Lessons on Recovery through Examination of a Peer-Based Housing Support Project

by

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Abstract

INTRODUCTION: Peer-based housing support for people with severe mental illness who are at risk of homelessness is a promising, though understudied, intervention approach.

OBJECTIVES: To examine how well an Edmonton pilot project implementing peer-based housing supports addressed factors contributing to independent living and recovery as described within its program design and logic model.

METHODS: Retrospective chart review of case files of 5 former clients described activities delivered by peer workers and other pilot project staff. Semi-structured interviews with 4 former clients and 8 mental health therapists characterized factors associated with the expected outcomes in the logic model. Project delivery was compared to the factors that were identified in the interviews to assess the extent to which delivery could achieve the intended outcomes.

RESULTS: Case files provided evidence that activities of peer workers not only addressed areas in the program design but extended beyond it, including issues related to medications, wellness, and victimization, among others. Interview data revealed additional factors believed to influence the outcomes of interest. Contrary to the project's logic model, these factors could be better organized as a "Recovery Wheel" ecological framework with five domains: personal, intrapersonal, interpersonal, institutional, and societal.

CONCLUSION: The ecological framework that emerged from this study consolidates and highlights factors identified in published recovery models and reveals others, specifically in the personal domain (cognition, personality, upbringing, and history), that have not previously been included. Results suggest that peer workers contribute to recovery and independent living through application of their lived experience. Further research is required to confirm and expand the Recovery Wheel with a larger and more diverse sample, and to explore how lived experience can be mobilized to promote recovery.

Preface

This thesis is an original work by Giri Puligandla. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Health Research Ethics Board, Project Name "Evaluating Long-Term Housing Stability, Skill Retention, and Recovery Orientation of Participants in a Peer Housing Support Project", No. Pro00032148, November 14, 2012. The research project also received administrative approval for research from the Northern Alberta Clinical Trials and Research Centre on behalf of Alberta Health Services, Admin File No. 31637, November 20, 2012.

This study surrounds the Peers Supporting Housing Pilot (PSHP) project delivered by the Schizophrenia Society of Alberta (SSA) between 2007 and 2009, The student investigator was intensively involved in the conceptualization, design, implementation, and early delivery of the PSHP project as Executive Director of the Edmonton & Area Chapter of the SSA between 2006 and 2008. At the time of writing this thesis, he was in a leadership role at Homeward Trust (the organization that funded the PSHP project) that supported exploration of appropriate service models to address homelessness and related issues. Based on his work with the PSHP project and interest in the potential of peer support, he had been involved in supporting a group of people living with mental illness in establishing a peer-led organization focused on integration of peer support in the delivery of mental health and related services. These experiences afforded him the capacity for insights that may not have been available to an impartial observer, serving at once as an asset while also threatening bias. The student investigator endeavored to maintain groundedness of the analysis in the data to ensure that his subjectivity would not play an indefensible role in inferences or conclusions.

Dedication

This study is dedicated to the people living with schizophrenia who inspired my development as a person and a professional. I also dedicate this study to my sons Arjun and Charlie, who were born while I was working on this thesis. May you grow up to live in a world more just than mine.

Acknowledgements

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List of Abbreviations

ACT – Assertive Community Treatment

AHS – Alberta Health Services

AISH – Assured Income for the Severely Handicapped

CHIME – Connectedness, Hope, Identity, Meaning, Empowerment

CMHA – Canadian Mental Health Association

CRHC – Capital Region Housing

CTI – Critical Time Intervention

DVD – Digital Video Disc

ESCAPE – Social recreational program of the SSA, meaning of acronym unknown

FACS – Forensic Assessment and Community Services

HIA – Health Information Act

ICM – Intensive Case Management

ILS – Independent Living Skills

MHCC – Mental Health Commission of Canada

OIPP – Outreach Innovative Pilot Projects

OT – Occupational Therapist

OTA – Occupational Therapy Assistant

PSHP – Peer Supporting Housing Pilot

PTSD – Post-Traumatic Stress Disorder

RQ1, RQ2 – Research Question 1, Research Question 2

RSA – Revised Statutes of Alberta

SSA – Schizophrenia Society of Alberta

Chapter 1: Introduction, Background, and Literature Review

This chapter provides necessary background on the Schizophrenia Society of Alberta's (SSA) Peers Supporting Housing Pilot (PSHP) pilot project, which is the focus of this study. The section on purpose clarifies the importance of the study in terms of examining recovery and related factors relevant to mental health service delivery and client outcomes. The research questions frame the study's examination of the prior delivery of the pilot project and related perspectives contributed by study participants towards this purpose. Context is provided by a review of the literature on related concepts, followed by positioning of the significance of the study in complementing existing knowledge.

1.1 Purpose of the Study

The purpose of this study was to explore the intended outcomes of the PSHP project (independent living and housing stability, recovery orientation, skills and supports, and social engagement) and to what extent PSHP delivery would have been able to achieve them. As it stands, the PSHP project remains a unique phenomenon in multiple respects, namely that it was the first time that a peer-based, housing-focused support service had been delivered in Canada (or elsewhere, as no documented cases were available) and offered an early opportunity for Alberta Health Services' (AHS) mental health therapists to work closely with peer workers to address housing insecurity and other challenges among their clients.

This study recruited people served by the pilot project through the SSA and AHS to examine the way the project was delivered through analysis of client case notes and the recollections of former clients. Both former clients and mental health therapists provided their thoughts on the factors underlying the intended outcomes and how they are interrelated.

Engaging mental health therapists and clients to reflect on the constructs of recovery and independent living could encourage a significant shift of the mental health system from a deficit-orientation to one that embraces recovery and a respectful relationship between clinicians and clients. Moreover, their perspectives could provide important advice for defining the delivery foci and inputs required to achieve the intended outcomes of the project, in effect testing and refining the program logic model.

1.2 Research Questions

Because data on PSHP project delivery were still available, the study examined how the project was delivered in terms of activities and outputs relative to its program model. In addition, the study explored perspectives of therapists and former clients on the outcomes referenced in the program model – specifically recovery orientation and independent living, but also social relations, housing stability, and access to skills and supports – and their thoughts on factors that may contribute to them, with the intention of applying that lens to critique the PSHP project's program model and delivery. For these purposes, the following research questions guided the study:

(1) How and to whom was the PSHP project delivered, and to what extent did PSHP project delivery address factors related to achieving recovery orientation, independent living, and other intended outcomes of the PSHP project program model?

(2) How do the expected outcomes in the PSHP project program model relate to each other, and what other factors not included in the original design contribute to recovery and independent living for people with mental illness?

1.3 Background

The SSA (www.schizophrenia.ab.ca) is a family-based organization committed to promoting the health and well-being of individuals and families affected by schizophrenia and related mental illnesses. Offering its services through its Chapters and Branches in most major municipalities, the SSA provides information, individual and family support, advocacy, outreach, and public education to its clientele and the general public. Since its incorporation in 1980 as a means for mutual support among family members often ignored and alienated by the mental health system, the organization has used the principles of peer support and mutual aid to assist both persons diagnosed with a mental illness ("clients") and their family caregivers. The Edmonton, Red Deer, and Calgary Chapters have offered various forms of recreational, housing support, and social engagement services using a peer model since approximately 2000 (SSA, 2007).

In 2007, the SSA Edmonton Chapter designed and developed the PSHP project, in which persons living with mental illness who had a recognized risk of losing their homes were provided a range of support services by a team of people with mental illness who had been hired and trained for this purpose. It applied a peer model to provide education, service linkage, and advocacy services to its clients in order to promote housing stability through learning of independent living skills and provision of social and service connections. At the time, the regional health authority (now AHS) was exploring the possibility of incorporating peer providers in its mental health teams and encouraged the SSA to pursue a pilot project to demonstrate its capacity to adapt its mutual support approach to offer peer-delivered services to work in conjunction with formal mental health services (AHS Director, personal communication, 2007).

The PSHP project was funded through a provincial government program called Outreach Innovative Pilot Projects (OIPP) administered by the Edmonton Housing Trust Fund (later renamed Homeward Trust Edmonton) with the intention of testing different models of service delivery to address the growing problem of homelessness in urban centres in Alberta. Specifically, the OIPP funding program marked the initial foray on the part of the Government of Alberta and the seven major urban centres in Alberta[1] towards a coordinated effort to end homelessness, culminating with the introduction of housing first as a programmatic intervention in 2009.

A conceptual model was developed to guide implementation and delivery of the project, presented as Figure 1 (SSA, 2007).

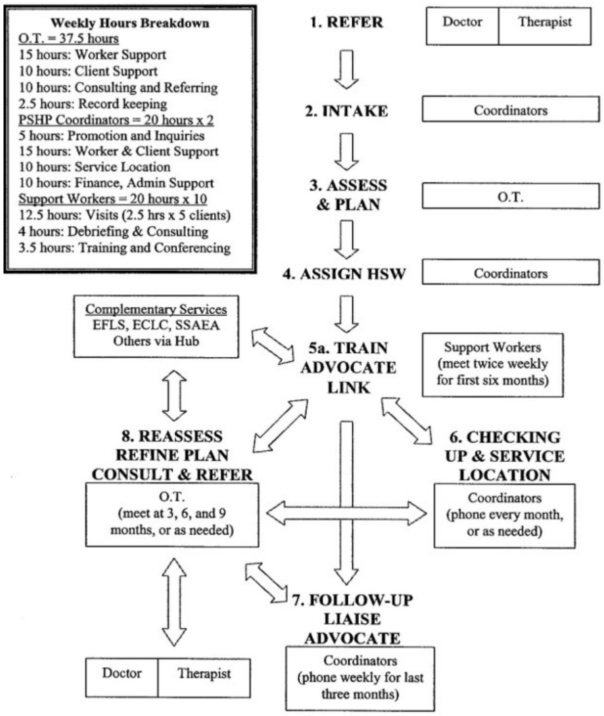

Figure 1: PSHP Conceptual Model

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[1] The seven cities include the Regional Municipality of Wood Buffalo, City of Grande Prairie, City of Edmonton, City of Red Deer, City of Calgary, City of Medicine Hat, and City of Lethbridge.

Client involvement was intended to be for a period of nine months, including six months of weekly face-to-face visits followed by three months of weekly phone contacts. Referral of clients came primarily from AHS mental health therapists. The intake function was assumed by an Occupational Therapist Assistant (OTA) who was supervised by an Occupational Therapist (OT). The OT was contracted to provide clinical supervision of the peer workers, develop Peer Support Plans, and conduct regular re-assessments at 3, 6, and 9 months after intake. The OT/OTA position was expressly conceptualized as an interface between the peer-provided service and AHS in order to avoid perceived barriers resulting from minimal knowledge of and trust in the peer model on the part of professional providers (Mowbray et al., 1996).

