaired residents was the first interviewee to bring to my attention the importance of WWH's boundaries. This theme followed through with the rest of the interviewees. They knew how boundaries work and did not work for them and other residents because of their experiences of successes and failures in other settings.

> Uh, well actually if it was me, I would say they should have some more regulations. Well, see. That's that's bad, too, because, the only place you really need more regulations would be in the area...area of drinking, and with this type of people, that's sort of hard to do. [R8-45]

The presence of boundaries such as rules, routines and structure showed that the staff cared enough about the residents to invest energy, thought and planning into establishing a safe and accepting environment. It was as if there was an understanding amongst the residents that they required boundaries and control because of their lethal addictions and the potential perils of living in the inner city. Interviewees did not see WWH's structure and regulations compromising its comfortable homelike atmosphere to the degree that they felt intolerably institutionalized and restricted. Nevertheless, comments suggested a mild overtone of dissatisfaction in security measures and rules that deprived the residents of all of the choices they would have if living in their own home. For example, the residents' visitors were restricted to designated staff monitored areas

and alcohol and drugs found on the residents in the building by the staff were confiscated. The residents were aware of the compromise needed between flexibility and inflexibility in the implementation of boundaries.

> But the only thing that ever bothers me and I mean, and, and it can't be helped...it's the only way you can do it. It's when they're doing bed checks. But, you gotta have that flashlight to do the bed checks, so you can you know make sure the body's breathing, you know. We'll it's just that I'm such a light sleeper that, that light, you know...like I say, there's no other way you can do that. You've gotta have light, so they can, you know, like say, see to make sure the body's breathing. But for me, being a light sleeper.its, annoying sometimes (laughs). [R8-774]

> The staff. Uh, freedom that they give us. To a certain extent. [R2-693]

Interviewees had opinions and problem solving strategies of their own regarding boundaries they felt were required in order to insure their security and safety, an indication that the residents were capable of intact logical thinking and internalizing of WWH's boundaries. They suggested two to three bedroom dorms at WWH to cut down on frustrations and thefts and to provide increased opportunities for them to interact with one another. Residents spoke of setting limits for themselves with other residents regarding not lending out their cigarettes and an awareness of the need to have their money locked away by the staff.

> Well uh, I just smartin up, I don't give anybody a smoke anymore now that... once you start given them a smoke you get bugged every two minutes. [R7-724]

> Uh, the, the idea, of smaller dorms and that is a good idea, as far as I can think. As I'm concerned, because it'll, it'll keep down on frustrations breaking out. You know, because no matter how good natured people are, you you know, 10, 11, 12 people in this room... especially with you know, our type of people, that have drinking problems, dope problems, whatever... you know sooner or later, it's gonna frustrate somebody. So the idea of a smaller dorm, I think that's, that's a real good plan. [R8-434]

The reality of boundaries is that they are grey and not black and white. Boundaries are difficult to apply in most populations, especially with the hard-to-house. Perseverance, creativity and compassion were required when setting limits in a digestible way for the residents. The residents' acting out was dependent on the residents' impairments and availability of substances. Staff were assessing reasonable limits for each resident from a moment-to-moment and day-to-day basis. There were times when I entered WWH to find residents settled and watching TV and/or conversing with one another. There were other times when the residents appeared more labile, intoxicated and unpredictable. WWH residents' behaviours could have resulted in rejection and eviction from the premises by this agency and its staff if the rules were too rigid.

The interviewees' responses suggested that an intricate relationship existed between staff and residents. It was apparent to the residents that the staff was putting effort into dealing effectively with their difficult behaviours. Although the residents knew the boundaries could be a test of wills for them and the staff, they felt that the staff was not giving up on them. This validated them as individuals worthy of protection rather than as lost souls left to survive on their own against the odds in a volatile environment.

> I know I break rules. I hope with being (new WWH building) closer to liquor ...hope they (WWH) don't change rules about liquor, search at doors...don't change anything...Don't give up nothing. [R3-74]

> Uncomfortable when G catches me drinking. [R4-86]

Feeling Connected to Others: Connections Between Residents and Staff

Two of the interviewees were previous residents who continue to visit WWH and the other ten currently resided at WWH. Their common bonds were their previous and present need for supportive individuals knowledgeable and tolerant of their dysfunctional and socially unacceptable behaviours. Although WWH is not a treatment centre, it exists to make life as comfortable as possible for this frequently long-term population with functional impairments hindering their ability to live independently. The interviewees attributed their experience of comfort at WWH to the effectiveness of the director and staff's personalities and abilities in contributing to the residents feeling validated by being understood, respected and accepted.

> I like all the staff (laughs). Actually, I should probably be part of the staff, I've been here (laughs) so much. They're always, well I won't say always, because they have their very bad days, but you know, on the whole... they're all easy to get along with, and, you know, they try and, try and treat you decent. [R8-229]

The interviewees' responses emphasized their appreciation and recognition of the WWH mandate to accept the hard-to-house whom facilities and people alike have repeatedly rejected and who have burned their interpersonal and environmental bridges. The interviewees perceived others outside of their circle of acceptance at WWH and the inner city questioning their human value, seeing them as dangerous to society, treating them as non-entities and blaming them for their circumstances. At WWH the residents felt recognized as worthwhile human beings with significant voices and identities.

> Because the bottom line is we're, we're still people. We're not the scum; we're not the assholes; we're not the rapists or murderers, or thieves, or... Goddamn junkyard dogs. We're just people. We're all people together, and actually it gets to be kind of like a tight-knit unit. [R12-895]

A powerful indicator for the interviewees that others were aware of their presence and of their individuality was the staff's protocol of greeting and addressing each resident by his name. Interviewees perceived WWH as being unique in providing an

accommodating and warm environment that met their needs for recognition as individuals. The effort and energy the staff put into providing a safe and accepting setting was important to the residents.

> Uh yeah, this place is unique, like, they don't got anything like it. I haven't been here in a year, but I got stuck again, and... G. and A. try to...accommodate me., and make sure that I wasn't sleeping out in the riverbank where you can get hurt, too. He kind of looked after people in here. They all worry. They're all pretty good here." [R5-206]

> (Sniffles) They've (staff members) given me confidence. A., G.,...B., F." [R2-231]

The residents' awareness of the staff providing an environment where their needs were understood and they were recognized as individuals had evolved into a reciprocal relationship between residents and staff of shared concerns and a sense of responsibility to each other. In fact, reciprocity could be seen as an indicator of WWH's success when residents express concern for the challenges that staff face. The interviewees' responses showed that the residents' empathic awareness of the staff's issues were just as important to them as having staff feel the same towards them. In action the reciprocal relationships between staff and residents was made evident by the small gifts and mementos such as stuffed teddy bears residents gave to the staff. The act of caring for others facilitated for the residents a sense of belonging and identity as individuals capable of caring for others.

> I mean like, you know, its like they (staff) all have their bad days but that is just human nature and just because a guy is having a bad you can't tell him, " Well, you go home and come back to work tomorrow" [R8-796]

> I feel closer to B. (staff members) given him tools to fix problems. B. not afraid to ask. G. and K. banker and bookkeeper. Trust A. there to sign anything." [R1-521]

Although their roles differed, staff and residents connected through interactions such as humorous and melancholy conversations. The residents and staff felt connected in a group environment through shared laughter, stories, feelings and opinions. I unexpectedly found an abundance of laughter at WWH and observed its power in bringing energy and life into the old, run-down building. Animated conversations transformed a bleak and dull environment into a lively and warm setting. The residents and staff were exposed to each other's unique personalities as well as common and uncommon life experiences. The residents and staff, through their personal interactions, brought out each other's uniqueness as well as common and uncommon life experiences. When I participated in this informal time with some of the residents and staff, a sense of belonging and acceptance evolved. The impoverishment of the background receded and the common experience of living in this human world together predominated.

For some of the residents the points of connecting with staff included sitting and spending time together watching hockey and soap operas and/or asking the staff for

favours i.e., cigarettes, coffee, the use of the telephone. The voiceless have a voice in the presence of an attentive and caring staff member. The staff and residents' compassion for each other took on a deeper meaning when the director and resident sat by the hospital bedside of another resident as he took in his last breath.

> They always say "Hi" to me or talk to you...they treat you good. [R5-483]

> Staff is great... F., special, does stuff for me, stop and talk to me, rest have to run beside them to talk to them... easy to get along with... run to keep up. [R3-94]

Feeling Connected to Others: Connections Between Residents

Unexpectedly, most residents spend a very long time at WWH and this extended presence provided opportunities for relationships to develop. Shared interests and histories, similar values and personalities and dysfunctional thoughts and behaviours drove these relationships. The relationship dynamics were complex in WWH. Friction, indifference, support and camaraderie prevailed amongst individuals who would barely exist beyond sleeping in the river-valley and on the streets if not for WWH altering this course. The interviewees' responses demonstrated the different experiences of residents sharing their moments of interaction with each other.

> A lot of good conversation. Uh, a lot of learning from different people that have been from different trails. And sometimes it could be uh, one of the

dumbest people, but they have one of the brightest ideas. You just have to give them the opportunity to trust you. And then they will open up to you. [R2-795]

People here I can call friends or acquaintances...I get along with. [R13-147]

Feeling Connected to Others: Connections Within the Inner City Network

Interviewees identified a bigger picture of their experience of feeling connected to others that went beyond the doors of WWH, to an inner city network that included nurses, police, cab drivers, waitresses, trustees, and others. The services of the homecare and psychiatric nurses maintained residents with medical and/or mental health issues outside of the hospitals. A trustee who understood this population and their impairments was essential in taking care of their financial needs. The compassion and humour of a police officer bringing a resident and his shopping cart, referred to as his fifth wheeler, back to WWH brought humanity and acceptance to the resident's life. They enhanced the residents' full power of their experiences of community where people are aware of each other, understood and interact collectively within a shared geographical space. Within the inner city, the residents' found a society that accepted them, even if it did so by default. Over time, they integrated into an inner city community where they were recognized as members and ultimately as residents of WWH. People usually seen as faceless and unengaged as they hover in dark/shadowy alleys and corners were recognized as part of the community.

And it's hot upstairs like major hot upstairs, so we sit outside and we're drinking beer, and we're doing whatever, and the bus drivers come by and they're like... We wave to them and everything: we gotta beer going. And the cops drive by; they don't need to stop. [R12-1092]

I go out for a beer, and the taxi driver brings me to WWH. I wouldn't like it if the driver did not know the way to WWH. [R3-79]

The Staff's Perception of Weather Worn Home's Success as a Residency

Staff was asked about their perceptions of WWH as a successful residency. Overall, they believed that the residents were the recipients of care and concern by an experienced staff who had a good understanding of their needs and the approaches required to create a safe and accepting environment. According to the staff, the residents have shelter, food, and medical care in addition to opportunities to socialize and interact with others in a safe place.

[Ex-staff from 10 years ago, now a health care professional] "I think it [WWH] provides the best quality of life for a subgroup of very hard-to-house individuals. And their alternative would have been literally sleeping on the streets. Because these are the organically impaired and a lot of them have deficits with their ADLs, so I think for that group they [staff]

provided really, maximum quality of care. And in an environment that was non-judgmental, of them, and almost accepting of where they were, wherever that was. And I think that type of environment is very appropriate, for that subgroup. You had residents in there who were extremely difficult to handle behaviourally and would have gotten kicked out of many of the other facilities, and I think that it's that ability to allow some of the drinking to continue, that the residents were able to actually stay there. And of course the other things that were very successful about it, I think that the people [residents] who had been there for a while,... I think developed a sense of family or community, that they would otherwise not, not experience in any other situation. [S1-270]

Staff's Attitude Towards the Residents

Staff recognized the benefits of WWH for a group of individuals unable to conform to the rules of other inner city agencies and/or behave appropriately in these settings. The staff projected an intuitive awareness of what the residents were capable of and able to do because of the residents' and staff's long-term involvement at WWH. In order for staff to be effective and take care of themselves they saw it as essential to understand the origin of the residents' impulsive behaviours and to try not to take it personally when they were the recipients of the residents' verbal outbursts or other inappropriate responses. Not everyone can face the challenge of working at WWH. The interviewees recognized the commitment, beliefs and energy required to deescalate and tolerate the residents' volatile behaviours.

> Well, first of all I would say to them [potential applicant for WWH staff positions], be compassionate and nonjudgmental. If you have those two qualities, your okay, but don't forget the boundaries. [S2-234]

> They [potential applicants] would have to look at the place, [WWH] carefully before they take a job... As toward their own values, and why as to their own interest in the job. They gotta make sure that they can relate to what's going on. Values and beliefs have to relate to what is going on. [S6-206]

It is easy for good qualities to be overlooked in a population seen as down and out. Their roots, connections and personalities are lost when they are perceived as ruined and derelict. The staff enhanced WWH's accepting environment by recognizing the residents' positive attributes and individualities. Their success in providing a long term, stable environment for the residents enabled the staff to know the residents as individuals with life histories and stories. Each resident brought a mystery that, with time, was more likely to be unraveled or understood by the staff.

In addition, the staff's role in modeling respectful interactive behaviours brought out the unused social repertoires of the residents' lives. Seeing and experiencing relationships demonstrated more appropriate verbal and non-verbal interactions. The staff's physical contact (gentle touch and guiding hands) with the residents was seen by staff as essential and valued by the residents especially when people have recoiled from

them. Residents who have experienced being unapproachable in society became approachable. They were seen as human beings beyond their problems and disorders. The residents were validated as individuals with a sense of identity and importance. The empathy and interest the staff expressed to the residents impacted on the emotional and moral atmosphere that reigned in WWH.

> I think their survivors and need to be quick on their feet, they know what's important, and they still know how to enjoy themselves...because if you don't have all the toys of life, then you use what you've got. [S1-968]

> They [residents] are funny, they're witty; they're smart. And they make you feel happy, even if you do something wrong. [S2-367].

Staff's Feelings of Insecurity

The intent of interviewing the staff was to capture their perceptions of WWH as a successful agency. However, a more detailed analysis of the data produced an understanding of the staff's unique experience working at WWH. The shelter had evolved over time and the staff had matured in their knowledge of the residents, as many have been there a long time. This growth had contributed to the staff's interest in continuing to expand their knowledge of this diverse population and refine their skills in caring for them. Their responses indicated that they were highly motivated in learning more about the residents' impairments and behaviours, such as the effects of substance abuse on their minds and bodies, in order to intervene more effectively with the residents

and utilize appropriate community resources as needed.

> You know like the mental health patients, I just try to understand you know, that they're new people, they're harder to, you know to work with them. [S9-156]

> Maybe we can use more in-services because there is always something we can learn. You know uh, give us, more ideas, like with our mental health group, and even in terms of the alcohol, I find it interesting when we have had people who tell us what alcohol does to the body and the brain. [S8-1025]

Overall, the interviewees felt comfortable in dealing with the more obviously impaired and chronically ill residents. All of the interviewees were confident that the majority of the residents fit the criteria of WWH's mandate. Some of the interviewees raised concerns about a smaller group of residents in there 30's to 40's who appeared to be less overtly and cognitively impaired. They queried if this population was at risk of becoming entrapped in an environment that would feed into their problems. The staff questioned whether there was a small portion of residents at WWH who could recover from their present circumstances. The fact that staff was reflecting on all aspects of these concerns was an indication of their investment in this agency and its clients.

> Unsuccessful when you supply a bed that, the guys just create an

environment they can be unhealthy in. [S3-219]

> Well, you know, uh, on one hand, we, will know we have the mandate you know... were suppose to be non-judgmental, were suppose to be here for the guys. And then, and then there's other times where we seem to fall; we seem to get away from it, and you, know, were actually housing some of the wrong people here. [S9-197]

Experiencing Losses

An issue that appeared to be just as important for the staff as their concern about entrapment for the younger residents was the intense challenge of watching residents deteriorate and die who they have come to know and care about. The older, frailer, and more vulnerable residents could go into seizures and die without alcohol in their systems. Their bodies were too fragile to cope with withdrawal. A staff member described this evolving state of chronic alcoholism as, "surviving to drink and then drinking to survive". One of the interviewees at this latter stage of abuse died two months after sharing his story with me. Drinking was a part of his survival as well as a contributor to his death. A plaque on the wall of WWH paid tribute to residents who have died, according to a staff member, from the direct effects of alcohol, injuries as a result of accidents, or as victims of inner city violence.

As iterated by one interviewee, it was more painful and difficult to focus on objectives that are going to make the resident's impending death more comfortable rather than focusing on objectives aimed at a rehabilitating him in order to prolong his life. This

was a challenge that required knowledge and skills to both accept that there was no cure for a resident and to recognize that he was experiencing a better quality of life then he would have if not for WWH. It was more comfortable to believe that the residents' deterioration could be avoided, although this false hope could set the residents up for failure. WWH's mandate redefines success for individuals trapped in a toxic lifestyle; from saving the residents to improving the quality of their lives that means abandoning one kind of hope for another. This required facing the harsh reality that some residents were beyond being saved and that the staff was powerless in changing this outcome.

During my involvement with WWH, two residents died less than a year after being interviewed. Considering that I felt sad about the loss of these two individuals, the intensity of these feelings would be even greater for the staff that had been involved in their lives for several years. It might seem like small consolation for the staff to know that a resident did not die alone on the street and that his spirit and unique self has influenced and been influenced by the staff. In this sense, the meaningfulness of the resident's life in WWH became meaningful in death. At times, WWH staff and the deceased resident's family have shared their stories about his life before and during his stay at WWH. After the death of one particular resident his extended family thanked the staff and sent a card expressing their appreciation to them for being there for him. These quotes capture the staff's feelings about caring for individuals at risk of illnesses and death.

> It's usually when [staff was asked about not feeling good about their work at WWH] somebody dies or is uh very ill. It's just that there was just a

funeral for Y. [resident] that's also sad. [S3-279]

You know, it's very heartbreaking working here at times. You know? Because I have been to every one of these funerals [of deceased residents names inscribed on the plaque]. [S8-410]

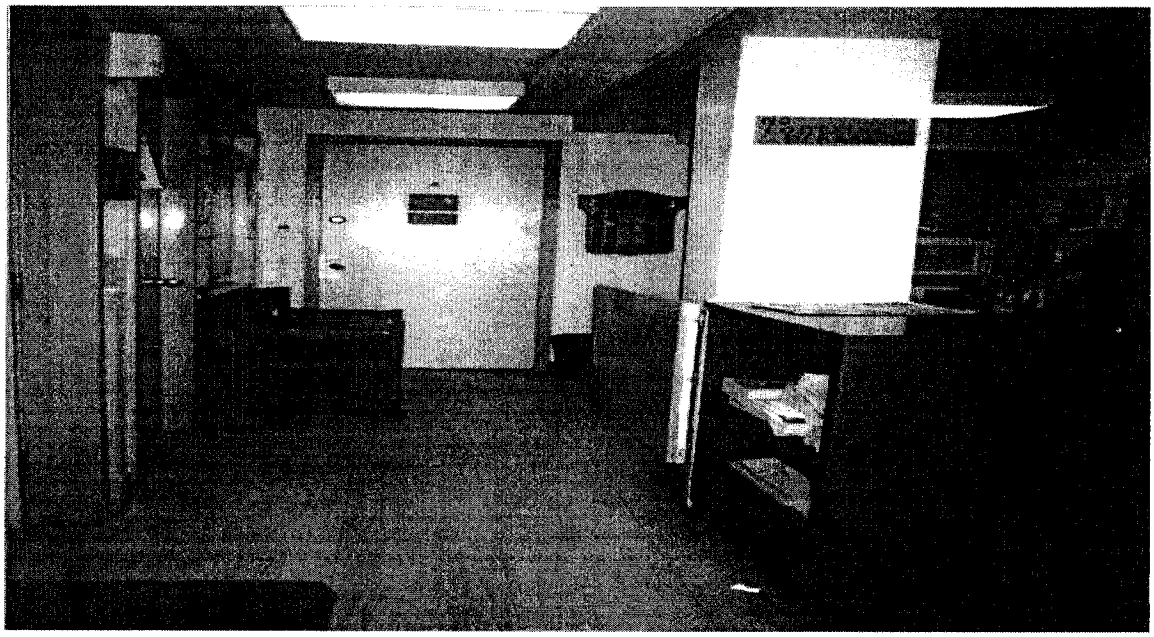

Figure 4-4. Offices Area with Plaque of Deceased Residents' Names (on Back Wall)

The Board Members' Perception of Weather Worn Home's Success as a Residency

I initially set out to describe how WWH's residents experience a successful residency. During this process, the realization that there were multiple and intricate factors responsible for this success became overt. My initial impression of WWH as a drop in for the down-and-out was influenced by WWH's structure and location, as an isolated and neglected building in the inner city. This impression changed drastically with learning about the extensive involvement of other individuals such as, the board members in supporting a neglected population.

Not only did the board members have a long-standing connection i.e., the chairman has been involved since the mid eighties, they have a variety of expertise as professionals i.e. lawyer, occupational therapist, accountant, pharmacist etcetera. Their collective resources have been advantageous to the residents. Although, they were on the periphery of the day-to-day operations of WWH, their involvement was important and necessary as a driving force behind the residents' experience of WWH as a successful residency.

Board Members' Long Standing Interests in WWH

The board members helped bring WWH from an agency barely surviving to an agency providing more than the necessities of life for the residents. WWH had gone through growing pains, resolution of these pains, to a thriving agency providing more than a roof over the heads of the homeless. The board members continued to express interests in finding ways to more effectively support the residents, and the staff within the

parameters of the mandate. They were looking at realistic indicators of success such as residents referring to WWH as their home and feeling respected by the staff etcetera.

> The executive director, a good one will always make it easier, easier for the board. I think that the challenges are, it has and always been uh, trying to ensure that we've given quality service, uh, quality accommodation within the restriction that we put in place. [B11-72]

> For a successful program, the residents; a resident states that WWH is his home, on some document. WWH is recognized as providing a useful function, or doing its job well. [B4-142]

Board Members' Understanding of the Residents' Needs

The board members' long standing involvement with WWH have resulted in increased knowledge for them of the needs of this hard-to-house population and an in-depth awareness of what does not work, such as forcing their values onto the residents. As reflected in the board members' quotes, residents have acquired increased stability in a compassionate atmosphere. It was apparent in the interviewees' comments that the board members' experiences with residents have developed into a genuine concern and respect for them.

> Well I think they [residents] get the basics. They're getting food and shelter and some semblance of safety. Um, with a nonjudgmental to it.

With an acceptance of who they are. [B12-594]

I think the site inner city [for WWH building] is appropriate because it's still within the confines of the residents' territory. And I think that most important that they feel um, they feel comfortable in their surroundings. If the chance was not to select the site [inner city] that would have been different for them to get to, in the sense of outside of their circle. [B5-350]

Group Interview with Participants from Community Agencies

Reciprocal Connections

The director and staff were seen as pivotal in providing both an internal and creating an accepting external environment that accommodated the residents' needs. In order for WWH to accommodate this population successfully, they required the support and a positive working relationship within the inner city network (see Figure 4-6 for Linkages Creating WWH's Collective Social Structure). Many individuals within the inner city network have come to understand that the environment needed to accommodate the personalities, personal motivations and coping styles of the residents, and not the other way around. The support between the inner city network and WWH has developed over time. It has become a shared world isolated from mainstream society.

The dialogue was animated and interactive, illuminating the reciprocal relationship between WWH and the agencies that shared a common understanding, collaboration of services and further information sharing regarding the homeless. The

participants perceived WWH as an integral part of the community collaborating with other agencies in order to provide the essential supports required in the inner city. WWH's apparent success could not be easily replicated because it did not function effectively in isolation from other agencies. These quotes capture a picture of the reciprocity existing between individuals sharing a collective understanding of the inner city's culture and a commitment to respond to the needs of its misunderstood and alienated population.

> I would never get anything done here without staff coordinating... filling in informing me when I can can test for TB.... Can't change residents... have to work within their parameters. [C7-104]

> There was a time when WWH was able to provide emergency beds which was really nice for us. And I don't know if they'll ever reconsider it, and I don't blame them one way or another, if they don't decide to, but we sure benefited from it. And one of the reasons is, not only are we full all the time, but beyond that sometimes a person will act out at our place, has to leave, but if he can go to WWH. I always hope that if a guy was barred at one place that he would be good somewhere else. [C3-569]

The reciprocal relationship between WWH and inner city agencies also included the residents' mutual respect and concern for professionals. WWH was perceived as a sanctuary to this professional who found comfort there. In some sense the residence was

providing a service that resulted in the person feeling "rejuvenated". I was also a recipient of the care and concern by an ex-resident who prepared a meal for me during one of my evening observation periods.

> When I use to come here, residents would say, "Hi, how are you?"... got more attention here than at home. When I need professional rejuvenation... come here, have a cup of coffee and chat with Y [resident] and F [staff]. [C4-545]

Community Participants' High Regard for Staff and Residents

The participants recognized WWH as a valued agency dealing effectively with the hard-to-house. According to their responses, WWH's success was the result of an effective interplay between an appropriate mandate for a specific population and the attitudes and abilities of the staff and director. They perceived the staff's approach and positive attitude towards the residents as being sensitive and effective in dealing with their heterogeneous needs. Both the staff's and residents' contributions to the community participants' perception of WWH as a unique facility is recognized in these responses.

> I think the staff is pretty clear on, on what they're suppose to do, and when and how, and we're really impressed with that, that the staff is pretty clear on everything from what their specific job is to what they can expect to do if something untoward happens. [C1-261]

> A concern for staff is the residents' use of needles...and safety. Staff know that providing education on needles reduces their anxiety [staff] and they are more receptive to residents. This doesn't work in all agencies. It's about facing things and getting on. [C2-223]

Overarching Theme: Connectedness

From my initial focus on the residents' experience of WWH as a successful residency emerged themes of security and safety, boundaries and feeling connected. The staff revealed their unique relationship with the residents and their commitment to meeting their needs. Interests in providing the hard-to-house with a safe and accepting environment was shown in the board members' responses. The community dialogue enlightened the reciprocal relationship between WWH and other inner city agencies sharing not only resources but also a common understanding of the inner city culture and its population. From these four subgroups of themes emerged a complex framework for WWH's success, and the overarching theme of connectedness.

> Connectedness is similar to transcendence. It implies an experience that is separate from day to day reality, but connectedness typically refers to perceptions and experiences of bonds with people living or dead across time or space (Unruh, Versnel and Kerr, 2002. p.9).

Connectedness was manifested in a shared understanding of WWH's success and meaningful relationships between all of the participants in the study, in spite of their

diverse backgrounds as professionals functioning in mainstream society and residents struggling to survive in the inner city. They shared a united understanding of WWH's mandate and belief in its value and effectiveness in supporting the hard-to-house, which had significant impact on the residents' day-to-day functioning. Emerged themes from the study demonstrated a communal component to the connectedness of reciprocal interactions, cohesions and patterns of support. Meaningful relationships amongst all of those involved in WWH's existence have yielded a congruency of purposes and values that have withstood the test of time.

Connectedness was also a function of WWH's environment and the residents' experiences of WWH as compared to other environments. The environment was essential to the widespread recognition of WWH and to the residents feeling that they were members of the community. The essence of the residents' experiences of WWH's was manifested in their ability to exist and survive despite severe disruptions in their lives.

The overarching theme of connectedness was in contrast to the profound disconnectedness (see Figure 4-8) that has pervaded in the lives of the residents, who were detached or in some sense disconnected from their bodies, minds, families and significant others. I met a resident at WWH whose lived reality appeared to be the epitome of disconnectedness. He had been wandering from ditch to ditch across North America prior to his return to WWH. Although he was disoriented and believing that evil spirits were after him he was able to let the U.S. customs official know that WWH was his home. As a result, he ended up under the concern and watchful eye of WWH's director, who was making arrangements for him to get medical treatment. Not only was the disconnectedness evident in his state of mind, but also in the neglect of his hygiene.