The model called for ten people living with mental illness who had learned to live successfully in the community to be hired and trained as Housing Support Workers (herein called "peer workers"). All peer workers worked in pairs and attended weekly meetings that were designed to promote knowledge sharing on effective methods of achieving clients' goals and, most importantly, provide a venue for the peer workers to access mutual support to deal with stress resulting from their employment. The peer workers also met weekly with the OTA to discuss activities with clients and personal issues as necessary.

Clients included people living with schizophrenia or related mental illnesses who were housed in independent living units (market or non-market) without dedicated housing supports. In addition, a set of criteria were considered for client eligibility, including severity and complexity of the individual's mental illness, history of violence or manipulative behaviour, and commitments from referring clinicians to work with the PSHP project team to communicate regularly and respond to early warning signs of crisis or relapse in a timely manner.

A program logic model developed as part of an evaluability assessment for the PSHP project is provided in Figure 2.

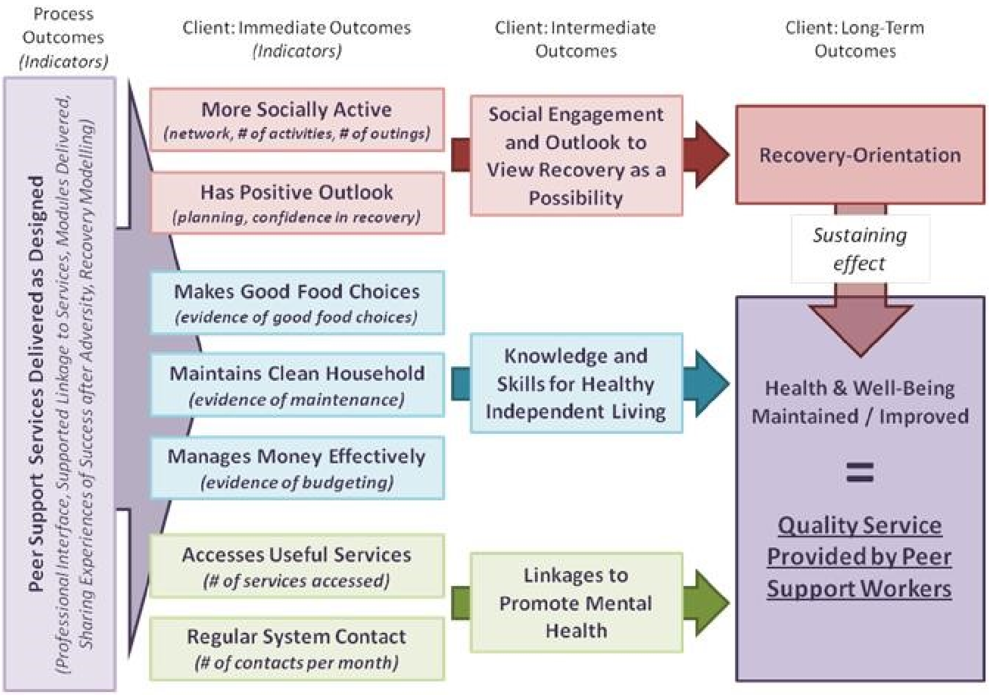

Figure 2: Program Logic Model for PSHP Project (Puligandla, 2009).

The peer workers received training from the OT, including a manual with key elements of the training program, client learning modules, and workbooks (SSA, n.d.), to address: housing and landlord-tenant issues; using public transportation; cleaning and home maintenance; preparing nutritious meals; financial literacy and money management; accessing services; and liaising with referring therapists. These were the primary targets for the intervention to promote the development of independent living skills for clients. The PSHP project team offered support in other areas as well, including social engagement (by virtue of regular contact and excursions with peers), personal hygiene and grooming, and acquiring household supplies to support care plans. The expectation was that the skills and knowledge gained by the clients would increase their social engagement, improve their outlook, build their independent living skills, and link them to supports. Social engagement and positive outlook were expected to produce an orientation towards recovery, sustaining the expected parallel improvements in health and well-being to promote independent living (including housing stability, the primary outcome required by the funder). In essence, for the purposes of framing this study, the main intended outcomes for the PSHP project can be represented using the simplified logic model illustrated in Figure 3.

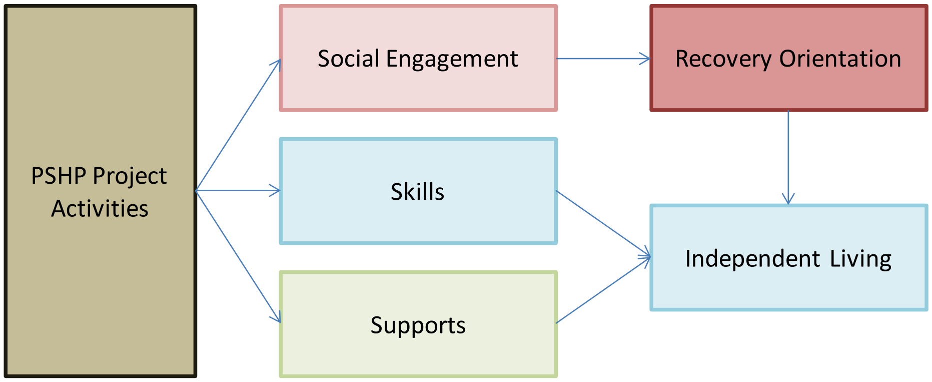

Figure 3: Simplified PSHP project program logic model for study purposes.

Two program intakes were planned of 25 clients each, the second beginning once the first group was in the phone-contact phase of the intervention. While only fifteen clients were receiving services in September 2008, there was a rapid increase over the next few months: there were approximately thirty clients served at the end of the pilot project (i.e., May 2009) and many others on a waiting list (former SSA branch manager, 2012, personal communication).

1.5 Literature Review

This section provides a summary of the literature relating to multiple concepts that are relevant to the design and delivery of the PSHP project, including: the relationship between mental illness and homelessness; case management practices, including Assertive Community Treatment (ACT), Intensive Case Management (ICM), and Critical Time Intervention (CTI); recovery; and peer support.

1.5.1 Mental Illness and Homelessness

The relationship between mental illness and homelessness is well-established in the research literature and in policy and practice (Hulchanski et al., 2009; Canadian Institute for Health Information, 2007). Estimates of the prevalence of mental illness vary greatly, with several studies showing a high rate of mental illness among homeless populations in major urban centres in Canada (Canadian Institute for Health Information, 2007). In Edmonton, 59% of people interviewed for the 2003 Edmonton Homelessness Study reported having a mental illness (Edmonton Joint Planning Committee on Housing, 2004). General recognition of the connection between mental illness and homelessness is evident in the framing of goals and strategies in plans to end homelessness in Edmonton (Edmonton Committee to End Homelessness, 2009), Alberta (Alberta Secretariat for Action on Homelessness, 2008), and elsewhere. The PSHP project was pursued primarily to investigate approaches to address housing instability and reduce risk of homelessness for people with mental illness.

Schizophrenia itself is common among the homeless population, with estimates in a standard psychiatric textbook ranging between 33% and 50% (Folsom & Jeste, 2002). Folsom & Jeste's (2002) systematic review reported a worldwide prevalence rate of 11% for schizophrenia among the homeless; Frankish and colleagues (2005) reported a 6% rate based on information on shelter users in Toronto. When the prevalence of schizophrenia among the general population is considered, it is clear that there is significant overrepresentation of people living with schizophrenia within the homeless population. Estimates of one-year prevalence of schizophrenia in the general population are approximately 1%, suggesting that people with schizophrenia have ten times the risk of becoming homeless than the general population (Folsom & Jeste, 2002). That said, diagnosis alone does not capture the severity and corresponding impact of a mental illness on an individual (Bellack, 2006), nor are some diagnoses clinically stable, in that they are not easily distinguished or differentiated from other mental illness over the long run (Ruggero et al., 2010). As such, studies examining the relationship between mental illness and homelessness refer to the concepts of 'severe mental illness' (for example, Herman & Mandiberg, 2010; Dietrich et al., 2011) or 'severe and persistent mental illness' (for example, Chue et al., 2004) as a way of accounting for the diversity of mental illnesses that can impact the lives they affect. The SSA, and by extension, the PSHP project, similarly cast a wider net by serving "people with schizophrenia or related disorders" (SSA, 2007, para. 1) preferring an inclusive model based on the shared realities of marginalization and poor quality of life among those living with severe mental illness.

Mental illnesses often remit for periods and then re-emerge in states of relapse (Bellack, 2006). With this ebb and flow over a lifetime, the individual's own capacities deteriorate and are restored, albeit with less likelihood of returning to normal functioning with each relapse (Altamura et al., 2001). The remission-relapse cycle, and more importantly, how to prevent relapse and promote remission, are central to scientific models of recovery (Bellack, 2006) and the stated goals of the PSHP project.

In addition to the role of relapse in contributing to their increased risk, there are numerous other individual-level explanations for the relationship between mental illness and homelessness, including reduced employability (Morrell-Bellai et al., 2000), a dearth of social and life skills (Chue et al., 2004), isolation and limited social networks (Klodawsky, Aubry, & Willis, 2007), and less engagement with health services (Kreyenbuhl, Nossel, & Dixon, 2009), among others. At the system level, as with any discussion regarding the social impacts of mental illness, stigma must be acknowledged, particularly in the way it can cause loss of family support (Morrell-Bellai et al., 2000; Lawn et al., 2007) and limit options for self-sufficiency due to "exclusion and invisibility" (Daiski, 2007, p. 277). Discourse often emphasizes the role of deinstitutionalization in moving people from large, comprehensive psychiatric institutions into the community. This, on one hand, was a substantial step towards self-determination and integration of people living with mental illness, but on the other, was a cruel dismissal into a world without empathy and an inadequate, fragmented community care system (Stuart & Arboleda-Florez, 2000). This rationale has been used to explain the rise in homelessness in North America since the early 1980s (Morrell-Bellai, Goering, and Boydell, 2000). Kiesler (1991), however, argued that closing hospital beds contributed to the problem not because it released a flood of vulnerable people into the community, but because people experiencing severe mental illness were denied admission into hospital when they needed it. When decreased availability of tertiary or residential care is combined with barriers to accessing community-based services (Compton et al., 2011; Forchuk et al., 2008; Kreyenbuhl, Nossel, & Dixon, 2009), there is a clear need to assist people living with mental illness in connecting with appropriate services.