His hair was matted and greasy, clothes were filthy and the odor emulating from his body made it challenging for me to remain in his presence.

Nevertheless, he demonstrated that in spite of the reality of his present existence, he had an enduring bond with WWH that overcame barriers such as distorted and disorganized thoughts. This story is an example of WWH's effectiveness in fostering bonds in the residents' environment that captured an exceptional "spiritual" experience that went beyond day-to-day reality and overcame barriers commonly seen as impenetrable and unmovable. The experience transcended explicit barriers to communication and resulted in an implicit profound understanding and interaction between people (Unruh et al., 2002).

Spirituality

Spirituality is recognized in occupational therapy literature as "A pervasive life force, manifestation of a higher self, source of will and self determination, and a sense of meaning purpose and connectedness that people experience in the context of their environment" (CAOT, 1997. p. 182). The discovery of spirituality in the study emerged from the overall thematic analysis of the data. Although the spiritual dimension is associated with all human beings it is not usually associated with the homeless, a group whose behaviour is understood as grounded in the streets of basic subsistence/existence and not the "existential universe". In the study the residents' spirituality was expressed through the residents' motivation to survive and connect with self and others.

For the most part WWH residents were not a target group that responded to rehabilitation and moved into mainstream society. However this interviewee, a previous

resident had abstained from substance abuse for over a decade. He reintegrated into mainstream society, furthered his education, and found employment. This ex-resident reunited with his adult child from whom he was estranged from for several years because of the resident's past substance abuse. He was in a long-term spousal relationship. With much clarity he captured the climate and his experiences of a residence that provided security and acceptance that he needed during a chaotic time in his life. His story touched on the two different experiences of self and being disconnected and connected with others before and after abstinence.

> I'd came here, you know to die an alcoholic cause that's where it was heading. So I was drinking everyday, and I wasn't drinking just, just straight booze that you buy from the liquor store... I was drinking other, um stuff in my addiction. Like I was drinking hair sprays. And um, you know extract, vanilla extract, rubbing alcohol, Lysol spray, those kind of things. Like, those are killers. Killer toxins. And I was drinking that. I, I, I knew I was living on the edge and didn't want to... You know, if anything ever came or happened to me...Like maybe a sudden illness uh, I, I didn't want to, didn't want to uh die alone. [R9-394]

The profound meaning of spirituality was evident in this story and revealed that answers to problems are not always straightforward. From his story I learned that personal transformation is not always foreseen or consciously planned. It brought to light a revelation of the self that can overcome the impediments of illnesses and

substance abuse. Because the ex-resident felt acceptance at WWH he was able to foster within himself spiritual personal growth that resulted in profound changes to his life style. He was able to find remarkable energy and commitment to retrieve from within him what was lost.

> And uh, while I was sitting there (bench in front of WWH), then something I don't know what it is, a presence or something, I felt this, and I heard this voice kind of thing, that said to me, " L. why don't you try it my way?" Just like that from nowhere, from out of nowhere, that, that voice. You know I, I wasn't a Christian or anything like that... You know at that point I was just interested in having a drink, and then that voice. So, one of the guys came, and came into the building and said L., lets have a drink, it's outside. I said, "I don't want to, I just want to hold off for a little while; just sit here for awhile, and see what happens." He said, "Well you better hurry, cause it's one of those... It's not gonna last very long. The guys are just going out,... Drinking like it's going out of style". So, I held off. I held off. And so, that was the first day of my sobriety. It was terrible but I, I stayed sober. I had been sober a few months. I think it was about three or four months. I was feeling the effects of withdrawal but my head was starting to clear. I was starting to feel; I was starting to feel the, emotions, that my emotions were coming back. The emotions I never knew I had. [R9-353]

While revisiting the data, I recollected a resident pointing out the importance of bringing a plaque located at the entrance from the old WWH to the new WWH. He liked the way it was worded and put together (see Figure 4-5). This plaque epitomized the philosophy and spirituality that was evident in the results of the data analysis. Although the resident stuttered and was a concrete thinker he effectively used the plaque to express what he could not say himself. I could not have found a better representation of the meaning of connectedness and spirituality at WWH.

Every stated goal and activity of WWH derives its meaning and life from its fundamental spirit. It is crucial and absolutely necessary that everyone involved grow to understand, appreciate and implement this spirit in all activities of WWH.

The more unity of spirit there is, the greater success there will be for those in our care.

The spirit and life force of gentleness, kindness, compassion and brotherly love. It is non-judgmental and non-condemnatory. It is the spirit that sees into the very heart of the pain and suffering of people, and holds out its hand of love. Its justice is always tempered by mercy and forgiveness. This spirit is one of service and surrenders to the needs of others. It does not exploit, use or manipulate. It is a spirit of unselfishness, always moving to unite, reconcile and make peace. It is the spirit of Abraham, of Jesus, St. Francis of Assisi, Mother Theresa, Gandhi and Martin Luther King Jr. It is the Great Spirit of our ancestors. It is the fire of love that becomes a flame in our own hearts. It overcomes fear and hostility inspiring us to work toward unity and peace. It is universal and everlasting. In spite of the obvious chaos and social upheaval in our world today, this spirit renews and saves us from despair and illusion. It never gives up. Such hope springs eternal in the human heart. It is not enslaved by the isms and cultic aberrations of our day. It respects science and reason and the mind of man, but it is not determined by any of them. It is the spirit of wisdom that transcends all human knowledge. It integrates all truth in serving the dignity of each person. It is a free spirit, enslaved by nothing, yet a loving servant of all. Such a spirit liberates and makes us look on one another as brothers and sisters in the one human family under God.

This is the fundamental spirit and guiding philosophy of WWH.

Figure 4-5. Spirit and Philosophy of Weather Worn Home as Worded on Plaque

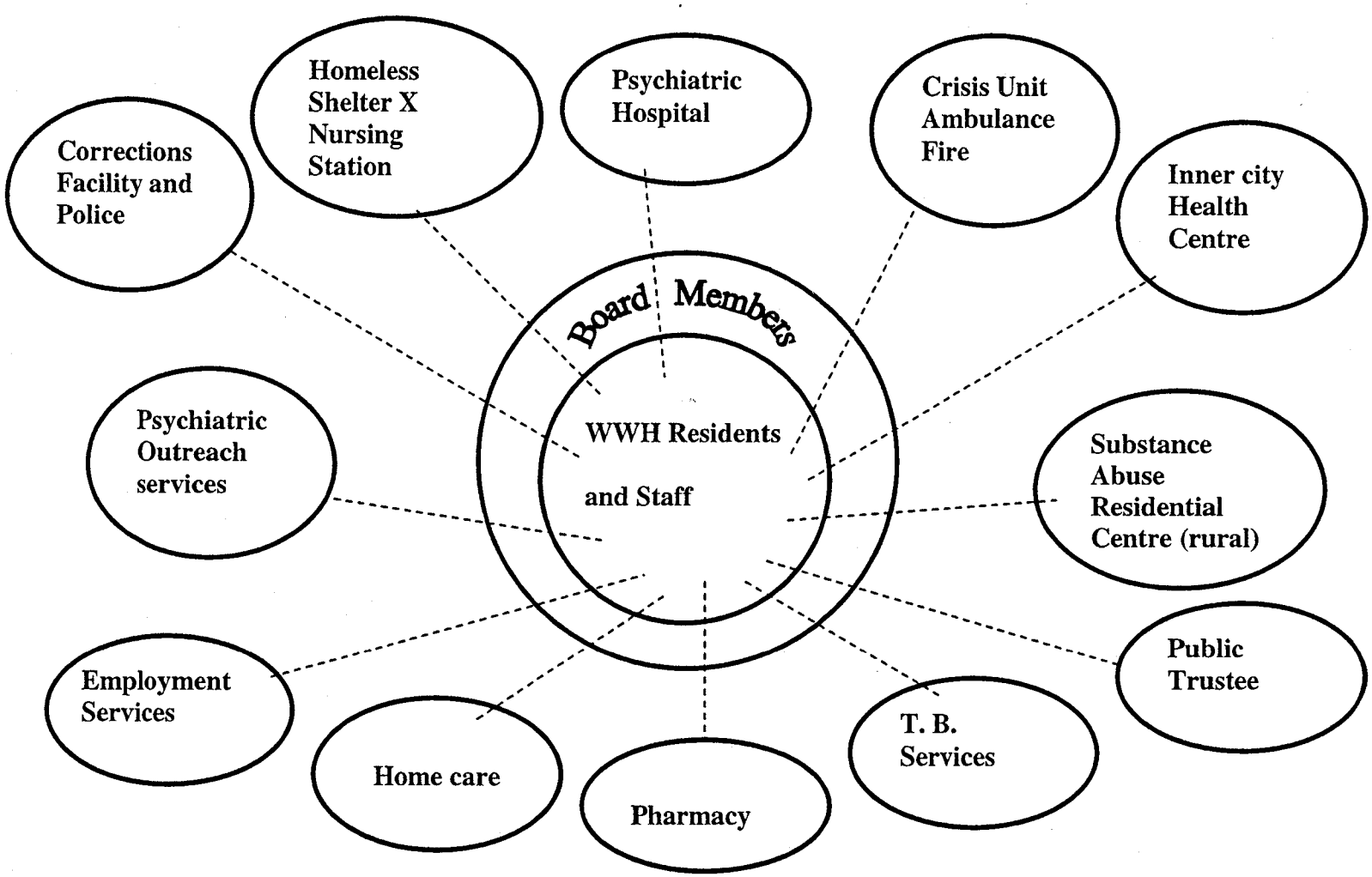

Figure 4-6. Linkages Creating WWH's Collective Social Structure

<table>
<tr><th>RESIDENTS</th><th>STAFF</th><th>BOARD MEMBERS</th><th>COMMUNITY</th></tr>
<tr><td>Security and safety relative to the residents' needs and their environment</td><td rowspan="2">Staff's recognitions of residents' needs</td><td rowspan="2">Board members' long-standing interests in WWH</td><td rowspan="2">Reciprocal connections between WWH and members of inner city agencies</td></tr>
<tr><td>Presence and flexibility of boundaries</td></tr>
<tr><td rowspan="3">Feeling connected to others:

Connections between residents and staff

Connections within the inner city network</td><td rowspan="2">Staff's concern about the residents' lifestyle and impairments</td><td rowspan="3">Board members' understanding of the residents' needs</td><td rowspan="3">Community participants' high regard for staff and residents</td></tr>
<tr><td rowspan="2">Staff's connections with residents' resulting in their experiences of losses when residents die</td></tr>
<tr><td>Connections between residents</td></tr>
<tr><td colspan="4">CONNECTEDNESS</td></tr>
</table>

Figure 4-7. OVERVIEW OF THE THEMATIC ASPECTS OF WWH AS A SUCCESSFUL RESIDENCY

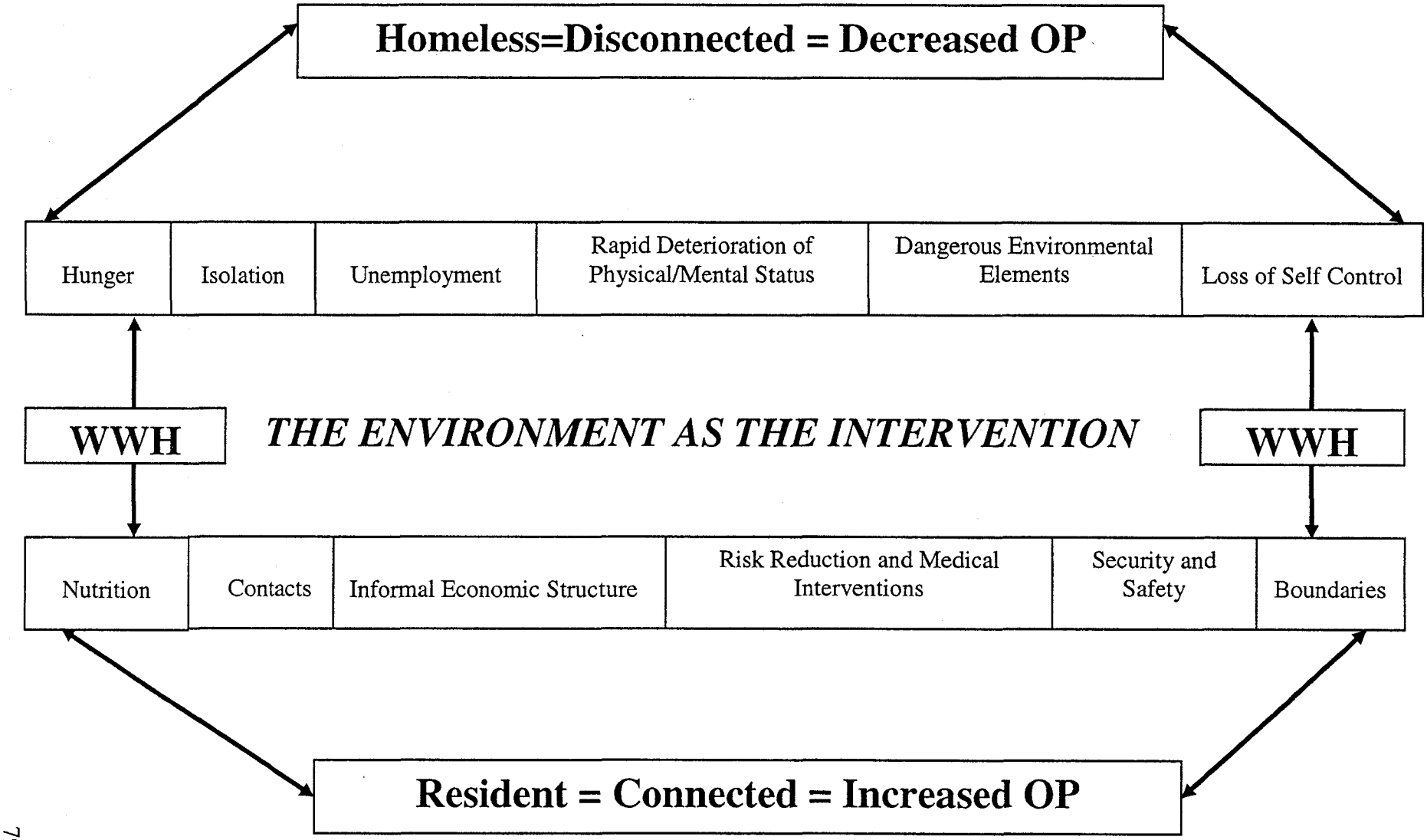

Figure 4-8. Occupational Performance (OP) as Related to Disconnectedness and Connectedness

Summary

As residents shared their experiences of a safe and accepting setting where they could return to for daily food and lodging, themes of feeling connected, security and safety and boundaries emerged. The findings from the study are important because the themes of how security and safety, boundaries and feeling connected are significant to the residents, a hard-to-house population, brought to the forefront that residents have personal insights into their own situation and what is meaningful to them in terms of a successful residency. By capturing the congruency of the participants' values, beliefs, and goals as they pertain to WWH I discovered an overarching theme of connectedness and related spirituality that was manifest in the relationships amongst those associated with WWH such as the residents, staff, board members, and members of inner city community support agencies.

Chapter V

Meaning and Discussion of the Findings and Experiences

Application of Occupational Therapy Models to the Findings

How the Findings Support the Client-Centred Practice Model (CCP)

In 1939, Carl Rogers coined the phrase Client-Centred practice (CCP) (Corring, 1999). CCP was a revolutionary approach to psychotherapy and human relations that evolved from theories of personalities and behaviours. CCP utilizes open communication and therapeutic use of self as a means to being sensitive to the clients' feelings and thoughts existing in their private world. From a psychological orientation the private world of the individual consists of his/her perceptions of his/her reality and from a sociological orientation reality consists of those perceptions common amongst various individuals existing in similar cultures (Rogers, 1984).

A key characteristic of CCP as developed by Carl Rogers is its phenomenological nature (Rogers, 1984). An important assumption arising from this characteristic is that clients are the best individuals to describe their experiences and their reality. The clients' perceptions of their lived experiences take precedence over the clinicians' interpretation (Rogers, 1984). For CCP to be effective a dynamic process of thinking on the clinician's part is essential in looking at the significance and worth of people.

Mary Law captures the essence of CCP in occupational therapy by endorsing an understanding of clients' life stories in order to understand what is meaningful to them regarding their everyday occupational performance (OP) (Law, 1999; Hammell, Carpenter, Dyck, 2000; Towsend, Birch, Langley, Langille, 2000). A fundamental

concept of CCP as utilized by occupational therapy is that therapists approach clients from the clients' frame of references, which includes their values, choices, and personal methods of coping and functioning. CCP requires the therapist to both acknowledge his/her beliefs and biases and to go beyond perceptions and experiences of occupational functioning in his/her life world in order to be open to what is meaningful in the life world of individual clients (Law, Cooper, Strong, Stewart, Rigby, Letts, 1996; Law, 1998).

From all of the participants' responses I discovered that the staff's approach to the residents from the residents and not the staff's frame of reference reflected the CCP philosophy of seeing the worth and significance of each unique person. Over the years that WWH has existed, those associated with the facility in supporting the residents have accomplished WWH's mandate by getting to know and appreciate the motivations and coping styles of this complex subgroup of homeless individuals in order to intervene at a workable level and enhance the residents' quality of life. CCP was a process and not a state of achievement that was reflected in the staff's relationships with the residents that has resulted in the residents' sense of security and acceptance.

How the Findings Support Person-Environment-Occupation Model (PEO) Emphasizing the Environment

The recognition of clients' roles and lives within a larger community context should be considered in all aspects of service delivery. Social and healthcare providers need to look at resources that fit with the unique cultural values of the clients' environment rather than try to make resources fit from the professionals' experiences of

their own environment (Law, 1998). The PEO model uses concepts developed from environment-behaviour theories and client-centred practice. The occupational therapist's focus of intervention using the PEO model is on recognizing the unique interests and needs of a client within his/her particular environment (Law et al., 1996; Law, 1998; Strong, Rigby, Stewart, Law, Letts, Cooper, 1999).

Emerging models of practice in occupational therapy emphasizes the PEO relationships by focusing on the "person" and their "environment" as essential factors in enhancing or deterring the client's occupational performance (Law et al., 1996; Strong, Rigby, Stewart, Law, Letts, Cooper, 1999). The PEO model is used to examine problems in OP by assessing the interplay between person, environment and occupational elements in order to understand the nature of their relationship and impact on OP (Law et al., 1996; Strong et al., 1999).

The residents have severe occupational deficits, which were both contributory to and the result of their debilitated states. In fact, their inadequacy in the areas of self-care, leisure, and productivity were obstacles to residential stability and put them at risk of harsh abject homelessness and dying on the streets. In the study presented here an adaptation of the PEO model illuminated the enabling aspects of the residents' environment. Although the profile of the residents was an essential piece of the study the environment (see Figure 5-1) was key to understanding the residents' ability to increase their occupational performance.

The enabling features of the community and WWH have made a big difference in the lives of the residents. The inner city (the residents' bigger environment) fit for them because they did not stand out and were not stigmatized and rejected. Within this

neighborhood and WWH the residents were able to function to the best of their abilities in regards to self-care, socializing and involvement in occupational activities. Overall, the residents maintained a healthier life style because the director and staff created an environment in order to provide entrance for the residents into a setting that was responsive to their true nature.

The PEO model highlighted the study's findings of appreciating the interplay between individuals' profiles, realities of their environment and there impact on human occupation. Those associated with WWH and providing services to the residents have an experiential understanding of what was necessary to alleviate some of the residents' suffering and to bring about realistic positive change for this hard-to-house population. They were aware of the need for an institution for the hard-to-house that does not personify the characteristics of institutions. The director and staff were intervening at a level that excluded making value judgments about the residents and integrating the residents' values into a service with relevant goals that take the residents' choices into consideration. WWH was the right environment for a subgroup of homeless people with the right expectations that are congruent with the residents' expectations and the community that they lived in. Weather Worn Home (the environment) was the successful intervention in making a difference in the lives of the residents. For it to be as effective as it was, it needed to exist in the inner city where the hard-to-house congregate.

The elements of the environment can be described in many ways. The Canadian Model of Occupational Performance (CMOP) (CAOT, 1997) has four elements: institutional, social, physical and cultural. An overview of the impact of the environment on the residents' perception of WWH as a successful facility in the inner city follows:

Environment: (WWH)

Institutional: stable source of funding and accessibility to the residents

Social: stable interpersonal relationships and social opportunities

Physical: shared living space i.e., dormitory, safe and secure building

Culture: nonjudgmental and tolerant attitudes

Environment: (inner city)

Institutional: government policies, eligibility for services, stability of social programs and medical services

Social: awareness of social opportunities and individuals who are potentially dangerous

Physical: economically challenged geographical area

Culture: tolerance of unusual behaviours, values and choices

In order to understand how the environment can be used to support a disenfranchised population, professionals need to shift paradigms and view environments usually seen as disabling as enabling. WWH was effective in recognizing this phenomenon and in creating a more functional life style for the residents although their lifestyle may still be considered dysfunctional in the eyes of others outside of the environment. Despite the inner city's appearance as a disabling environment in terms of the availability and use of drugs and alcohol etcetera taking the residents out of this environment would be akin to taking fish out of water. The staff and those associated with the operations of the facility understood both the culture of the larger environment

(inner city) and how to create a culture within WWH that made it more preferable to residents than taking their chances on the street.

Occupational therapy is a profession whose philosophies are grounded in principles of open mindedness to others and the importance of their respective environments. WWH is not a traditional institutional culture that occupational therapists typically find themselves in but its philosophy embodies occupational therapy principles by seeing, accepting and working with the enabling factors in a client's unique environment.

WWH philosophical perspective personifies occupational therapy concepts such as CCP and PEO. These concepts were never formalized or recognized until the study but operationalized through WWH's evolutionary process of appreciating the residents' profile (a high needs and unique sector of the homeless population) and adapting the environment to fit with this profile. Occupational Therapy models Person-Environment-Occupation (PEO) and Client-Centred Practice (CCP) concepts captured an understanding of "successful" programming for the hard-to-house, from the perspectives of the recipients of those services such as WWH's residents. Figure 5-1 illustrates the importance of using an environment such as WWH as an intervention to improve the residents' day-to-day lives and occupational performance.

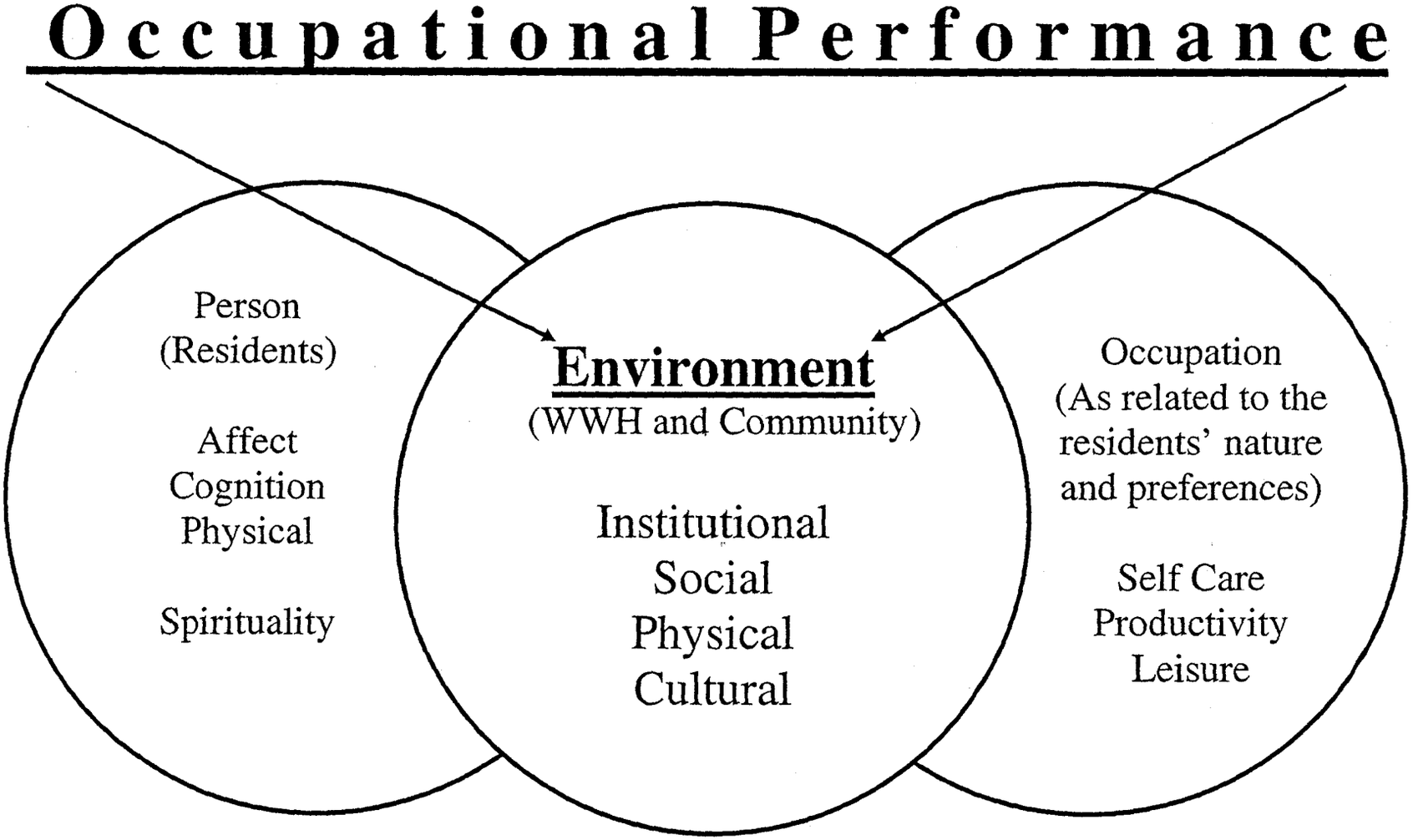

Figure 5-1. Person-Environment-Occupation Model Emphasizing the Environment

The Experience

Poverty and subsistence survival have been and will always be a reality in the world around us. The number of homeless around the world estimated at one billion people including those living in uninhabitable shelters affirms the expansiveness of this tragedy (Begin & Saoub, 1991). Worldwide and close to home evidence shows there are no single cause and no single solution to solving the problems associated with homelessness (Cohen et al., 1994). From looking at homelessness from a macrocosm of the literature review to a microcosm view within Weather Worn Home (WWH), I experienced an overwhelming sense of the enormity and complexity of homelessness.

Broader definitions of homelessness as used in the United Kingdom include individuals in shelters and single resident occupancy and thus would include those individuals living at WWH (Cohen et al., 1994). WWH has all the universal homeless issues. Within the shelter I became aware of the intricacies and of the many-sided reasons for the residents' present circumstances.

I was conflicted in both wanting to believe some of the residents could turn their lifestyles around while at the same time recognizing that their dysfunctional conditions were chronic and unremitting. It was a struggle to resist counseling on a couple of occasions, when it was more emotionally comfortable to fall back on my preconceived beliefs that a healthy existence should be wanted by all. This tumultuous experience lead me to question if society's harsh and punitive judgments of the homeless as being intentionally self-destructive and responsible for their status relates to a need to deny the reality that a marginalized standard of existence may be the only acceptable option for some people.