1.5.2 Support Models for People Living with Mental Illness

Due to the high prevalence of mental illness among the homeless, interventions developed to address general homelessness and reduce (or eliminate) it have emphasized approaches originally used for people living with mental illness. Case management refers to a range of models that use development of a supportive relationship with an individual to facilitate continuity and comprehensiveness of care and foster the highest level of functioning possible in the least restrictive setting (Goering et al., 1997). There are five main approaches to case management, including:

(1) The expanded broker model, which involves assessing clients and referring them to relevant services;

(2) The rehabilitation model, which focuses on improving clients' living skills through the provision of interpersonal support and assistance in resolving crises and accessing services;

(3) The personal strengths model, which identifies community resources and settings that build upon clients' strengths, rather than focusing on their disability-related deficits;

(4) The full support model, also known as ACT, which combines teaching living skills with clinical management provided by a multidisciplinary team of professionals; and

(5) ICM, which is an application of certain dimensions of the full support model, but are applied in the contexts of rehabilitation and personal strengths models and defined by small caseloads and high frequency of contact with clients (Goering et al., 1997).

Adaptations of the ICM and ACT models are used in Edmonton within the Housing First program associated with the plans to end homelessness (Homeward Trust, 2013). The design of the PSHP project intervention emulated some aspects of the rehabilitation, full support (ACT), and ICM models: clients' needs were assessed and a service plan was developed (general case management); they were provided with support, crisis intervention, and linkage to services with a focus on developing living skills (rehabilitation model); caseloads were small and visits with clients were frequent (ICM); and there was collaboration among the OT/OTA, peer workers, mental health therapists, and physicians (ACT).

Among recognized approaches for case management CTI shares a common origin with the Pathways to Housing ACT model, in that it was first used in New York City in the early 1990s for homeless people living with severe mental illness (Herman & Mandiberg, 2010). By providing case management and resource linkages during this ‘critical time’ of transition, the expectation is that “a time-limited intervention provided during this key period might have lasting benefits by helping to strengthen a network of community support that would last beyond the period of the intervention itself” (Herman & Mandiberg, 2010, p. 503). CTI has been adapted using peer workers under the supervision of a psychiatrist to decrease emergency department visits and increase engagement in outpatient services among individuals who were frequent users of the Columbia Comprehensive Psychiatric Emergency Program (Dr. Dan Herman, personal communication, 2011). In many respects, Project Connect bears many similarities with the PSHP project, including the use of peer workers, supervision by a clinician, length of client participation (six months face-to-face, or longer if required), and focus on connecting clients to community-based services (Dr. Ilana Nossel, personal communication, 2011).

1.5.3 Recovery

Historically, the prevailing focus for mental health care in North America has been on the “reduction of symptoms and improvement of functioning” (Ostrow & Adams, 2012, p. 70). Underlying these goals is an assumption that people living with severe mental illness should only have “guarded expectations about restoration of a premorbid level of functioning” (Bellack, 2006, p. 432) with only 20% achieving this goal, another 20% in classic Kraepelinian decline, and the remaining 60% in a perpetual limbo, neither improving nor declining in the long-run but experiencing variability over a chronic course of illness (Bellack, 2006). Long-term outcome studies cited by Slade and Longden (2015) have found “recovery rates for schizophrenia in excess of 50%” (p. 2), but the true rate of recovery for people with schizophrenia or other severe mental illness is difficult to know because most studies use symptom remission or return to pre-morbid functioning as outcomes (Drake & Whitley, 2016). This concept of remission, defined as at most having mild symptoms that do not interfere with daily living, has been deemed by some as a “necessary but not sufficient step toward recovery” (Bellack, 2006, p. 433). Bellack (2006) goes further in stating that “recovery does not require total symptom remission, but it can be achieved in the presence of mild to moderate symptoms” (p. 434). This suggests that understanding recovery from mental illness requires decoupling from outcomes based in the psychiatric lens and its focus on symptom remission.

As suggested by Drake and Latimer (2012), people experiencing mental illness often reject mental health services or are dissatisfied with them, arguing “that professionals’ goal of stabilization does not correspond to their aspirations for ‘recovery’” (p. 48). Indicators such as attaining education, employment, independent living, social relations, and community participation are often held as evidence of recovery (Drake & Latimer, 2012; Liberman et al., 2002; Bellack, 2006), which in effect speak to a return to a “normative level of functioning” (Bellack, 2006) or “eliminating the deviant status imposed by society” (Onken, Craig, Ridgway, Ralph, & Cook, 2007, p. 10). Mueser and colleagues (2004) insist that recovery is not only relief from symptoms and social success, but most importantly is defined within the context of what people themselves define as important and having personal meaning from their perspectives.

Nonetheless, “improvement in coping with symptoms and the stresses of daily life…allows people to spend less time on their symptoms and more time pursuing their goals” (Mueser et al., 2004, p. 36). Liberman and Kopelowicz (2002) encapsulate these components in what Slade and Longden (2015) call “a widely used definition [of] recovery [that] comprises full symptom remission, full or part-time work or education, independent living without supervision by informal carers, and having friends with whom activities can be shared, all sustained for a period of two years” (p. 3).

The clinical definition of recovery as an outcome has been criticized for leaving “several questions that need to be addressed…how many goals must be achieved to be considered recovered? For that matter, how much life success is considered ‘normal’?” (Ralph & Corrigan, 2005, p. 5). Slade & Longden (2015) contrast clinical recovery – defined as an outcome that is observable, rated by a clinician, and whose definition does not vary between individuals – with the idea of personal recovery – characterized as a process, subjectively defined and rated by the person experiencing it, with different meanings between individuals but with some common aspects. The idea that recovery should be defined from a personal standpoint and as a process, not an outcome, has been stated by Anthony (1993), considered the “classic” (Moran & Russo-Netzer, 2016, p. 273) and “most widely cited” (Slade & Longden, 2015, p. 3) definition in the recovery literature: “recovery is described as a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness” (Anthony, 1993, p. 17). Leamy and colleagues (2011), through a systematic review and narrative synthesis of existing literature on personal recovery, developed the CHIME conceptual framework for describing recovery as composed of five first-order components: connectedness, hope and optimism about the future, identity, meaning in life, and empowerment. CHIME is referenced by many as the dominant framework for defining personal recovery from mental illness (Duff, 2016; Shanks et al., 2013; Slade & Longden, 2015; & Slade et al., 2014). Research has validated this framework with mental health clients (Bird et al., 2014), but there were other themes that emerged: support to improve material circumstances and offer assistance with daily activities of living; addressing problems associated with misdiagnoses and consequent inappropriate medication regimens; and concerns that recovery was more about service cuts than better services (Bird et al., 2014). This latter idea, that the mental health system's focus on recovery could be a smokescreen for an economic agenda as opposed to a humanitarian one, is referenced by others in the context of neoliberal policies emergent in the 1990s when the recovery concept began to have some traction (Braslow, 2013; & Duff, 2016).

To some extent, the CHIME framework appears as a utopian view of recovery from the perspective of the marginalized mental health patient. Mead and Copeland (2000) suggest that it is a mistake to assume "that people know what they need and want…People who have been in the mental health system for many years have developed a way of being in the world, and particularly being in relationship with professionals, in which their self-definition as patient has become their most important role" (p. 321). This ideation of systemic barriers to recovery orientation is supported by the fact that mental health clients are frequently institutionalized, are often heavily medicated, and offered few social opportunities other than sheltered activities and paternalistic housing options (Drake & Whitley, 2014, & Anthony, 1993). Thus, as Bird and colleagues (2014) report, recovery orientation likely entails individualized rehabilitation to shift people from a disability paradigm by "helping clients reach their goals rapidly by providing highly individualized supports…[such as] supported housing, supported employment, supported education, and strengths case management" (Drake and Latimer, 2012, p. 50). Similarly, Drake and Whitley (2014), through examination of autobiographical, qualitative, and quantitative literature, bring forward additional influencers that serve to further augment the CHIME conceptual framework for recovery, including normative life processes, agency in treatment decisions, focus on happiness and meaningful relationships, sanctuary through private housing, meaningful employment for pride and income, social connectedness through peer support, empowering and humane relationships with providers, and protection from stigma and victimization. The framework proposed by Davidson and colleagues (2007) complements these factors by providing a set of basic components of recovery as well as practice guidelines for recovery-oriented service delivery. These are presented in Table 1.

Basic Components of Recovery in Serious Mental Illness
Being supported by others, including professionals, family, friends, and peers
Renewed hope, commitment, sense of self, and purpose derived spiritually or from others
Engaging in meaningful activities and normal social roles that contribute to the community
Redefining self in roles other than "mental patient", accepting illness as gift and limitation
Overcoming stigma by developing resilience and actively fighting against it.
Assuming control as an active agent in transforming from disability to recovery
Managing symptoms by choosing treatments to bring them under a degree of control
Becoming empowered and exercising citizenship to demand normal rights and responsibilities

Draft Practice Guidelines for Recovery-Oriented Service Delivery
Involving people in delivery of services
Addressing basic needs and removing barriers to access
Ensuring continuity of care
Determining needs and strengths from a functional not a diagnostic standpoint
Offering individualized recovery planning
Having clinicians serve as a guide for recovery by linking to the community
Mobilizing coping mechanisms and addressing discrimination
Viewing people in recovery as citizens as opposed to clients

Table 1: Components of recovery and draft practice guidelines for recovery-oriented services (Davidson et al., 2007)

Onken and colleagues (2007) propose an ecological framework that incorporates the CHIME elements and many of those included in other frameworks, but groups them in person-centred, exchange-centred, and community-centred levels, with a strong emphasis on ensuring accommodations for disabilities as a civil right with a goal to not only return people to mental health but to achieve social integration.

The construct of recovery has received a lot of attention and scrutiny because of its shifting of paradigms and power structures. It remains a mysterious phenomenon especially when disconnected from simplistic clinical definitions focused on symptom elimination. Moreover, recovery itself is a subjective experience that, in contemporary discourse, is non-linear and necessarily determined by the person experiencing it. On the other hand, ecological models like that of Onken and colleagues (2007) suggest that recovery is as much a function of the external environment as it is of individual characteristics.

As Ostrow and Adams (2012) reiterate, there is "a lack of research on recovery-oriented services and studies using recovery as an outcome…[but] reports indicate that consumer involvement is essential to improved service systems and outcomes, and reflect recovery values in many of their findings…" (p. 74). In the words of the National Coalition for Mental Health Recovery (2011), "in the emerging field of 'evidence-based practice', we know from our full range of lived experiences what works because we are the evidence!" (n.p.). Consequently, a key instrument referenced in all frameworks to approach this vision of recovery, both in terms of person-centred service provision and ultimately recovery-as-inclusion, is peer support.