Two weeks into the daily visits to WWH, I experienced an acute awareness of the individuality of the residents. My initial shock to the dingy and grey environment transformed into a feeling of comfort being in the presence of colourful and interesting personalities. The impoverishment of the background faded and the residents became individuals each with his unique character traits, morals, values and purposeful activities. I felt the humanness in individuals caught up in a cycle of poverty, compromised mental and physical health, and estranged relationships with family and significant others.

Through the residents' accounts of their lived experiences I saw the whole person with strengths, vulnerabilities and a personal history. I realized that there were both "sameness and differences" to the residents' and my existence (van Manen, 2002). The residents interviewed were not so different from myself in their need for a safe personal space where they belong and are valued. They had family connections and contacts in mainstream society. These hard-to-house individuals had an array of feelings and needs no different than the array of feelings and needs that exist in all of us. This enlightenment came with time and not short-term involvement.

Occupational therapy concepts (CMOP & PEO) made it easy to understand and to communicate the purposefulness of the residents' activity repertories in self-care, productivity and leisure. An occupational therapy perspective made me more sensitive to the uniqueness in each individual and in his or her lives. Through the process came a deeper level of understanding and appreciation of occupational therapy's models and concepts. The experience filtered down to the level of emotions, values and beliefs that had previously been muted by my extensive experience working in institutional environments. I gained a greater knowledge and sensitivity as to how the occupational

therapy profession and its concepts and philosophies can be practically applied to sectors outside of institutional settings, in particular the social domain.

During the data gathering and analysis, came the realization of how easy it is to overlook everyday opportunities for learning. These opportunities permeate in a variety of society's environments and are unseen because of the appearance of faces and facades that appear vacant of knowledge and thus create no interest in the onlooker. This enlightenment was critical in that it allowed me to look beyond my biased scope of life and to see individuals in the unique aspects of the community in which they live. My naivety about life in a shelter in the inner city was altered and new filters much more sensitive to the variation in others and their environments emerged.

During the process of collapsing the data and writing the report, it was tempting to use all the residents' quotes because each quote represented a special moment of interaction and sharing of their experiences and emotions. The residents' distinctive "lingo" or vernacular with its personalized meanings and shared themes were embedded in each quote bringing back the richness of the total experience.

Comparisons of Findings With Literature Review

Understanding the Homeless

Staff noted that the faces of the homeless have changed over time with a younger population of incurable drug users due to the availability of more potent substances of abuse, and a larger proportion of individuals with a wide range of mental health issues. These changes were also identified in the literature reviewed (Hagen, 1989; Johnson & Freels, 1997). It was reinforced in both the study findings and the literature review that

the issues amongst this disenfranchised group of individuals is complex and cannot be simplified to "they did it to themselves" (Bottomley et al., 2001). Similar to the studies on the etiology of homelessness the circumstances that the WWH residents found themselves in were a result of their unique characteristics combined with psychosocial and environmental stressors that predisposed them to homelessness.

Programs for the Homeless

The study's findings and literature review reinforced the need for individualized and innovative services for the homeless. Solutions are more complex than just providing a mat inside a building and a roof over the heads of the homeless to protect them from the weather. Complex and intangible aspects of a setting such as unconditional acceptance and an understanding of the street culture are needed for the homeless to participate in services that agencies provide. Prescribing interventions from the presuppositions of who the homeless are and not from finding out what is important to them leads to an inefficient and ineffective allocation of resources.

Harm Reduction

Harm reduction strategies are employed worldwide and include practices such as syringe exchanges, modifications to the legal system so that those afflicted with substance abuse disorders receive healthcare monitoring and interventions to help reduce risk to themselves and others (CCSA, 1996). Interagency collaboration between legal, social and healthcare sectors is an integral component of harm reduction strategies.

Proponents of harm reduction view the risky behaviours of individuals with addictions as a public health concern that needs to be addressed by taking into consideration the realities of the individuals' present use of substances (CCSA, 1996). The reality of addictions amongst most of the residents fit with Hajela's (2003) assumption that addiction has an element of choice to it that can be lost once the individual reaches a stage of losing control to the substance. The disease becomes progressive, relapsing and fatal because of its physical, psychological and social consequences to the individual. The prevalence of medical issues amongst the homeless with mental illnesses and/or substance abuse issues is not only evident in the abundance of research on these issues but also in the study's findings.

Many of the residents at WWH suffer from a variety of medical issues such as HIV, heart and liver disease, and TB etcetera. In WWH a harm reduction philosophy provided acceptance and choices that supported residential stability. As a result, the staff could endeavour to reduce the harm risks facing their clients by utilizing harm reduction strategies that take into consideration the residents' medical issues. Staff was able to monitor and provide resources such as home care nurse, bath assist, and etcetera to the residents in need of these services. New inroads into the concept of harm reduction philosophy and strategies have provided a safer place for WWH residents with persistent and chronic substance abuse disorders.

Harm reduction philosophy and strategies continue to be controversial on a worldwide level and at the local level such as WWH. Although the use of drugs and other substances of abuse contribute to the spread of diseases such as AIDS and promotes criminal activities such as the selling of illegal drugs, harm reduction policies run

contrary to society's norms. People opposing the use of harm reduction do not understand its place in helping others and in fact believe it contributes to the proliferation of substance abuse (CCSA, 1996).

In the findings it was noted that the staff sometimes struggled with coming to terms with the residents' declining and terminal conditions and accepting that they could only help reduce the residents' exposure to more harm. Overall, they saw the value of harm reduction strategies in helping the residents function as well as they were able to and thus preventing them from dieing alone on the streets.

Positive Environments

Studies are needed to look at positive environmental variables that promote good outcomes for specific sectors of the homeless population (Cournos, 1987; Goldfinger el al., 1999). Mosher (1999) looks at the impact of atmosphere in engaging individuals with mental illnesses including those that are homeless in temporary residential mental health treatment programs. He studied the effectiveness of healing social environments that involve indirect interventions based on respect, validation and empathy (Mosher, 1999). Traditional therapeutic techniques and language were replaced with "standing by attentively" and "trying to put your feet in the other person's shoes" (Mosher, 1999, p144). The philosophical foundation of his residential programs was strongly influenced by phenomenological/existential thinkers such as Husserl (1859-1938) the founder of phenomenology (Mosher, 1999).

A qualitative study of a residential program offering a homelike supportive environment for individuals diagnosed with schizophrenia demonstrated the importance

for the clients of the "experiences of comfort" and " and being confirmed in a client-care provider relationship" (Pejlert, Asplund, Norberg, 1999. p. 663). The narrative analysis showed the importance of the client-staff relationship in helping the participants feel validated. Themes of increased self-confidence and feeling a part of the community amongst participants who struggle with isolation and low self-esteem emerged from the data. These findings are similar to the study's results showing the importance of a positive environment to WWH residents' experiences of an atmosphere that was conducive to a comfortable homelike environment.

Unexpected Findings

Participants' Perception of the Shelter

An unexpected initial discovery was the staff's long-term commitment to WWH. Four staff members have worked there from twelve to seventeen years and seven staff members have worked from two to eight years. Not all of the staff has a formalized education related to working with individuals with a variety of medical, substance abuse and psychiatric disorders. Through experiential learning they have gained a perspective of the residents and street culture that has enabled them to sustain a diverse population with differing challenges such as brain injuries, substance abuse, schizophrenia, hepatitis, HIV and so on. Residents appeared to be benefiting from the staff's mixture of skills, styles and motivations and their ability to pool together their individual and collective resources and perspectives. This tweaked my curiosity and supplied some of the impetus to investigate what makes WWH work for its population.

It dawned on me after going through the data that the familiar concept of "shelter" was not in the collective consciousness of the study participants. The use of the term shelter, which is usually associated with emergency and temporary night time "flop houses", did not fit for WWH with its more complex workings and relationships, yet that is how it is categorized officially. An indicator of WWH being more than a shelter to staff and board members was illustrated in the responses of the interviewees who wanted to see more recreational activities and opportunities for the residents to socialize and a need for more linkages to outside agencies such as nursing homes, homecare and health centres to support the residents.

The residents had a more realistic understanding of their status living at WWH than I did. They did not see themselves as homeless and in fact saw WWH as their home of choice, an indication that there was an emotional connection to the environment. Residents saw the run down structure from a different vantage point than others outside of their circumstances. Narrow and difficult to access hallways and stairways (for handicapped residents and emergency personal with stretchers), poor ventilation and the dilapidated state of the building blended into the homelike atmosphere. The experience of WWH as a safe and accepting homelike environment from the residents' perceptions excluded the deficient structural aspects of the building and instead involved the residents' internal personal and emotional experiences of WWH.

Since the study a new Weather Worn Home building has officially opened and the building in which I gathered the data for the study has returned to an empty shell. The new WWH facility had a rippling effect on those involved with WWH like a stone thrown into the water and disturbing it for a time but eventually settling. With the

opening of WWH's new doors came accessible hallways (for emergency personnel and the physically handicapped), a state of the art safety/security system, spacious and modern rooms and new opportunities and challenges for the staff, board members and residents. Although the residents now sleep in what most would consider a more secure and safe building one wonders about the kinds of adjustments that had to be made and what was left behind.

The old WWH had a homelike atmosphere where the residents found safety and acceptance and it will take time for the new place to be "home". Just as the old WWH transcended its dilapidated physical characteristics, the new WWH will transcend its new and well-polished physical characteristics because it is the human connections that made the difference and enhanced the residents' experience of WWH as a safe and accepting place. This illustrates the need to attend to the" environment" as a symbolic place that transcends its physical characteristics.

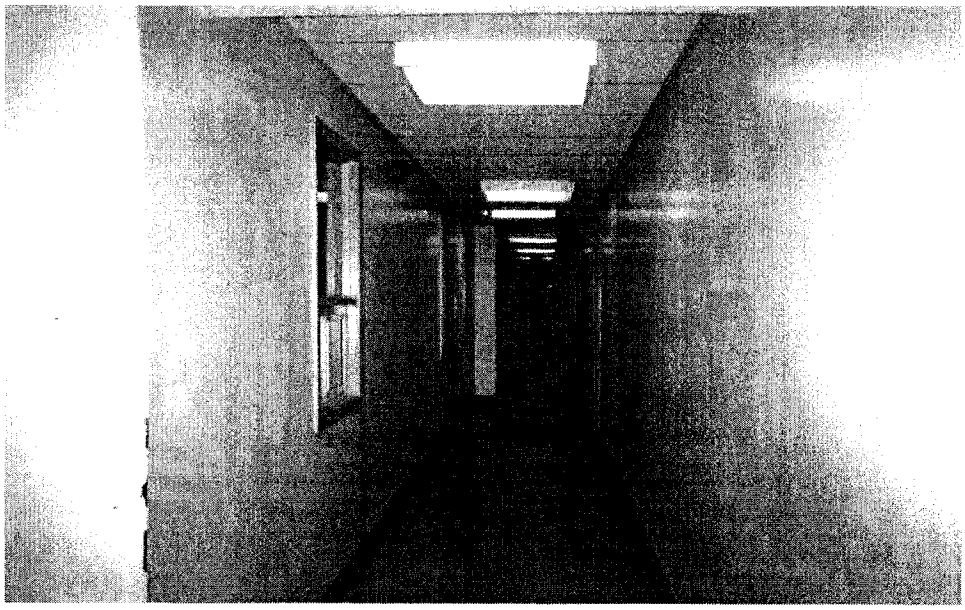

Figure 5-2. Hallway Leading to Dormitory of Old WWH

Figure 5-3. Stairway to Upstairs Dormitory of Old WWH

Humour

After a short period of time I recognized the importance of laughter as a connection between residents and those associated with WWH. A special means of communicating through humour was in the sharing of stories and memories that contributed to a healthy, warm and energetic atmosphere that softened the seriousness of the situation. It was interesting to note that an occupational therapy student experienced the importance of humour during her fieldwork placement in a homeless shelter for men in Ontario. She found humour to be effective in establishing a rapport with the residents and in engaging them in social and leisure activities (Heubner & Tryssenaar. 1996). Similar to her discovery, I saw the benefits of humour and laughter for both staff and

residents in facing and surviving difficult and strained circumstances together. Humour was a special form of communication with overtones of mutual respect and affection for each other.

Humour enhanced the residents' personalities and contributed to their positive identities as interesting people that others want to be around. Humour and laughter were coping mechanisms that they learned living by their "wits". It also helped to normalize the residents' existence by showing that they enjoyed a good laugh and that even in their deteriorated condition humour and laughter were still employed.

Productivity

Productivity comes in many forms. The purpose and meaning of occupation is not in the activity itself but in its meaning to the individual who is engaged in the activity (CAOT, 1997). Residents make a contribution that society is not aware of in regards to productivity. Within their environment residents were able to fulfill their innate desire to be productive. This included collecting bottles, recycling other people's unwanted items and taking on temporary labour jobs. Society is generally not aware of the perceived value of these activities to the residents because it is not identified with this population. Because not everyone can work their way out of poverty it is important to look at occupations as meaningful in different ways and in the context of the environment in which they take place. Residents saw the purpose in their occupational activities in that they both contributed and motivated them to work to help sustain themselves and provide self-fulfillment.

Residents' Openness to Social and Healthcare Professionals

Interestingly, the residents' acceptance of professionals was not unusual because of their positive experiences with other professionals i.e., nurses, social workers etcetera, who worked within the inner city and were nonjudgmental of this population. It was not just the residents who benefited from these relationships. Residents' long-standing involvement with these agencies and the development of mutual concerns between the residents and professionals associated with these agencies resulted in their appreciation of one another.

Implications of the Study

Implications for Policy Making

Although this study was not intended to explore social policy about homelessness in its broadest definition, public policy at all levels of federal, provincial and municipal is a major contributing factor to the status of health and social support received by the residents of WWH. The plight of individuals who are homeless, which is on and off in the collective consciousness of the public, are often put to the top of the public agenda when stories related to homelessness make their way into the daily news. Edmonton's most recent homeless count includes 1,160 people of whom 650 were absolute homeless and 510 were sheltered homeless such as the residents of WWH (Edmonton Homeless Count Committee, 2000). In December 2003, the Alberta Government allocated three million dollars to help community-based organizations to implement community homeless plans. Homeless plans need to address the complexities of the issue.