1.5.4 Peer Support

The importance of peer support in mental health service delivery has long been recognized as a key contributor to recovery from mental illness, based on the principle that client involvement is essential to ensuring recovery values are reflected in the system and how services are delivered (Ostrow & Adams, 2012; Mead & Copeland, 2000). In essence, peer support embodies a person's shift in identity from "patient to an identity of 'expert by experience'…[and to] new ways of meaning making that facilitate personal worth and social power" (Loumpa, 2012, p. 55-56). Further, in Schon's (2010) qualitative study of recovery and peer support among participants in a consumer-run organization in Sweden, "the 'power of identification' [with peers] emerged as…a powerful contributor in the recovery process, confirming and normalizing [participants'] own illness experience and past experiences of psychiatric care" (p. 85).

Peer support has many definitions. The Mental Health Commission of Canada provides nine putative definitions, settling on a compromise position that defines peer support as taking place between two or more people who share lived experience and centers on changing conditions for the better or promoting successful coping (O'Hanlon et al., 2010). Several conceptual models have been proposed. In some instances, there is a focus on the 'alternative' nature of peer support, based within the ex-patient/consumer movement and built in opposition to the perceived oppression of the mental health system (Mead & MacNeil, 2004). On the other end, especially relevant to the use of peers in formal services like the PSHP project, peer support can be conceptualized as "involving one or more persons who have a history of mental illness and who have experienced significant improvements in their psychiatric condition offering services and/or supports to other people with serious mental illness who are considered to be not as far along in their own recovery process" (Davidson, Chinman, Sells, & Rowe, 2006, p. 444). In this definition, there is a clear delineation between the 'giver' and the 'receiver' of peer support, as opposed to the essence of mutual, reciprocal support ingrained within some frameworks (Davidson et al., 2006).

Peer support is commonly used in the treatment of substance use disorders and for helping people cope with other chronic illnesses (O'Hanlon et al., 2010; Davidson et al., 2006), but has suffered from a “lack of recognition of the legitimacy and utility of this resource in mental health” (Davidson et al., 1999, p. 166). The origin of peer support in the consumer movement has created tension in the way it is viewed and couched within the broader context of the mental health system. From a consumer perspective, peer support implies reciprocity (Dennis, 2003, in O’Hanlon et al., 2010; Mead & MacNeil, 2004; Mead, Hilton, & Curtis, 2001; & Repper & Carter, 2011), which places it at odds with the traditional hierarchical structure of the mental health system, in which the professionals exert significant power over their patients. Mead and colleagues (2001) suggest that peer support, by virtue of its origins, must remain an alternative to the conventional approaches in mental health care. This can be considered one end of the spectrum for how peer support is conceptualized in the literature and in practice. The other end involves employing people living with mental illness as providers of mental health services, but not in a way that meaningfully acknowledges and mobilizes the lived experience they bring to their work. Somewhere in the middle of this spectrum there is a large grey area in which peers are integrated in service delivery and provide complementary or supplementary services alongside professionals and other mental health workers (Davidson et al., 2006).

The literature is clear on the challenges in defining how peer support is operationalized in the context of a paid employee working within or in partnership with conventional mental health services (O’Hanlon et al., 2010; Davidson et al., 2006; Mowbray et al., 1996; Repper & Carter, 2011; Solomon, 2004; Mead & MacNeil, 2004; Moll et al., 2009). Mowbray and colleagues (1996) conducted a qualitative study of the role of peer providers within this context, highlighting several issues regarding how they relate to mental health professionals and clients, and the challenges they faced in their roles and responsibilities. At its core, peer support providers offer “a sympathetic understanding of mental illness – something which is often defined outside of professional-consumer relationships – [that] may add a special form of support…that can lower the social distance between provider and recipient" (Mowbray et al., 1996, p. 59). The difficulties associated with maintaining this relationship while at the same time offering 'role sophistication' to elevate their work above mutual support can lead to challenges experienced by the workers, including job dissatisfaction, lowered productivity, and turnover, all a result of 'role strain' (Mowbray, 1996).

Peer support has been applied within some of the service delivery models described earlier. Project Connect, like the PSHP project, used peer workers in their CTI model as a way to enhance the connection between the team and their clients (Dr. Ilana Nossel, personal communication, 2011). This follows an initiative in Denver, which Sherman and Porter (1999) describe as the first case management intervention in the US to hire and train people living with mental illness to work as case management aides. Further, in the ACT fidelity guidelines, there is an explicit requirement for people living with mental illness to participate on the ACT team as direct providers in order to "provide role models, peer support and unique engagement strategies" (Salyers & Tsemberis, 2007, p. 13). Nonetheless, in their survey of 56 ACT teams in Ontario, Randall and colleagues (2012) found that providing a peer worker as part of the team was among the five areas with the lowest compliance, although ACT program coordinators tended to regard it as very important.

The Mental Health Commission of Canada claims that studies on peer support have "demonstrated not only the benefits to individuals involved, but also to the mental health system and communities as a whole, by saving millions of tax-payers dollars through reducing the use of the most expensive types of services" (O'Hagan et al., 2010, p. 8). In contrast, the Schizophrenia Patient Outcomes Research Team (Dixon et al., 2010) offers a summary statement (as opposed to an explicit recommendation, which requires sufficient evidence) regarding the potential for peer support services to eliminate stigma and offer role modeling for clients, but highlights the challenges in existing studies to draw a clear line between the specific mechanism of action of peer services and the direct benefits they produce. There were significant challenges reported in conducting a meta-analysis of the impact of peer support due to the lack of fidelity criteria or clear typologies for peer interventions, the heterogeneity of peer providers and recipients, and the complete absence of any follow-up data for any outcome measured (Lloyd-Evans et al., 2014). Considering there continue to be issues decoupling remission and conventional clinical outcomes from recovery orientation (as discussed in the previous section), it is no wonder that there are challenges in empirically connecting the poorly defined concept of peer support within the still-developing construct of recovery, particularly as a subjective, self-defined phenomenon. In many respects, there appears to be dissonance between the evident perceived value of incorporating peer support in delivery of clinical interventions and the actual implementation of peer support, or the hiring of peer workers, in conventional mental health systems. Nonetheless, the considerable literature on peer support offers strong theoretical foundations for its use and provides examples of the benefits it can produce. However, there is still much to be learned about how peer-delivered services can be differentiated from conventional services and the ways in which they contribute to positive outcomes for people they serve.

1.6 Significance of Study

The study presents details of one of a very small number of documented paid peer worker services, specifically one that focused on instrumental goals for people with mental illness at risk of homelessness and was operated by a community-based organization but worked closely with clinicians within the formal mental health system. Examining the delivery of the PSHP project provides insights into how a peer-based case management service was operationalized relative to its original design and to what extent, in retrospect, it may have addressed factors relevant to achieving the outcomes included in the project's logic model. Further, the study complements the existing literature by offering perspectives from mental health clients and therapists regarding factors that contribute to recovery and independent living. Consequently, the results and inferences produced by the study can inform mental health system change by clearly identifying barriers and facilitators impacting recovery of people with mental illness. Also, they can assist service providers in design of intervention models that incorporate peer-based delivery or have recovery and independent living as desired long-term outcomes.

Chapter 2: Research Approach and Design

2.1 Overview of Study Design

A mixed method design was used to examine the intended outcomes of the PSHP project and how the project was delivered in order to inform conceptualizations of recovery and service delivery models that can support it. Quantitative data were collected from former PSHP client participants directly through administration of self-report instruments and indirectly from secondary data contained within their client case files. Qualitative data were collected using individual interviews conducted with the same clients, as well as interviews conducted in a similar fashion with several therapists. Using mixed methods facilitated interaction between quantitative data gleaned from the small sample of client participants and the considerable qualitative data available from therapists and clients, which generated a clearer picture of the intended outcomes of the PSHP project and how the PSHP project was delivered, especially the role of the peer workers.

This study received ethics clearance from the Health Research Ethics Board of the University of Alberta, administrative approval from AHS/Edmonton Area Regional Research Administration via the Northern Alberta Clinical Trials and Research Centre, and operational approval from AHS – Addiction & Mental Health, Edmonton Zone.

2.2 Sample

Two groups of participants were recruited for this study: former PSHP project clients (herein referenced as “clients”) and AHS therapists (herein referenced as “therapists”). An opportunistic sampling method was applied for recruitment as they were introduced to the student investigator. Recruitment limits and timelines were established, but active recruitment continued until an appropriate number of participants had been reached to at minimum generate theoretical saturation in the qualitative component of the study. The sampling approach favoured recruitment of therapists over mental health clients due to the relative ease with which the former group could be recruited. The recruitment process resulted in a total of eight therapists and five former PSHP clients participating in the study.

2.3 Inclusion Criteria

The primary inclusion criterion for client participants was that they received services from the PSHP project. Thus, client participants would have satisfied the eligibility criteria to be served by the PSHP project. The inclusion criteria for therapists recruited to participate were that they either referred one or more clients to the PSHP project, or they currently had clients referred to the project on their caseload. The only exclusion criterion for potential client or therapist participants was that they were unable to contribute any data for the study due to unavailability or could not provide informed consent.

2.4 Participant Recruitment

The SSA identified the initial pool of potential client participants through the PSHP project archives. A peer employee of the SSA was paid by the student investigator’s supervisor to review PSHP files and build a spreadsheet with the names, contact information, and referring therapist contact information for all mental health clients served by the PSHP project. The spreadsheet prepared by the SSA employee was sent to AHS and cross-matched against active therapists in Community Mental Health Services to generate a list of therapists of the potential participants in the spreadsheet. An email containing the names of and contact information for these active therapists and the number of eligible participants (but not any identifying information) associated with each one was sent to the student investigator. An internal email was sent by an AHS director to each of the therapists with the names of the clients they had on their caseloads who were eligible for participation in the study. Therapists also received the recruitment materials including information letters, client recruitment scripts, consent forms for providing the student investigator with their clients' contact information under Section 55 of the Health Information Act (HIA) of Alberta (RSA, 2000), and the student investigator's contact information. Recruitment materials are provided in Appendix A.

Potential client participants had the choice of either having their contact information passed to the student investigator (their consent would be required, using the provided HIA consent form) or contacting the student investigator using the phone number on the handout provided to them. Therapists engaged as part of client participant recruitment were also asked for their permission to be contacted later for an interview. Following this, the student investigator sent an email to each therapist, introducing himself, offering context to the study, and inviting the therapists to contact him directly. Eight therapists and one client were recruited through AHS.

Recruitment through the SSA was much simpler than the process used to recruit through AHS therapists. The peer SSA employee who compiled the therapist contact information spreadsheet also prepared one with contact information for people referred to or served by the PSHP project, contained within PSHP project archives. Another peer SSA employee, also paid by the student investigator's supervisor, called each of the phone numbers in this spreadsheet. If the person on file was reached, the peer employee explained the study using a script and, if they expressed interest in participating in the study, asked for their consent to pass their contact information to the student investigator so they could be contacted by him.

Multiple attempts were made at recruiting participants through AHS, in addition to one attempt through the SSA. Multiple attempts through the SSA were not possible because of a change in the availability of staff. Seven former clients were referred to the student investigator by the SSA. Of those, the student investigator was able to recruit four.

2.5 Informed Consent

Three versions of the client participant information letter were prepared: a script for AHS therapists to use in explaining the study to a potential participant, a corresponding handout for therapists to pass on to potential participants, and the full information letter for use in the initial in-person meeting with potential participants prior to obtaining consent. A separate information letter was provided to therapists for their own recruitment as participants. All information letters used for recruitment in this study are provided in Appendix A. The information letter for clients was prepared at a Grade 6 reading and comprehension level, and the content of both the information letter and consent form were explained verbally by the student investigator. All participants were made aware of the risks and benefits of participating, their right to withdraw from the study or withhold content derived directly or indirectly from information they provided during the course of their participation in the project, and, for client participants, that they would receive an honorarium for participation.

The study used data contained in PSHP project archives, held and owned by the SSA. As discussed above, the initial pool of potential participants was identified by the SSA through the PSHP project archives, and their PSHP referral information was shared with AHS in confidence.

The student investigator's access to PSHP archives for a particular client participant was contingent on the participant signing the consent form. Once consent had been obtained, the student investigator could match the name of the study participant to records in the PSHP project archives held by the SSA for the purposes of conducting review of their case files.

2.6 Compensation

Financial compensation for mental health client participants was included in the study design and recruitment process to try to minimize under-enrolment by offering fair compensation as an acknowledgment of their contributions, without undue inducement or unreasonable acceptance of risk among participants (Halpern, 2011). Client participants received $10 for data collection at the first meeting, $15 for the second meeting, and $25 for the third meeting. Cash payments were used because participants may not have had access to adequate transportation to make use of gift cards for Walmart, Safeway, or other stores. Therapists were not provided with an honorarium for their participation because interviews were conducted during work time with authorization from their employer.

2.7 Data Collection

2.7.1 Study Phases

Each phase of data collection and associated data sources are provided in Table 2.

Phase of Data Collection	**Activities**
Phase 1 (First Meeting – Mental Health Clients Only)	Demographic Questionnaire (10 minutes), Clinical Information Questionnaire (15 minutes), Housing Stability Questionnaire (15 minutes)
Phase 2 (Second Meeting – Mental Health Clients Only)	Semi Structured Interview - Thoughts on recovery (20 minutes), Thoughts on independent living (20 minutes), Thoughts on peer support and/or recollections of the PSHP project (20 minutes)
Phase 3 (PSHP File Review – Mental Health Clients Only)	Former PSHP Client Case Files, specifically reasons for referral, OT/OTA notes, and the number and purposes of peer worker visits as described in their visit logs.
Phase 4 (Meeting – Therapists Only)	Semi Structured Interview - Thoughts on recovery (20 minutes), Thoughts on independent living (20 minutes), Thoughts on peer support (20 minutes)

Table 2: Summary of data collection phases.

Phase 1 of data collection began at the initial meeting with the clients, if they agreed to participate and signed the consent form. Information on their demographic characteristics, clinical factors (including diagnosis and history), mental health program usage, and housing stability was collected. The first meeting did not extend beyond half an hour for any of the participants.

In Phase 2 of data collection, a short semi-structured interview (60 to 90 minutes) was conducted with participants who completed Phase 1. The purpose of the semi-structured interview was to gain insights into the participants' perspectives on the concepts of independent living, recovery, and peer support. The participants' responses to open-ended questions on these subjects were guided by prompts about factors influencing housing stability, skill development and retention, and the role of social contact and peer influences, in addition to concepts that emerged through application of the constant comparative method (Charmaz, 1995). PSHP clients were asked specific questions to gather feedback on their experiences in the PSHP project and their opinions on the benefits they received from participation in the project, specifically related to housing stability, acquisition or enhancement of independent living skills, social contact, and recovery orientation.

In Phase 3 of data collection, the student investigator reviewed client participants' respective records in the PSHP project archives, particularly the client case files that contained all referral, intake, service delivery, discharge, and follow-up documentation and records for each client. The student investigator developed and used templates to gather information on reasons for referral, activities of the OT/OTA, the number and purposes of contacts with their respective peer workers, and the content of the logs kept by the peer workers and the OT/OTA.

In Phase 4 of data collection, therapist participants were involved in one meeting in which consent was obtained and a semi-structured interview immediately followed. The interview was conducted with the therapist participants in the same way as with the client participants, following an informal, conversational approach that allowed tangential or peripheral ideas to influence the flow of information and expand the qualitative data beyond the confines of the pre-determined concepts that were formally part of the interview protocol.

2.7.2 Data Sources

Data sources for the study included the PSHP client files and self-reported information provided through the qualitative and quantitative portions of participants interviews. Table 3 provides a summary of data collection steps, data sources (and data collection phase), specific tools and methods used, and the purpose of collection. All data collection tools are provided in Appendix B.

Data	**Data source & phase of data collection**	**Tools and methods used**	**What is being collected**	**Purpose of collection & alignment with research questions (RQ1, RQ2)**
Demographic information	Client Participant self-report (Phase 1)	Demographic Questionnaire (Appendix B)	Age, Gender, Ethnicity, Marital status, Education level, Income source(s)	Determine profiles of client participants. (RQ1)
Clinical information	Client Participant self-report (Phase 1)	Clinical Information Questionnaire (Appendix B)	Primary diagnosis, Age of onset, Age of diagnosis, Services used	Supplement profiles of client participants. (RQ1) Determine level of engagement with mental health services. (RQ1)
Housing Stability	Client Participant Self-Report (Phase 1)	Housing Stability Questionnaire (Appendix B)	Recall of number of residences, moves, or incidences of homeless in past three years; and indication of threats to housing period in same period	Determine housing stability through composite measure of greatest number of months in one residence, number of times homeless, and number of months homeless in past three years; and what, if any, factors threatened their housing over the same period. (RQ1)
Semi-Structured Interview	Client and Therapist Participant self-report (transcribed) (Phases 2 and 4)	Interview Protocol (Appendix B)	Perspectives on concepts of independent living, peer support, and recovery	Determine participant perceptions of what contributes to PSHP project intended outcomes (independent living, social engagement, housing stability, and recovery orientation). (RQ2) Client participants only: recollections of participation in the PSHP project. (RQ1)
PSHP Activities and Outputs	PSHP Client Binders (Phase 3)	File Review	Numbers, types, and characteristics of activities recorded in case notes and other documentation over the course of the client's participation	Determine how the PSHP project was delivered and compare to participant perceptions of what contributes to PSHP project intended outcomes (RQ1, RQ2)

Table 3: Summary of data sources, methods and tools, data being collected, and purposes.

2.7.3 Demographic and Clinical Information Questionnaires (Client Participants Only)

Two self-report questionnaires were administered by the student investigator to gather demographic and clinical information about each of the client participants. Participants were asked to choose an alias to be recorded on each questionnaire to ensure there would be no directly identifying personal information associated with what was collected on the forms. Completed forms were also kept in separate files for the same purpose. A password-protected electronic document was kept with a record of each participant and their alias to be used for connecting data for analysis.

The Demographic Questionnaire asked about the participant's current age, gender identity, ethnicity, family or relationship status, highest level of educational attainment, and income source(s). For age, gender, ethnicity, and education level, the participants' verbatim responses were recorded on the questionnaire. Similar questions from Homeward Trust's Housing First Intake Assessment Form (Homeward Trust, n.d.) were used for categorizing their responses. For the question on family and relationship status, a mixture of response types from the Housing First Intake Assessment Form and other selections were used.

The Clinical Information Questionnaire asked about the participant's major diagnoses (allowing for multiple responses), the age at which they believe their mental illness(es) first began, the age at which they were first diagnosed as having a mental illness, and the age at which treatment for their mental illness(es) started. The participants' responses to these questions provided context regarding the duration of their illness(es) and some information on their illness and treatment history. The last part of the Clinical Information Questionnaire asked the participants about mental health services they had used in the three years prior to their participation in the study, ever in their lives, or never. The purpose of this component of the questionnaire was to determine if the clients had accessed services to help them maintain their mental health or their independence in the community. A list of 35 relevant services was generated from a directory provided by AHS and information contained in the InformEdmonton database regarding programs offered by the Canadian Mental Health Association (CMHA) and SSA. Participants could also indicate other programs or services they felt were relevant and were missing from the list, specifying whether they used them in the previous three years or prior to that.

2.7.4 Semi-Structured Interview (Client & Therapist Participants)

The semi-structured interview protocol (Appendix B) included three open-ended questions on the constructs of independent living, recovery from mental illness, and peer support. All client participants brought up their participation in the PSHP project without prompting, so they were asked about their experiences with the PSHP project. Therapists were asked similar questions about peer support in general. Prompts were provided to clarify the meaning of these constructs and probes were used to try to interrelate independent living, social relations, recovery, housing stability, and peer support. Questions and clarifying statements were phrased using plain language to avoid problems with interpretation of technical language or theoretically based jargon.

The semi-structured interview was digitally recorded with verbal, recorded consent of the participants. Digitally recorded interview data were transcribed by a professional transcriptionist and returned to the student investigator as Word documents. Transcripts were anonymized by the student investigator, replacing any potentially identifying information, including names of locations or acquaintances, with general terms (as examples, changing the name of a therapist to "AHS therapist", or a CMHA self-help group to "agency self-help group"). One client participant refused to be recorded, so with the participant's permission, handwritten notes were taken by the student investigator to capture the participant's responses. These notes were then typed into a Word document and stored electronically with the other transcripts.

2.7.5 Housing Stability (Client Participants Only)

The Housing Stability Questionnaire asked participants to provide the length of time, measured in full months, that they had been in their current housing situation, up to a maximum of 36 months if they have lived in the same place for the last three years. The information collected was used to determine the length of time, measured in full months, that they were in the most stable (i.e. continuous) housing situation. Information was also collected on the number of times and cumulative length of time the participants had been homeless during the past three years, based on Alberta Human Services' definition of chronic homelessness (Homeward Trust, n.d.). The data collected were used to determine the relative stability and security of the participants' housing over the three years prior to their participation in the study.

Finally, the participants were asked if at any time in the past three years they had had their housing lost or threatened by a number of factors, including eviction, hospitalization, involvement with the justice system, loss of financial or social resources, among others. This question was based on a set of questions in the Homelessness Asset and Risk Screening Tool (HART), developed by Tutty and colleagues (2012) and the Calgary Homeless Foundation, relating to housing stability and transitions, and the Residential Timeline Follow-Back Inventory (Tsemberis et al., 2007). Information on risk factors affecting housing stability was used to complement data gathered from qualitative interviews on systemic and personal factors contributing to independent living, recovery, and housing stability.