The homeless contrary to public perceptions are not a homogenous group and are individuals like everyone else in the community. Generic services do not serve the needs of people without homes any more then they serve the needs of people with homes. Policy making on homelessness requires a broad vision that takes into consideration the intricate and diverse issues and concerns such as mental illnesses and /or substance abuse, lack of low cost housing, community supports etcetera. Although the needs of the homeless can be grouped into administrative categories for planning, there needs to be an individually oriented expression of the approaches and delivery of supports and interventions. WWH has learned to do this successfully.

For WWH to be perceived as successful by the residents, new and innovative solutions had to evolve through the staff's and board members' exposure and understanding of the street culture and how it fits for indigent persons. They were monitoring new trends in their population and working on increasing their knowledge of healthier lifestyles in the context of the residents' environment, the inner city. Their approach considers the social and health costs to individuals forced to conform to expectations that frustrate and escalate the residents' burden at price to their dignity, their feeling accepted and improved functioning. The study's findings revealed that implementing change needed to be a product of the "environment" in order for residents to reach improved well-being relative to their previous physical and mental state. When looking at social polices for the homeless the environment needs to be considered as a means to achieve successful outcomes and minimize the gap between the ideal and real world.

Policy makers need to consider the importance of including people involved in the social, legal and healthcare sectors who have a role to play in the implementations of services for the homeless to be equal partners in policy development. It is they that have the experience. An understanding between individuals such as the police, nurses and social workers regarding realistic positive outcomes for the homeless population has helped to make WWH successful. Instead of fragmented services for the homeless an approach that includes formalized liaison and communication networking amongst those who work with and are familiar with the homeless may prove to have more effective outcomes.

Client-centred practice provides a foundation to looking at how the system can provide social and health care services to the socially disadvantaged. It is important for service providers and policy makers to ask questions in a creative and open minded way in order to understand the lived realities of the homeless, what they are willing to do and what is important to them. This requires an evolutionary approach of thinking outside accepted social norms in terms of what is needed to sustain certain sectors of the homeless population and supporting more programs like WWH that are viewed by some groups as contributing to the problem through their more relaxed residency regulations. The practical application of models such as CCP and PEO are difficult to use when service providers and policy makers have different values, beliefs and goals than the recipients of the services.

Policies that incorporate harm reduction strategies need to be considered in the field of homelessness in order to "do no harm" but also to use strategies to lessen the effect of and protect clients from further harm to their health status. The consideration of

harm reduction gives policy makers additional strategies to reflect on and apply to this hard to house and by implication manage population. A variety of ideas regarding social policy including harm reduction will assist individuals who are working in the inner city to promote programs and attitudes that will enhance the lives of the destitute.

The study started out using the concept of success as stated in WWH's mandate and evolved into understanding the residents' perceptions of WWH in meeting their needs for a successful residency. Through the residents' perspective I discovered in their language and through their eyes why they are hard-to-house and what support means to them. This is essential in understanding what is necessary to bring about meaningful social change at the local level to all sectors of the homeless population.

Implications for Occupational Therapy

Occupational therapists are amongst many other professionals who are beginning to see a role for themselves in working with the homeless. Because homelessness is detrimental to people's physical and mental health and functional status occupational therapy assessment and treatment skills are beneficial for this population (Quinn 1993; Heubner & Tryssenaar, 1996). Occupational therapists have also integrated into their profession philosophical concepts i.e., PEO and CCP that can facilitate an understanding of the hard-to-house and the analysis and use of their environment to enable functioning.

In fact, occupational therapists have been using and altering the environment for years to support individuals with disabilities in their physical environment to achieve optimal level of functioning and well being. Environmental interventions can be applied to individuals with a variety of impairments such as mental illness and/or substance abuse

and associated functional impairments. From the study, I expanded my ideas of meaningful occupations and the importance of understanding other types of environments. By exploring other environments occupational therapists can gain a comprehensive and varied understanding of individuals and their occupations.

New understandings can challenge professionals to expand their knowledge and come up with innovative ideas about occupational therapy approaches in other sectors of society. This requires a challenge to explore beyond current comfort zones and move into new and exciting directions for personal and professional growth. Susser, Goldfinger & White (1990), recommend that healthcare professionals experience the environment of the homeless mentally ill in order to set appropriate priorities and adaptable interventions. Implementing occupational therapy programs in environments such as WWH means looking at different sectors of society their values, beliefs and choices from a different vantage point and finding ways to provide occupational therapy services that fit with populations such as WWH residents.

Implications for Future Research

Studies on residential treatment interventions aimed at abstinence along with residential stability contribute to the marginalization of individuals similar to WWH residents by excluding them from their research protocols. WWH residents have organic brain disorders, aggression and incessant addictions that seem similar to the lost and invisible individuals who were either excluded or relapsed and lost their place in the treatment intervention being studied. Lack of studies on this missing population prevents potential readers from seeing both the resiliency and vulnerability in this population as

revealed in the study findings of WWH's residents. Research protocols needs to be adapted to include the opinions of the cognitively impaired populations many of who have problems with communication and who are most in need of services. Qualitative research methods provide creative approaches in gaining insights and knowledge from this impaired population into their conditions and lifestyles.

Potential research participants vary in their capabilities to contribute to research findings. Their contributions are invaluable and needed. In an attempt to understand a sector of society (residents at WWH) I needed to find and use alternatives such as interview guides to the usual open-ended questions used in phenomenology. This provided a stimulus for the residents to address the focus of the study: Weather Worn Home's successfulness in meeting its mandate. In the development of knowledge research efforts need to be put forward in order to gain an understanding of values and ways of thinking of different sectors of society from their perspective.

The phenomenological approach does not purport to provide theories, cause and effect, and solutions to problems (van Manen, 1997). It does however provide a means in which to understand from the participants' perspective what specific phenomena means to them. The importance of reflecting on what specific phenomena means to a marginalized population allows those who can influence the status of the homeless such as policy makers to delve into their world and to get a glimpse of what is important to the homeless.

Limitations of Study

Methodology Issues

The quality of a phenomenological study finding of this type of research puts the onus on the researcher as an instrument of data gathering and data analysis. Because a phenomenological study requires an insightful and intuitive awareness of its philosophy the application of its philosophical approach to the operational procedures of a research study were challenging. I struggled in using the phenomenological reflective process effectively in order for themes to emerge from the participants' stories and give a true meaningful description of the life experiences of the residents. The residents' cognitive impairments further challenged this.

Several of the participants were eager to share information about themselves and the setting. All of the residents lasted the allotted time in spite of their cognitive difficulties because they were living the phenomenon and thereby able to get to the crux of what WWH means to them as a successful agency. Although their cognitive abilities i.e. expression and comprehension were limited and varied, each participant shed insight into their lives and experiences of Weather Worn Home (WWH).

Because of the residents' impairments in articulating, transcribing the interview tapes was challenging. I checked for the accuracy of the transcriptions using interview guides, personal notes and tapes. Backup measures such as cross checking the data sources were used to ensure the accuracy of the information transcribed.

An area of concern that could have compromised the data was the monitored temptation to counsel the residents. With extensive years of experience and self-

monitoring interactions with clients in other settings to get a valid understanding of their concerns I was able to do the same while interviewing the residents.

Individuals' realities and perceptions continuously evolve and change. The residents' perceptions, feelings, thoughts and beliefs about their life experiences at WWH were snap shot pictures shared in the moment. If the study were replicated new realities and perceptions would emerge especially in light of the move to the new building.

Summary

This qualitative study shared the lived experiences of a group of inner city sheltered homeless adult males. Through their reflections and stories, the power of the phenomenological approach to uncover meaning in their lives and to support occupational therapy theory development was illuminated. Successful outcomes were documented through the internal experiences of the participants and not measured externally via occupancy rates and characteristics. Concepts such as the meaning of "success" and "home" were seen to be in the eyes of the beholder.

The complexity of the homeless issue needs to continue to be investigated from different approaches. At the same time there is a need to attend to individuals struggling in the moment with minimal resources and options if any. This requires reevaluating what homelessness means and how programming can accommodate this diverse population. WWH fits for this very small sector of the homeless but how many others come under the umbrella of "homeless". Although the residents' experiences and perceptions cannot be generalized to a broader homeless population, this phenomenological study challenged the stereotypes associated with the homeless. A very small group of residents through

their diversity, variable needs and purposeful activity brought an awareness of the individuality to the facelessness of the homeless.

References

Allen, C.K. (1985). Occupational Therapy for Psychiatric Diseases: Measurement and Management of Cognitive Disabilities. Boston: Little, Brown.

Ashworth, P., & Lucas, U. (1998). What is the world of phenomenography. Scandinavian Journal of Educational Research 42, 415-431.

Bachrach, L. (1992). What we know about homelessness among mentally ill persons: an Analytical Review and Commentary. Hospital and Community Psychiatry 43, 453-463.

Barnard, A., McCosker, H., & Gerber, R. (1999). Phenomenography: A qualitative research approach for exploring understanding in health care. Qualitative Health Research 9, 212-226.

Barnes, D. (1996). An analysis of the grounded theory method and the concept of culture. Qualitative Health Research 6, 429-441.

Barth, T. (1994). Occupational therapy interventions at a shelter for homeless, addicted adults with mental illness. American Occupational Therapy Association Mental Health Special Interest Section Newsletter, 17 (1), 7-8

Begin, P., & Saoub, A. (1991). Homelessness in Canada. Ottawa: Minister of Supply and Services

Bernard, R. (1995). Research Methods in Anthropology: Second edition: Qualitative and Quantitative Approaches. Walnut Creek, California: Altamira Press.

Bishop, P., Jason, L., Ferrari, J., & Huang, C. (1998). A survival analysis of communal living self-help, addiction recovery participants. American Journal of Community Psychology 26, 803-821.

Bottomley, J., Bissonnette, A., & Snekvik, V. (2001). The lives of homeless older adults: please tell them who I am. Topics in Geriatric Rehabilitation 16, 50-64.

Bowdler, J. (1989). Health problems of the homeless in America. Nurse Practitioner 12 (7), 44-5.

Brink, P., & Wood, M. (1994). Basic Steps in Planning Nursing Research from Question to Proposal: Fourth Edition. Sudbury, Massachusetts: Jones and Bartlett Publishers.

Brinsmead, F., Bubel, A., & Devam, S. (2000). [WWH Feasibility Study]. Unpublished raw data.

Burns, N. (1989). Standards for qualitative research. Nursing Science Quarterly 2, 44-52.
Cain, D. (1990). Further Thoughts about non-directiveness and client-centred therapy. Person-Centered Review 5, 89-99.

Calloway, M., & Morrissey, J. (1998). Overcoming service barriers for homeless persons with serious psychiatric disorders. Psychiatric Services 49, 1568-1572.

Canadian Association of Occupational Therapists (1997). Enabling Occupation: An Occupational Therapy Perspective. Ottawa, On: CAOT Publications ACE.

Canadian Centre on Substance Abuse (1996) Harm Reduction: Concepts and Practice. A Policy Discussion Paper National Working Group on Policy. http://www.ccsa.ca/docs/wgharm.htm accessed February 2 2004.

Carling, P. (1993). Housing and supports for persons with mental illness: Emerging approaches to research and practice. Hospital and Community Psychiatry 44, 439-449.

Cobb, A., & Hagemaster, J. (1987). The criteria for evaluating qualitative research proposals. Journal of Nursing Education 26, 138-143.

Cohen, C. (1994). Down and out in New York and London: A cross national comparison of homelessness. Hospital and Community Psychiatry 45, 769-776.

Cohen N., Putman J., & Sullivan A. (1984). The mentally ill homeless isolation and adaptation. Hospital and Community Psychiatry 35, 922-924.

Conrad, K., Hultman, C., Pope, A., Lyons, J., Baxter, W., Daghestani, A., Lisiecki, J., Elbaum, P., McCarthy, M., & Manheim, L. (1998). Case managed residential care for homeless addicted veterans. Medical Care 36, 40-53.

Corring, D. (1999). Are you listening? The missing perspective on client-centred care. Occupational Therapy Now I, 8-10.

Cournos, F. (1987). The impact of environmental factors on outcome in residential programs. Hospital and Community Psychiatry 87, 845-854.

Creswell, J. (1998). Qualitative Inquiry and Research Design: Choosing Among Five Traditions. Thousand Oaks, California; Sage Publications Inc.

Egan, M. & DeLatt, D. (1994). Considering spirituality in occupational therapy practice. Canadian Journal of Occupational Therapy 61, 95-101.

Eggins, B. (2000). Homeless shelter users in the post deinstitutionalization era: Comment. Canadian Journal of Psychiatry 45, 8-44.

Evans, R. (1999). The Pedagogic Principal. Edmonton, Alberta: Qual Institute Press.

Finlayson, M., Baker, M., Rodman, L., & Herzberg, G., (2002). The process and outcomes of a multimethod needs assessment of a homeless shelter. American Journal of Occupational Therapy 56, 313-321.

Fisher, P., & Breakey, W. (1991). The epidemiology of alcohol, drug, and mental disorders amongst homeless persons. American Psychologist, 46, 1115-1128.

Flanagan, S., Doyle, M., Browne. S., Larkin, C., & O'Callaghan, E. (2000). A survey of the self-rated quality of life of individuals with schizophrenia in community residential settings. Irish Journal of Psychological Medicine 17, 22-24.

Giorqi, A. (1999). A phenomenological perspective on some phenomenographic, results on learning. Journal of Phenomenological Psychology 30, 1-16.

Goldfinger, S., Schutt, R. Tolomiczenko, G., Seidman, L., Penk, W., Turner, W., & Caplan, B. (1999). Housing placement and subsequent days homeless among formerly homeless adults with mental illness. Psychiatric Services 50, 674-670.