2.7.6 PSHP Client Files (Client Participants Only)

Data were collected through a review of client binders retrieved from the SSA office for each client participant in the study. The information in the PSHP client binders was collected for the purposes of determining to what extent the project was delivered according to the program model. "Observation/Progress Reports" containing case notes for peer workers, the OT, the OTA, and Project Coordinators were the primary document type reviewed, and the details for each case note were recorded on paper and then entered into Excel. These details included:

- The date of an activity or interaction with or on behalf of the client,
- The person(s) involved in the activity (client, peer worker, OT, therapist, etc.),
- The type of activity (attempted contact, home visit, visit and outing, etc.), and
- The objectives, issues, or focus areas addressed during that activity or interaction.

In addition, notes were written to record other information contained in the client binders, as described in Table 4.

Document Type	Information collected
Referral Form	Client issues, strengths, and service considerations
Brief Synopsis Report	Client background and history
Peer Support Plan	3 month plan including goals and suggested activities
Observation/Progress Reports	Activity logs and case notes for PSHP staff
Correspondence	Fax cover sheets, letters written for client appeals and applications

Table 4: Documents Examined and Information Gathered in PSHP Client Files

2.8 Data Analysis

2.8.1 Client Characteristics and Contexts

Demographic and clinical characteristics of participants from paper data collection tools were entered into Excel and analyzed to present profiles of the former PSHP clients who participated in the study. Descriptive statistics of demographic and clinical information were used to contextualize other data. Data collected through the Clinical Information Questionnaire and Housing Stability Questionnaire were analyzed to determine client participants' service usage and housing stability and contextualize other data analysis.

2.8.2 Delivery of the PSHP Project

All five client participants had PSHP client binders available in the SSA Edmonton Branch office. While all five technically were accepted and served by the PSHP project, one client refused services after one visit and attempts by the client's therapist, PSHP staff, and others to convince the client to continue. Thus, data from only four clients were included, i.e. those who had continuing interaction as participants in the PSHP project.

The four client case files consisted of binders with all major sources of information needed for the client file review, including: referral, intake, discharge documentation; brief synopsis (client history summary); records of correspondence between PSHP staff and others (e.g. clinicians, client, etc.); and case notes written and signed by the peer workers, OT/OTA, and Coordinators. The case notes were detailed but succinct, providing the time and locations of contacts in addition to a clear summary of work performed and topics of discussion between the PSHP staff and clients or clinicians. Attempts to contact clients or clinicians were recorded as well. Case notes contained a copy of letters that were submitted as appeals or new applications for service access. Copies of completed program application forms or documents confirming submission of the same were not in the client binders for verification.

Review of the Observation/Progress Reports in the PSHP client case files produced a typology of activities performed by the peer workers, OT/OTA, other PSHP and SSA staff, and clinicians connected to the client. Activities were defined based on three characteristics: outputs or foci of services mentioned in the case notes ("outputs"), who was involved in the activities, and the contact type. The typology of PSHP outputs and contact types was developed using a constant comparative method to ensure all data codes could be categorized into clear and discrete types for counting and analysis without ambiguity. This involved reviewing client binders, open-coding interactions and generating categories of interaction types concurrently, and re-reviewing client binders to selectively code interactions using categories developed from the review of other client binders. These interaction data were summed to determine frequencies of outputs and different types of contacts in order to compare them to the expected outputs and interactions from the PSHP program model. A paper tool was developed to write down this information during client file review for later entry into Excel. Each case note corresponding with a unique interaction with or on behalf of a client was recorded as a row in the spreadsheet. Each row of data included the date of the interaction, the primary person involved, the type of interaction, and the issues, topics, or objectives addressed in that interaction. Once a complete list of outputs and contact types was confirmed, they were grouped into categories for ease of presentation. Contact types were grouped into four categories: peer contacts, clinician contacts, attempted clinician contacts, and other contacts. Data were then graphed over time (months in the PSHP project) for each client to show changes in engagement over the course of clients' participation in the PSHP project.

2.8.3 Perspectives on Factors Supporting Recovery Orientation

The number of participants in the qualitative component of the study was sufficient to achieve theoretical saturation. A total of twelve participants, including four clients and eight therapists, contributed interview data which were sufficient to achieve theoretical saturation based on iterative review of data collected through the study. For all clients but one, these data consisted of transcripts from semi-structured interviews and information from their client files. For one client, data were available from handwritten interview notes and the client file.

The primary purpose, or frame, for inductive analysis in this study was to determine any factors participants connected to the key concepts associated with the logic model for the PSHP project, specifically skills and supports for independent living, recovery orientation, housing stability, and social engagement. Focusing on such specific constructs at the outset would appear to contravene Glaser & Holton's (2004) principle that data in a Grounded Theory study should be analyzed without preconceived notions that may bias, obscure, or force interpretations. However, this is impractical in a reality of ethical scrutiny requiring explicit purposes, defined methods, expected outcomes, and an understanding of how the study fits within the context of existing research and knowledge gaps. Nonetheless, the student investigator pursued a middle ground, using the constructs to guide qualitative data collection and initial analytic steps and then discarding them as soon as the data began to overflow between and outside of their boundaries. In other words, the PSHP evaluation frame served as a pretext for qualitative analysis, but the coding, categorization, and theory generation steps were not constrained by it.

Transcribed interview data were analyzed through line-by-line open coding. Open coding involved picking out concepts and, as much as possible, verbatim statements that appeared significant to the person conducting the analysis. Practically, codes were generated by reviewing

Word files of interview transcripts and using the software’s comment function to record quotes, concepts, or memos. Coding occurred in multiple passes: previous interviews were re-analyzed when new interview data were collected. This facilitated deconstruction of the data so that patterns of codes and concepts could emerge across participants’ contributions, as opposed to simply identifying themes within each participant’s interview data (Charmaz, 1995). Emergent codes informed new prompting questions in later interviews, thus analysis fed data collection and vice versa. The codes were extracted from Word using the XPS printer function in the software, which allows for isolation of comments and other reviewer mark-up into a separate document. This XPS document served as the initial set of codes for analysis in the categorization and selective coding stage.

As codes were isolated in XPS documents, intuitive groupings, or preliminary categories, became apparent. This stage necessitated a less technological approach to the analytic process: sticky notes and pieces of paper with codes and preliminary categories were physically arranged on poster board into distinct groupings (Figure 4).

Figure 4: Early grouping of open and selective codes and categories.

Codes or preliminary categories that could not be grouped were kept in an “other” pile. The size of the “other pile” was continually reduced with each re-categorization. Using this process, the codes and categories were redefined, regrouped, or clarified as further data collection and analysis occurred; gaps and negative cases (codes or cases that did not align with others in the category) were resolved by going back to previously collected/analyzed data and rethinking categorization strategies.

Once a set of stable categories emerged, these were tested against new data sources, specifically new interview transcripts. New categories that emerged from analysis of new data forced the student investigator to deconstruct previous categories and reorganize codes and combine preliminary categories into new sets of groupings. This cyclical process produced an assortment of categories that grew larger and more theoretically sound as they encompassed more codes collected from the data. At the same time, the “other pile” was also being reduced to the point where there were no longer any codes that could not be grouped. This marked the confirmation of theoretical saturation and the transformation of the data groupings into “core variables” that could be organized and connected. The core variables were checked against relevant notes in the client case files that suggested similar factors or themes, and by referring to literature to clarify connections among the codes, categories, and core variables. This theoretical sampling process resulted in reorganization of the core variables and further contextualization of their relationships to one another.

2.9 Presentation of Results, Discussion and Conclusion

The results of the study are presented in two separate chapters, followed by one concluding chapter for discussion of the results and presentation of conclusions of the study.

Chapter 3 presents client characteristics and information on the delivery of the PSHP project (Phase 1), including qualitative data and analysis from client recollections of the PSHP project (Phase 2) and quantitative data from Phases 1 and 3 of the study, to address Research Question 1 (i.e., how and to whom was the PSHP project delivered, and to what extent did PSHP project delivery address factors related to achieving recovery orientation, independent living, and other intended outcomes of the PSHP project program model?). Chapter 4 describes factors that emerged from qualitative analysis of client and therapist interviews (Phases 2 and 4) that relate to the outcomes in the PSHP program model and address Research Question 2 (i.e., how do the expected outcomes in the PSHP project program model relate to each other, and what other factors not included in the original design contribute to recovery and independent living for people with mental illness?). Chapter 5 contains the discussion incorporating results from the previous two chapters, limitations in the design of the study and considerations for future research, and conclusions with implications for policy, practice, and further study.

Chapter 3: Results - Client Contexts and Delivery of the PSHP Project

In this chapter, analyses of quantitative data are presented to address Research Question 1: *How and to whom was the PSHP project delivered, and to what extent did PSHP project delivery address factors related to achieving recovery orientation, independent living, and other intended outcomes of the PSHP project program model?* Section 3.1 (Client Characteristics and Contexts) presents data from the instruments used in Phase 1 of the study. Sections 3.2 (Delivery of the PSHP Project) and 3.3 (Case Examples) present data from PSHP client case files used in Phase 3 of the project. Section 3.2 focuses on the outputs of, or activities delivered by, the PSHP project; Section 3.3 highlights the types of client contexts and circumstances that the PSHP project addressed through its delivery; and Section 3.4 presents first-hand client participant recollections and impressions of PSHP project delivery.

Clients from whom data are presented in this chapter are identified as A, B, C, D, or E in presentation of demographic, clinical, housing stability, and service delivery data. This system is also used in the Discussion chapter when referencing client participants with respect to PSHP project delivery and data drawn from their client files.

3.1 Client Characteristics and Contexts

3.1.1 Client Characteristics

Demographic information of client participants is presented in Table 5, followed by a summary of their clinical characteristics in Table 6.

Client	Age	Gender	Ethnicity	Relationship Status	Education Level	Income Sources
A	25-35	M	Caucasian	Single	Completed High School	AISH, Part-Time Work
B	51-65	M	Caucasian	Divorced	Some High School	AISH, Pension, Subsidized Housing
C	51-65	M	Other	Single	Completed High School	AISH, Pension, Rent Supplement
D	51-65	M	Caucasian	Divorced	Completed College or Technical School	AISH, Pension, Subsidized Housing
E	51-65	F	Caucasian	Separated	Completed High School	AISH, Pension

Table 5: Demographic characteristics of client participants.

Most clients were in the 51-65 age category. All but one identified as Caucasian. All were living independently at the time of their interviews (in 2014), but three had been divorced or separated at the time of their participation in this study. All but one had completed high school; one client had completed post-secondary college or technical school. All clients received AISH; four clients received supplemental income from a pension program and one worked part-time. Three clients reported receiving some kind of housing subsidy, either through a rental supplement or tenancy in subsidized housing.

Client Participant	Primary Diagnoses	Age of Onset	Age of Diagnosis	Age at First Treatment
A	Schizoaffective Disorder	0-12	18-24	25-35
B	Depression, Dysthymic Disorder, Diabetes, COPD/Emphysema	0-12	13-17	13-17
C	Schizophrenia	25-35	25-35	25-35
D	Schizophrenia, Back Injury	0-12	36-50	36-50
E	Depression, Dysthymic Disorder, Arthritis, Back/Neck Injury	13-17	18-24	18-24

Table 6: Clinical Characteristics of Client Participants.

Two clients reported a diagnosis of schizophrenia, and two clients reported an affective disorder, specifically depression and dysthymic disorder. One client essentially fit in both categories with a diagnosis of schizoaffective disorder, which has characteristics of both schizophrenia and an affective disorder. Three recalled the onset of psychiatric symptoms when they were young children, one indicated onset was during the client's teen years, and the remaining client participant reported onset in adulthood. There were varying lengths of periods between recalled onset and diagnosis of psychiatric symptoms, however most commenced treatment shortly after diagnosis. Three client participants reported physical health issues, two of which were associated with injuries.

3.1.2 Mental Health Service Engagement

Information collected from all clients on usage of services is presented in Table 7. All clients reported using clinical services and community programs in the three years preceding their participation in the study. All but one client reported seeing a therapist in a Community Mental Health Clinic and seeing a psychiatrist. One client reported staying overnight in a city hospital, while another client worked with a Mental Health Coordinator at a city hospital to avoid admission. One client reported use of Forensic and Community Services (FACS), including a psychiatrist, counselor, and other services available through the program. None reported seeing a psychologist, social worker, or occupational therapist in the past three years, however two had seen a psychologist in the past. Four clients reported receiving home visits from a Community Support Worker; two of those clients received those services in the past three years.

Community programs were less frequently used by clients compared to clinical services. Most of these programs were offered by AHS, including the Pathways Vocational Program, Employment Program, Housing Supports, and Spiritual Values Group. One client reported receiving Home Care through AHS. In terms of programs offered by community-based organizations, two clients indicated use of CMHA's Housing Program or Practical Support Services. All but one indicated that they had never used services offered by the SSA, although one reported participating in the ESCAPE program. All other clients reported not using programs offered by the SSA; none offered the PSHP project as a response when asked if there were other programs or services that they recalled using, even beyond the past three years.

Program/Service	Past 3 Years	Ever	Never
Clinical Services			
Visit from the Crisis Team	2	1	2
Visit to a Community Mental Health Clinic	4	1	0
An Outpatient or Day Treatment Program in a Hospital	0	1	4
Home Visit from the Community Support Team	2	2	1
Appointment with a Psychologist	0	2	3
Appointment with a Psychiatrist	4	1	1
Appointment with an Occupational Therapist	0	1	4
Appointment with a Social Worker	0	1	4
Forensic Assessment and Community Services	1	1	3
Stay in a city hospital psychiatric unit overnight or longer	1	1	3
Appointment with Mental Health Coordinator in city hospital	1	0	4
Community Programs			
AHS Pathways Day Program	0	1	4
AHS Pathways Vocational Program	1	0	4
AHS Employment Program	1	0	4
AHS Housing Supports	1	0	4
AHS Spiritual Values Group	1	0	4
AHS Home Care	1	0	4
CMHA Housing Program	1	0	4
CMHA Soc Rec	0	1	4
CMHA Practical Supports	1	0	4
SSA ESCAPE	0	1	4

Table 7: Mental health service usage by client participants.

3.1.3 Housing Stability and Security

All client participants were in the same housing for the past three years. None reported any time being homeless during the same period. All clients but one reported that their housing had been threatened in the past three years: two clients reported victimization (abuse), one reported an increase in utility costs, and another reported a rent increase. One client reported that money management and mess were threats to housing security. Another client was concerned about the long-term security of the housing situation because the client's roommate was aging and affordability would be an issue if the client had to rent the unit alone. One client provided details regarding victimization by others that threatened the client's housing, including a drug dealer who would regularly come to the client's apartment, use substances in the bathroom, and not leave. Another example given by the client was when a neighbor used to have prostitutes come to the building, and they would come to the client's apartment asking for cigarettes and drugs.

3.2 Delivery of the PSHP Project

In this section, information is presented on the nature and frequency of outputs of the PSHP project, organized by the typology generated from reviewing and recording data from PSHP client case files covering various periods of client participation between 2007 and 2009. The types of outputs include Administrative Activities, Instrumental Support Activities, Clinical Support Activities*,* Social Support Activities, Service Access Activities, and Social Inclusion Activities. A summary of the outputs within each type of activity is presented in Table 8.

Activity Type	Outputs
Administrative Activities	Processing Activities, Clarifying Boundaries, Purchasing Supplies
Instrumental Support Activities	Food Security, Hygiene, Cleaning, Telecommunications, Public Transit, Managing Tenancy, Money Management, Legal Issues, Identification, Shopping
Clinical Support Activities	Supporting Therapeutic Alliance, Medication Issues, Health and Wellness, Symptom Issues, Substance Use, Updates and Check-Ins, Care Planning
Social Support Activities	Social Activities, Cultural Support, Family Issues, Exploitation Issues, Advice and Mentoring
Service Access Activities	Submitting New Applications, Submitting Formal Appeal, Connecting to Services
Social Inclusion Activities	Employment Support, Volunteer Support, Educational Support

Table 8: Summary of outputs by activity type.

3.2.1 Relative Frequency of Outputs

Outputs were grouped into quartiles in order to compare how often they were performed relative to others. The frequency of output instances in case notes, grouped by quartile, is presented in Table 9.

PSHP Project Outputs by Frequency, in Quartiles			
Fourth (Highest) Quartile		**Third (2nd Highest) Quartile**	
Cleaning	65	**Managing Tenancy**	28
Symptom Issues	59	**Therapeutic Alliance**	28
Updates and Check-ins	51	**Clarifying Boundaries**	26
Money Management	48	**Care Planning**	26
Social Activities	37	**Family Issues**	21
Health and Wellness	36	**Connecting to Services**	20
Processing Activities	35	**Purchasing Supplies**	18
Medication Issues	33	**Exploitation Issues**	18
Second (2nd Lowest) Quartile		**First (Lowest) Quartile**	
Shopping	16	*Substance Use*	7
Food Security	15	*Legal Issues*	6
Hygiene	13	*Submitting Formal Appeal*	6
Advice and Mentoring	13	*Volunteer Support*	4
Employment Support	11	*Telecommunications*	3
Public Transit	10	*Educational Support*	3
Submitting Applications	8	*Cultural Support*	2
		Identification	1

Table 9: Frequencies and quartiles of PSHP outputs.

Outputs in the top two quartiles accounted for 549 mentions of activities performed by the PSHP project staff for clients, or 82% of all activities. Outputs in the first quartile alone accounted for over half, or 54%, of all activities recorded in the PSHP client files. As data were not recorded pertaining to the amount of time spent on each output, and multiple output types could be attributed to a single activity recorded in a client case note, frequency of outputs does not equate with time spent on these activities by PSHP project staff. Nonetheless, a substantial number of mentions of an output relative to others does suggest a difference in importance in light of the explicit and intentional notations of these activities in the client files. In other words, the frequency of outputs may not necessarily mean more time was spent on them, but they were a focus area for a number of interactions with the clients.

3.2.2 Administrative Activities

Three output types were grouped under the heading Administrative Activities. They are summarized in Table 10 and Figure 5.

Output	Description
Processing Activities	Include referral, intake, and discharge activities, working with clinician to complete intake or discharge processes.
Clarifying Boundaries	Includes activities related to addressing worker, client, or clinician concerns or questions regarding boundaries of the peer worker role
Purchasing Supplies	Includes purchases of household supplies approved by the OT/OTA.

Table 10: Descriptions of Administrative Outputs.

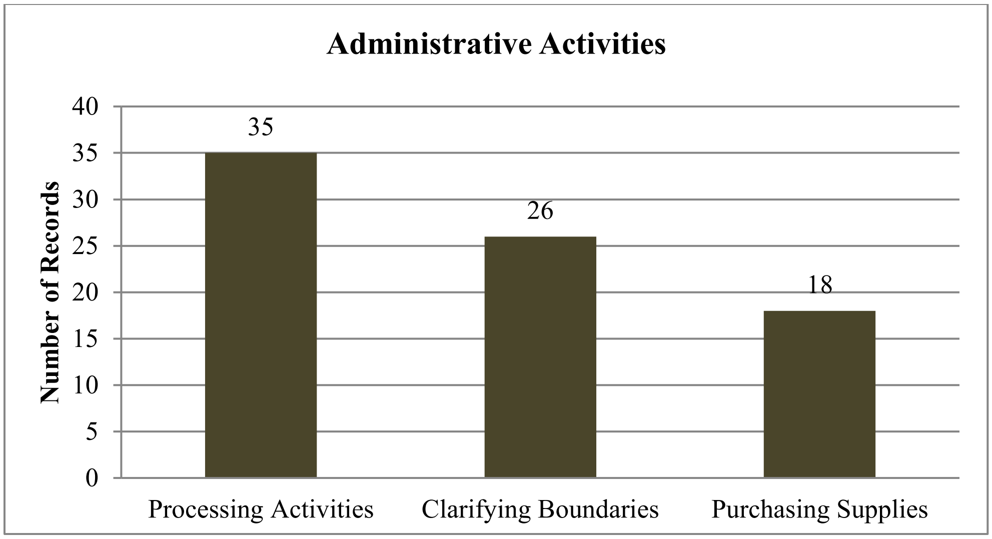

Figure 5: Frequency of Administrative Activity Outputs.

Processing Activities was in the fourth quartile among all output types. This corresponds with both the comprehensive record of clinician contacts contained within each binder and frequent contacts between the OT/OTA and therapists, among others. Outputs related to referral, intake, worker assignment, and discharge were included in this category.

Clarifying Boundaries was in the third quartile among all output types. Records include two instances where clients conveyed concerns about what they considered "breaches of confidentiality" (Peer Worker Case Note) after learning that their information was shared at the weekly peer worker meetings or with their therapists. They also include instances of peer workers explaining to clients that social recreational activities were outside of scope for the project.

> The client also expressed a desire to begin recreational activities with the staff. We informed [the client] that we could not participate within [the scope] of the program. (Peer Worker Case Note)

Other instances included incidents when peer workers withdrew due to challenging behavior on the part of a client.