Goldsmith, J. (1999). Addictive disorders. Psychiatric Clinics of North American 22, 1-15.

Hagen, I. (1989). Participants in a day program for the homeless: A survey of characteristics and service needs. Psychosocial Rehabilitation Journal 12, 29-37.

Hajela, R. (2003) Addiction beyond substances: Gambling, food, sex, and relationships. Patient Care Canada 14, 52-66.

Hammell, K., Carpenter, C., & Dyck, I. (2000). Using Qualitative Research: A Practical Introduction for Occupational and Physical Therapists. Toronto, Ontario: Churchill Livingston.

Hartwell, S. (2003). Homelessness and substance use. Substance Use and Misuse 38, 475-502.

Hayne, Y., & Younge, O. (1997). The lifeworld of the chronic mentally ill: Analysis of 40 written personal accounts. Archives of Psychiatric Nursing II, 314-324.

Herman, D. Opler, L., Felix, A., Valencia, E., Wyatt, R., & Susser, E. (2000). A critical time intervention with mentally ill homeless men: Impact on psychiatric symptoms. Journal of Nervous & Mental Disease 188, 135-140.

Heubner, J.E., & Tryssenaar, J. (1996). Development of an occupational therapy practice perspective in a homeless shelter: A fieldwork experience. Canadian Journal of Occupational Therapy 63 (1), 24-32

Hurlburt, M., Hough, R., & Wood, P. (1996). Effects of substance abuse on housing stability of homeless mentally ill persons in supported housing. Psychiatric Services 47, 731-736.

Jason, L., Ferrari, J., Smith, B., March, P., Dvorchak, P., Groessl, E., Rechota, M., Margaret, C., Bishop, P., Kot, E., & Bowden, B. (1997). An exploratory study of male recovering abusers living in a self-help, self-governed setting. The Journal of Mental Health Administration 3, 332-339.

Johson, T., & Freels, S. (1997). Substance abuse and homelessness selection or social adaptation? Addiction 92, 437-446.

Kasprow, W., & Rosenheck, R. (2000). Mortality among homeless and non-homeless mentally ill veterans. Journal of Nervous & Mental Disease 188, 141-147.

Knisley, M., & Fleming, M. (1993). Implementing supported housing in state and local mental health systems. Hospital and Community Psychiatry 44, 456-464.

Kohlman-Thompson, L. (1992). Kohlman evaluation of living skills. Rockville, MD: American Occupational Therapy Association.

Lam, J., & Rosenheck, R. (2000). Correlates of improvement in quality of life among homeless persons with serious mental illness. Psychiatric Services 51, 116-118.

Lamb H. (1984). The Homeless Mentally Ill: A task force report of the American psychiatric association, Washington, D.C.: American Psychiatric Association.

Lamb H., & Lamb D. (1990). Factors contributing to homelessness among the chronically and severely mentally ill. Hospital and Community Psychiatry 41, 301-305.

Law, M. (1998). Client Centered Occupational Therapy. Thorofare NJ: SLACK Incorporated.

Law, M., Baptiste, S., Carswell-Opzoomer, A., McColl, M., Polatajko, H., & Pollack, N. (1994). Canadian occupational performance measure, 2nd ed. Toronto: Canadian Association of Occupational Therapists.

Law, M., Cooper B., Strong, S., Stewart, D., Rigby, P., & Letts, L. (1996). The person-environment occupation model: a transactive approach to occupational performance. Canadian Journal of Occupational Therapy 63, 9-23.

Law, M., Baptiste, S., & Mills, J., (1995). Client-centred practice: What does it mean and does it make a difference. Canadian Journal of Occupational Therapy 62, 250-257.

Lincoln, Y. S., & Guba, E. G. (1986). Keep trustworthiness and authenticity in naturalistic evaluation. New Directions for Program Evaluation 30, 73-83.

Link, B.G., Susser, E., Struere, A., Phelan, J., Moore, R., & Strueining, E. (1994). Lifetime and five year prevalence of homelessness in the United States. American Journal of Public Health, 84, 1907-1912.

Lipton, F., Nutt, S., & Sabatini, A. (1988). Housing the homeless mentally ill: A longitudinal study of a treatment approach. Hospital and Community Psychiatry 39, 40-45.

Lipton, F., Siegal, C., Hannigan, A., Samuels, J., & Baker, S. (2000). Tenure in supportive housing for homeless persons with severe mental illness. Psychiatric Services 51, 479-486.

McCabe, S., Macnee, C., & Anderson, M. (2001). Homeless patients experience of satisfaction with care. Archives of Psychiatric Nursing XY, 78-85.

Marshall, C., & Rossman, G.B. (1995). Designing Qualitative Research: Second edition. Thousand Oaks, California: Sage Publications Inc.

Mitchell, H. & Jones, D. (1997). Homelessness: A review of the social policy background and the role of occupations and the role of occupational therapy, British Journal of Occupational Therapy 60, 315-319.

Morse, J. & Richards, L. (2002). Read me First: For a Users Guide to Qualitative Methods. Thousand Oaks, California: Sage Publications Inc.

Morse, J., & Field, P. (1995). Qualitative Research Methods for Health Professionals: Second Edition, Thousand Oaks, California: Sage Publications Inc.

Mosher, L. (1999). Soteria and other alternatives to acute psychiatric hospitalization: A personal and professional review. The Journal of Nervous and Mental Disease 187, 142-149.

Nuttbrock, L., Rahav, M. Rivera, J., Ng-Mak, D., & Struening, E. (1997). Mentally ill chemical abusers in residential treatment programs: Effects of psychopathology on levels of functioning. Journal of Substance abuse Treatment 14, 269-274.

Nuttbrock, L., Rahav, M., Rivera, J., Ng-Mak, D., & Link, B. (1998). Outcomes of homeless mentally ill chemical abusers in community residences and a therapeutic community. Psychiatric Services 49, 68-76.

Olfson, M., Mechanic, D., Hansell, S., Boyer, C., & Walkup, J. (1999). Prediction of homelessness within three months of discharge among inpatients with schizophrenia. Psychiatric Services 150, 1-15.

Patton, M. (1990). Qualitative evaluation and research methods: Second edition. Newbury Park, California: Sage Publications Inc.

Patton, M. (1997). Utilization-Focused Evaluation: The New Century Text: Edition 3. Thousand Oaks, California: Sage Publications Inc.

Pejlert, A., Asplund, K., & Norberg, A. (1999). Towards recovery: living in a home-like setting after the move from a hospital ward. Journal of Clinical Nursing 8, 663-674.

Quinn, B. (1993). Community occupational therapy in Canada: a model for mental health. Mental Health Special Interest Section Newsletter, American Occupational Therapy Association 16(2), 1-4.

Rebeiro, K. (2001) Enabling occupation. The importance of an affirming environment. Canadian Journal of Occupational Therapists 68, 80-89.

Restall, G., & Ripat, J. (2003). A framework of strategies for client-centred practice. Canadian Journal of Occupational Therapy 70, 103-112.

Rogers, C. (1984). Client Centered Therapy, Orange Street, London: Constable and Company Limited.

Sandelowski, M. (1993). Rigor or rigor mortis: the problem of rigor in qualitative research revisited. Advance Nursing Science 16, 108.

Schutt, R., & Goldfinger, S. (1996). Housing preferences and perceptions of health and functioning among homeless mentally ill persons. Psychiatric Services 47, 381-386.

Shordike, A., & Howell, D. (2001). The reindeer of hope: An occupational therapy program in a homeless shelter. Occupational Therapy in Health Care 15 (1/2), p 57-68.

Spradley, J. (1979). The Ethnographic Interview, Florida: Harcourt Brace Jovaniovich College Publishers.

Srebnik, D., Livingston, J., Gordom, L., & King D. (1995). Housing choice and community success for individuals with serious and persistent mental illness. Community Mental Health Journal 31, 139-159.

Strauss, A., & Corbin, J. (1990). Basics of Qualitative Research: Grounded theory procedures and techniques. Newbury Park, California: Sage Publications Inc.

Streubert, H., & Carpenter, D. (1999). Qualitative research in nursing: Advancing the Humanistic Imperitive: Second Edition. Philadelphia, Pennsylvania: Lippincoff.

Strong, S., Rigby, P., Stewart, D., Law, M., Letts, L., & Cooper, B. (1999). Application of the person-environment-occupation model: A practical Tool. Canadian Journal of Occupational Therapy 66, 122-133.

Stuart, H., & Arboleda-Fiorez, J. (2000). Homeless shelter users in the post deinstitutionalization era. Canadian Journal of Psychiatry 45, 55-62.

Susser, E., Goldfinger, S., & White, A. (1990). Some clinical approaches to the homeless mentally ill. Community Mental Health Journal, 26, 463-480.

Tanzman, B. (1993). An overview of surveys of mental health consumers' preferences for housing and support services. Hospital and Community Psychiatry 44, 450-455.

Townsend, E., Birch, D., Langley, J., & Langille, L. (2000). Participatory research in a mental health clubhouse. The Occupational Therapy Journal of Research 20, 18-45.

Townsend, E. (2003). Reflections on power and justice in enabling occupation. Canadian Journal of Occupational Therapy 70, 74-85.

Tryssenaar, J., Jones, E.J., & Lee, D. (1999). Occupational performance needs of a shelter population. Canadian Journal of Occupational Therapy 66 (4), 188-195.

Unruh, A., Versnęl, J., & Kerr. (2002). Spirituality unplugged: a review of commonalities and contentions, and a resolution. Canadian Journal of Occupational Therapy 69, 5-19.

Urbanowski, R. & Vargo, J. (1994). Spirituality, daily practice, and the occupational performance model. Canadian Journal of Occupational Therapy 61

van Manen, M. (1997). From meaning to method. Qualitative Health Research 7, 345-369.

van Manen, M. (1997). Researching lived experience: Human Science for an action sensitive pedagogy. London, Ontario: the Althouse Press.

van Manen, M. (2002). Writing in the dark: Phenomenological studies in interpretive inquiry. London, Ontario: the Althouse Press.

Williams, J., Karls, J., & Wandrei, K. (1989). Person-in Environment (PIE) system for describing problems of social functioning. Hospital and Community Psychiatry 40, 1125-1127.

Williams, S. & Bloomer. J. (1987). The bay area functional performance evaluation (second edition). Pequannock. NJ: Maddak, Inc.

WWH "A Place We Call Home" (unpublished). [Brochure]

Appendix A: (the actual poster will be on 11" x 17" paper)

WWH
IS MOVING TO A
GREAT NEW BUILDING!

YOUR HELP IS NEEDED TO
MAKE IT A
SUCCESSFUL MOVE

WWH WILL BE STUDIED BY A GRADUATE STUDENT FROM THE UNIVERSITY OF ALBERTA

THE STAFF AND THE STUDENT WOULD LIKE TO TALK TO YOU ABOUT THIS STUDY ON THE FOLLOWING DATES AT LUNCH TIME

April _____ *April* _____

Appendix B: Script for Orientation Meeting

"Anne is a researcher and will be spending time at WWH to get to know how WWH works. This is to help plan for the move to the new building. She would like to hear from you and about your life at WWH. Anne also wants to understand what a regular day at WWH is like by spending a day with two of you as you each go about your day. If you would like to talk to Anne about WWH and maybe spend a day with her please, let staff member_____know after lunch. More people can be part of the talks. You can let the staff member know whether you would like to spend a day with Anne, talk to Anne or both. Because Anne is here for a limited time, she can only talk with a small number of residents. Names will be drawn from those who wish to talk to Anne, spend a day with her or both until she has the number of people she requires. The rest of you who want to help will be involved in a later part of her study, and when she is watching what goes on at WWH if you wish.

When Anne is watching what goes on at WWH she will follow different staff members around at different times, including the times staff are with the residents, when staff are doing house checks, and at meal times and recreation times. A schedule of the days Anne is at WWH will be hung in the main office area, for anyone who does not want to be around when Anne is here. Are there any questions?"

Appendix C: Schedule of the Days research at WWH

<u>These are the times Anne will be following different staff members at WWH for the study.</u>

(Numbers to the right of the times refer to different staff members)

April 17 Tuesday	8:30 AM to 11:30 AM (#1)
	11:30 AM to 2:30 PM (#1)
April 18 Wednesday	10:30 AM to 1:30 PM (#2)
April 19 Thursday	10:30 AM to 1:30 PM (#2)
April 20 Friday	8:00 PM to 11:00 PM (#3)
	11:00 PM to 2:00 AM (#4)
April 21 Saturday	12:30 PM to 3:30 PM (#5)
April 22 Sunday	3:00 PM to 6:00PM (#6)
April 23 Monday	10:30 AM to 1:30 PM (#7)
April 24 Tuesday	10:30 AM to 1:30 PM (#8)
April 25 Wednesday	10:30 AM to 1:30 PM (#9)
April 26 Thursday	11:00 PM to 2:00 AM (#10)
	2:00 AM to 5:00 AM (11)
April 27 Friday	3:00 PM to 6:00 PM (#12)

Appendix: D

Interview Guide for Residents

Introduction:

Thank you, for volunteering to do the interview. As was stated in the meeting, I want to learn about your life at WWH. I have some questions that I would like to ask you about your life here. To begin with, I want to know a little more about you, as it will help me understand your experiences at WWH.

Demographic Information:

1. Age:
2. Marital status:___Married___Common-law___Never Married___ Separated___ Widower___
3. Education: What was the last grade you completed in school? What other learning do you have (i.e., self taught)?
4. Ethnic Origin: Would you tell me about your family background?
5. Employment history: What was your last job? When was that? For how long? Why did you leave your job?
6. How long have you lived in the inner city?
7. How long have you lived at WWH? How did you come to live at WWH? Have you ever lived in a place like WWH anywhere else?
8. Where did you live before?

Core Questions

1. WWH has been your home for ____ years. What do you like about WWH? What keeps you here? Can you tell me about some of the events or things that happen here that make you feel good? What things are helpful to you?
2. What has not been helpful for you at WWH? What events or things about WWH at times cause you to worry? Are there things you would like to change about WWH that would make it feel more comfortable?
3. If you knew someone who was thinking of coming here, what would you tell him about WWH?
4. I hear that all the residents are moving to a new WWH building. You have told me about some of the things that are good about WWH and some things that are a concern. What would you like to be the same about WWH when you move to the new building? What would you give up about WWH and still find WWH works for you?
5. People who create places like WWH have ideas about what makes these residences work for the people who live in them. If you were to tell the people who create places like WWH what you feel makes them work, what would you say?
6. The WWH brochure (shows participant brochure) is titled WWH a place we call home. Do you call it home? If not, what do you call it?
7. Do you feel comfortable (at ease) at WWH? What makes you feel comfortable here? What makes you feel uncomfortable here?

8. What do you think about the staff here? Is there anyone you feel closer to than others? Can you tell me what things about them make you feel that way? In what ways does the staff help you? What do they do that you feel is not helpful?
9. Can you tell me what types of things help to make you feel safe? Describe an experience that would help me to understand how you feel safe here. Can you tell me what types of things make you feel unsafe here? Describe an experience that would help me to understand how you do not feel safe here?
10. If you could change one thing about WWH (i.e., rules, furnishings, rooms, services) what would it be? What would you make sure stayed the same?

Is there anything more you would like to say about your life here?

Thank you for giving me this time and sharing your story about WWH with me.

Appendix: E

Interview Guide for Staff and Board Members

Introduction:

Thank you, for volunteering to do the interview. You know my study is to assist in determining what WWH does that makes it "successful" on meeting its stated mandate (show paper with the written large type statement of the mission). As was mentioned in the consent form (indicate the form) I want to find out what you feel is "success" for WWH. This includes understanding a little about whom you are and your experiences with WWH.

Demographic Information:

1. Age:
2. Marital status: ___Married___Common-law___Never Married___ Separated___ Widower____
3. Gender:
4. Education: What formal preparation do you bring to WWH (i.e., years of education and type)?
5. Ethnic Origin: Would you tell me about your family background?
6. Employment History:
7. How long have you been an employee or board member of WWH? Have you been an employee or board member with a similar agency?
8. Could you tell me how you became an employee or board member of WWH? What makes you continue to work or stay a board member with WWH? What are

the challenges in working or being a board member here? Are they specific to WWH or would they be similar in other places like WWH?

Core Questions

1. Given WWH's mandate on a scale of one to five how successful do you think WWH has been? What makes you identify that rating? On a scale of one to five how unsuccessful do you think they have been? What makes you identify that rating?
2. Could you tell me about some of your experiences at WWH that will help me to understand why you think WWH has been successful or unsuccessful?
3. If you knew someone who wanted to work at WWH, what would you tell him or her about working at WWH?
4. If you knew someone who wanted to be a board member of WWH, what would you tell him or her about being a board member of WWH?
5. When you are feeling good about the work you are doing here or being a board member what is happening at WWH? When you are not feeling good about the work you are doing here or being a board member what is happening?
6. With the move to the new facility, if you were to take something with you about WWH that makes it successful, what would it be? What do you believe WWH could give up and still be successful?
7. Do you feel moving to the new facility will change WWH? Can you say more about why you think or don't think the move will change WWH?
8. Is there anything you would like to change about WWH to make it more successful?

9. How do you think residents are being helped at WWH and not being helped at WWH?
10. What do you think is success for the residents? What do you think is not success for the residents?
11. The WWH brochure (show brochure) is titled WWH a place we call home: In what way is it a home for the residents? In what way is it not a home for the residents?

Is there anything else you would like to say about WWH?

Thank you for giving me this time and sharing your story about WWH with me.

Appendix: F

Interview Guide for Community Dialogue_____June 20 2001

Thank you for participating in this community dialogue. Our desire is to have your assistance in determining what WWH does that makes it "successful" in meeting its stated mandate

My initial shock to the dingy and grey environment transformed into a feeling of comfort being in the presence of colourful and interesting personalities.

"TO PROVIDE SHELTER FOR THE HARD TO HOUSE".

1. Given WWH's mandate how successful or unsuccessful do you think they have been'?
2. Could you tell us about some of your experiences and involvements with WWH that will help us to understand why you think WWH has been successful or unsuccessful?
3. How do you think residents are being helped or not at WWH?
4. What do you think is "success or not " for the residents?
5. WWH deals with a heterogeneous population. Although the majority of residents have substance abuse, there are a variety of co-morbid conditions including personality disorders, schizophrenia, cognitive impairments, medical issues etc.
    a) What do you believe has worked for WWH staff in managing this diverse population and what do you believe has not worked?
    b) What do you believe has been your role in supporting WWH's staff in managing this diverse population?
    c) Is there other ways staff and/or other individuals and community agencies can intervene in identifying what the issues are for the residents and facilitating supports for them.
6. Is there anything you would like to change about WWH and/or how other agencies and individuals are involved in WWH to make it more successful?
7. With the move to the new facility, what do you believe needs to be transferred to make it successful?
8. What do you believe WWH could give up and still be successful?
9. Do you feel moving to the new facility will change WWH? Can you say more about why you think or don't think the move will change WWH?
10. Is there anything else you would like to say about WWH?

Thank you for taking the time to share your thoughts and observations.

A. Shand Graduate Student
MSc Occupational Therapy Program
Faculty of Rehabilitation Medicine
University of Alberta

Appendix: G (this will be on WWH letterhead)

An Exploratory Study of WWH

INFORMATION FOR CONSENT FORM (Residents)

Purpose: WWH is planning a move to a new facility. It is important that the new place provide similar service to you as the old place. I am a graduate student from the University of Alberta. My study is to learn what it is that you find most helpful about WWH.

How the Study will Work: Beginning in April 2001, for three weeks I will be at WWH watching what goes on here. I will take notes on what I am watching to help me remember. To assist me to understand how WWH serves the people who live there you are invited to talk to me about your life at WWH. Each talk could be up to forty-five minutes long. I will take notes on our talk and our talk will be tape-recorded to help me remember what was said. Three members of the research committee and me will be reading the notes and listening to the tapes. You are invited to share your experiences through signing the consent to be observed and to talk to me.

Discomfort: You may feel some discomfort with being watched, but overtime you will probably get use to it. At any time you do not want me watching you, let me or [neutral person] know. During the talks, you may stop any time you wish or you may change the topic.

If you decide that you want to take part in this study, you have a number of rights:

- You can decide to stop being a part of this study at any time
- You may ask me questions at any time.
- You do not have to answer any questions you do not want to
- All notes are kept secret unless there is a concern for your safety or someone else's safety. In this case, I will let a staff person know about the concern.
- The notes will be kept for at least five years after the study is done. The notes taken will be kept in a safe place, like a locked file cabinet. Your personal information will not be attached to the notes.
- Your name will also never be used when I talk or write about WWH.
- The information gathered for this study may be looked at again in the future to help us answer other study questions. If so the Ethics Board will first review the study, to ensure the information is used ethically.

Please put your initials here if you understand the information on this form _____.

If you have, any questions call Anne Shand (Researcher) at 425-5901 and Professor Sharon Brintnell at 492-2067
(Department of Occupational Therapy, University of Alberta)

If you have any concerns please contact... a nurse at Health Centre at ... .

Appendix: H (this will be on WWH letterhead)

An Exploratory Study of WWH

INFORMATION FOR CONSENT FORM (Staff and Board members)

Purpose: WWH is planning a move to a new facility. It is important to identify what is unique and special about WWH that can be transposed with the physical move. I am a graduate student from the University of Alberta. My study explores what staff and residents perceive as successful about WWH and its activities.

How the Study will Work: Beginning in April 2001, for three weeks I will be on site to experience and observe the day-to-day operations of the program. These observations will take place at different two-hour periods of the day. I will be using notes to remember the events, behaviours and activities observed. Tape-recorded interviews will be conducted during the following two weeks. Each interview will be approximately forty-five minutes long. I will also take notes during the interview. Three members of the research committee and me will be reviewing the notes and tapes. You are invited to share your views and experiences through participating in the study and signing the consent to be observed and interviewed.

Discomfort: It is not unusual to feel some discomfort when being observed, but overtime you should feel more at ease with the process. If there is a certain activity that you do not want observed, please let me know. During the interviews, you may refuse to answer questions or stop the interview at any time, if you feel uncomfortable with any of the questions.

In participating in this study, you have a number of rights:

- Your participation is entirely voluntary; you may decline to participate at anytime or withdraw from the study
- You may ask me questions at any time
- You do not have to answer any questions you do not want to
- All information will be held confidential (or private) except when professional codes of ethics or legislation (or the law) requires reporting
- The information you provide will be kept for at least five years after the study is done. The information will be kept in a secure area (i.e. locked file cabinet). Your name or any other identifying information will not be attached to the information you gave. Your name will never be used in any presentations or publications of the study results.
- The information gathered for this study may be looked at again in the future to help us answer other study questions. If so, the Ethics Board will first review the study, to ensure the information is used ethically.

Please put your initials here if you understand the information on this form _____.

If you have, any questions call Anne Shand (Researcher) at 425-5901 and Professor Sharon Brintnell at 492-2067
(Department of Occupational Therapy University of Alberta)

If you have any concerns please contact Dr. Paul Hagler Associate Dean for Graduate Studies and Research in the Faculty of Rehabilitation Medicine at 492-9674.

Appendix: I

WWH Housing Society

A Community Dialogue of WWH

INFORMATION FOR CONSENT FORM

Purpose: WWH is planning a move to a new facility. It would be important to identify what is unique and special about WWH that can be transposed with the physical move. Because you are an important community resource to WWH and its residents, we want to find out what in terms of your involvements and experiences with WWH you feel is important to transfer to the new facility.

How the Dialogue will Work: Professor Sharon Brintnell will facilitate the meeting. She will ask questions regarding your perceptions of success for WWH and the significance of community resources in contributing to the success. Anne Shand will take notes as well as record the meeting. You are invited to share your views and experiences through participating in the dialogue and signing the consent to be recorded.

In participating in this study, you have a number of rights:

- Your participation is entirely voluntary; you can decline to participate at anytime or withdraw from the dialogue
- You may ask us questions at any time
- You do not have to answer any questions you do not want to
- All information will be held confidential (or private) except when professional codes of ethics or legislation (or the law) requires reporting
- The information you provide will be kept for at least five years after the study is done. The information will be kept in a secure area (i.e. locked file cabinet). Your name or any other identifying information will not be attached to the information you gave. Your name will also never be used in any presentations or publications of the study results.
- The information gathered for this dialogue may be looked at again in the future to help us answer other study questions. If so the ethics board will first review, the study to ensure the information is used ethically. The tapes will be destroyed at the same time as the other gathered information.

Please sign here if you consent to participating in the dialogue.

_____ _____

Print your name here Signature

If you have, any questions call Anne Shand (Researcher) at 425-5901 and Professor Sharon Brintnell at 492-2067(Department of Occupational Therapy University of Alberta)

If you have any concerns please contact Dr. Paul Hagler Associate Dean for Graduate Studies and Research in the Faculty of Rehabilitation Medicine at 492-9674.

9518-102A Avenue, Edmonton, AB T5H OG1

Bus. (780) 425-5901 • Fax. (780) 425-5903,

BN/Registration Number 13052 4358 RR 0001

Appendix: J

Script for Taped Verbal Consent

As was mentioned at the meeting, I am a graduate student from the University of Alberta. I want to learn about WWH by watching what goes on here and inviting others like you to share with me their life at WWH. I will take notes on what I am watching to help me remember. Each talk could be up to forty-five minutes long. I will take notes on our talk and our talk will be tape-recorded to help me remember what was said. Three members of the research committee and me will be reading the notes and listening to the tapes. You may feel some discomfort with being watched, but overtime you will probably get use to it. At any time you do not want me watching you, let me or [neutral person] know. During the talks, you may stop any time you wish or you may change the topic. If you decide that you want to take part in this study, you have a number of rights:

- You can decide to stop being a part of this study at any time
- You may ask me questions at any time
- You do not have to answer any questions you do not want to
- All notes are kept secret unless there is a concern for your safety or someone else's safety. In this case, I will let a staff person know about the concern.
- The notes will be kept for at least five years after the study is done. The notes taken will be kept in a safe place, like a locked file cabinet. Your personal information will not be attached to the notes. Your name will also never be used when I talk or write about WWH.
- The information gathered for this study may be looked at again in the future to help us answer other study questions. If so the Ethics Board will first review, the study to ensure the information is used ethically."

Do you have any questions?

Do you understand what you have been asked to do?

Do you consent to being observed and/or to talking to me?

An Exploratory Study of WWH

Part 1: Researcher Information		
Name of Principal Investigator:		
Affiliation:		
Contact Information:		
Name of Co-Investigator/Supervisor:		
Affiliation:		
Contact Information:		
Part 2: Consent of 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 the research study?		
Have you had an opportunity to ask questions and discuss the study?		
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your care.		
Has the issue of confidentiality been explained to you? Do you understand Who will have access to your records/information?		
Part 3: Signatures		
This study was explained to me by:		
Date:		
I agree to take part in this study.		
Signature of Research Participant:		
Printed Name:		
Witness (if Available) signature		
Printed Name		
I believe that the person signing this form understands what Is involved in the study and voluntarily agrees to participate.		
Researcher:		
Printer Name:		
A copy of this consent form must be given to the subject.		

Appendix L: Transcriber's Agreement of Confidentiality

An Exploratory Study of WWH

AGREEMENT OF CONFIDENTIALITY

Whereas, it has been explained to me that any information about participants in the project secured by me, or available to me, in the pursuit of me duties, is of a confidential nature, and

Whereas, I understand, as a condition of me employment that I am expected to maintain this confidentiality

I, the undersigned, hereby undertake to respect that confidentiality and to take all reasonable precautions to safeguard it.

Name:_____(please print)

Signature: _____

Date: _____

Witness: _____(please print)

Signature: _____

Date: _____