> [Client] had some concerns about a breach in confidentiality. [Therapist] had discussed items that were mentioned in the previous staff meeting. We mentioned that we [all peer workers] were all part of [the client's] support team: we all need to share information to ensure [the client's] successes. (Peer Worker Case Note)

Purchasing Supplies was in the second quartile among all output types. This output includes records of purchases with or on behalf of clients, and are usually associated with Public Transit and Shopping outputs under the Instrumental Activities category. Supplies ranged from alarm clocks and lamps to mattresses and clothing. There is evidence that other government or community sources, for example AISH and St. Vincent de Paul Society respectively, were pursued prior to approving Support Expenses for household supplies, furniture, or clothing. Each client was allowed up to $150 per month for the first six months of their participation for supplies, rent supplements, bus passes, and other Support Expenses (SSA, 2007). Peer workers were provided with corporate credit cards to ease the administrative and financial burden of paying for client costs out of pocket and submitting claims; a knowledgeable informant indicated that there were no instances of abuse of this arrangement (former SSA staff, personal communication, 2015).

3.2.3 Instrumental Support Activities

Ten output types were grouped under the heading "Instrumental Support". They are summarized in Table 11 and Figure 6.

Output	Description
Food Security	Includes training modules or activities related to food preparation, grocery shopping, meals, nutrition, or accessing food banks.
Hygiene	Includes training modules or activities related to personal hygiene or grooming.
Cleaning	Includes training modules or activities related to cleaning, hoarding, and household organization.
Telecommunications	Includes activities related to set up, use, or issues with telephones or computers.
Public Transit	Includes training modules or activities related to taking public transit, including performing other activities.
Managing Tenancy	Includes training modules or activities related to landlord-tenant relationships, advocacy for tenants, housing search, or pursuing rental assistance.
Money Management	Includes training modules or activities related to personal finance, money management, or financial issues.
Legal Issues	Includes activities related to addressing or discussing legal issues of clients.
Identification	Includes obtaining government-issued identification for the client, such as a driver's license or health care card.
Shopping	Includes training modules or activities related to grocery shopping or going to stores to purchase household supplies.

Table 11: Description of Instrumental Support Outputs.

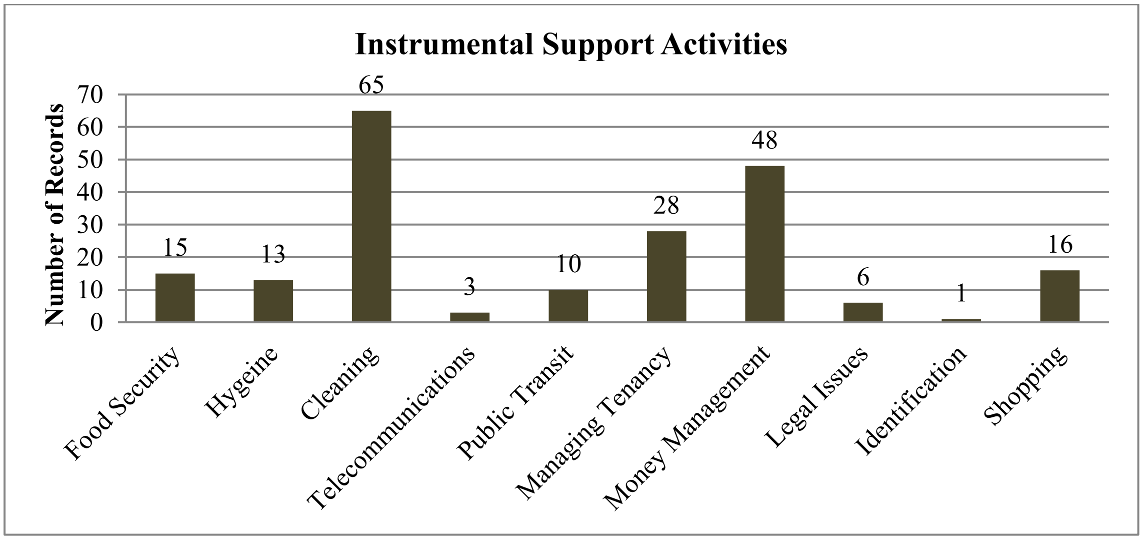

Figure 6: Frequency of Instrumental Support Outputs.

Cleaning and Money Management were both in the top quartile among all output types, and Cleaning was the most frequently recorded output across all clients. One reason for the frequencies of these outputs is that both areas were included in the Basic Skills for Independent Living that were taught and promoted as a core element of the PSHP program model. Both also appeared in Peer Support Plans for all four clients, thus there was an explicit focus on these areas on the part of the peer workers. For one client, the vast majority of PSHP services provided were related to hoarding and cleanliness issues. Thus, most of this client's contacts were marked under Cleaning. Money management was taught using a workbook designed and produced especially for the PSHP project by Edmonton Financial Literacy Society, and it contained an assortment of activities that peer workers tended to fall back to when there were no other more desirable activities during visits or outings.

Managing Tenancy was at the top of the third quartile among all output types. While there was a training module prepared to support positive landlord-tenant relations as a core focus area of the PSHP program model, this output also referred to discussions and problem-solving regarding infestation of mice in the housing of one client, negotiating repairs with the landlord of one client, and addressing non-payment of rent for another client, among others.

Shopping and Public Transit often occurred related to the same peer contacts, when peer workers would accompany clients to stores to purchase groceries (usually as part of a training module) or household supplies. The records relating to Telecommunications were associated with getting a client a phone, which was a requirement of participation in the PSHP project (so the clients could be contacted by workers and clinicians) and a cost that could be covered under Support Expenses. Hygiene was frequently recorded by peer workers in case notes because it was included in most clients' Peer Support Plans, however only records related to poor hygiene were recorded as outputs for the purposes of the study. In many instances, a comment about poor hygiene was followed by comment about the client's mental health or general wellness:

> We went over the "Personal Grooming Inventory" [in the hygiene training module], no items were being completed…[client] was feeling tired this past week, having slept too long during the day, [client] was not getting enough sleep at night. [Client] felt like

> [client] was near death from the pills, which was [causing] lack of sleep. (Peer Worker Case Note)

There was one instance where peer workers helped a client get a health care card (Identification). Instances of legal issues were mostly related to peer workers providing guidance to a client who was being threatened with a lawsuit as a result of an accident. While suggestions were provided to access legal aid to address the issue, it was unclear from the case notes whether the matter had been resolved by the time the client's participation in the PSHP project had ended. A formal arrangement between the SSA and the Edmonton Community Legal Centre for the PSHP project was intended to provide legal assistance in the cases of evictions or other issues under the Residential Tenancies Act; aside from mentioning it as an option, there was no indication that the organization was pursued as a possible avenue for resolving this client's legal issue.

3.2.4 Clinical Support Activities

Seven output types were grouped under the heading Clinical Support. They are summarized in Table 12 and Figure 7.

Output	**Description**
Supporting Therapeutic Alliance	Includes activities related to supporting a positive working relationship between the client and clinicians outside of the PSHP project.
Medication Issues	Includes activities related to discussing effectiveness or side effects of medications either with clients or their referring clinicians.
Health and Wellness	Includes activities relating to discussing or addressing physical health of clients, including nutrition, fitness, illness, or general malaise, and accessing physicians and dentists.
Symptom Issues	Includes activities relating to discussing or addressing deterioration of mental health with clients or clinicians.
Substance Use	Includes activities relating to discussing or addressing use of illicit substances or alcohol, either by the client or relating to their living situation.
Updates and Check-ins	Includes activities relating to updating clinicians or clients on PSHP activities.
Care Planning	Includes activities relating to developing, updating, or clarifying care plans with clinicians or clients.

Table 12: Description of Clinical Support Outputs.

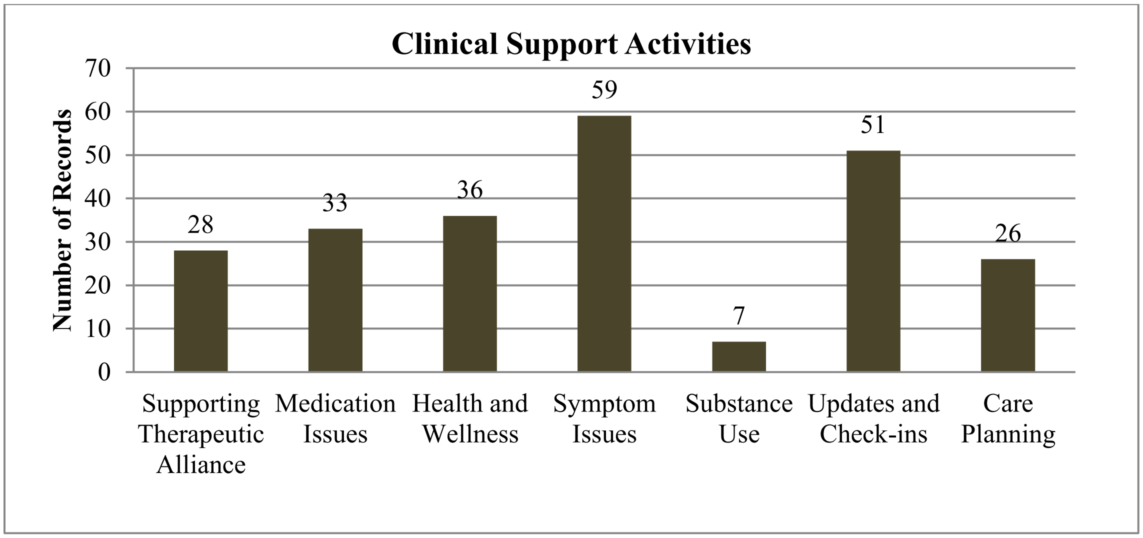

Figure 7: Frequency of Clinical Support Outputs.

Symptom Issues was the second most frequently recorded output, with Health and Wellness and Medication Issues also in the top quartile among outputs. These three outputs co-occurred with each other in multiple case notes. The following excerpts from case notes speak to the interrelationship among medications, symptoms, and side effects:

> [Client] mentioned that [client] is taking meds in the morning (2) as well as in the evening (4). Doctor authorized it. Gets up between 7 and 8 AM but must lay back down at 10 AM because feels like [client] will pass away. Mental health state remains around 5 on a scale of 1-10 but voices rarely bother [client]. (Peer Worker Case Note)
>
> [Client] was feeling tired and lacked motivation, getting up just as we got there. [Client] said meds seemed to be the reason for this. We suggested [client] talk to doctor about [previous] increase in dosage, because of the side effects. (Peer Worker Case Note)

Clients experiencing positive symptoms (e.g., voices, delusions) appeared to be comfortable talking about them with the peer workers. There did not appear to be any indication of peer workers delving into the meaning of these psychotic phenomena with the clients.

Supporting Therapeutic Alliance was a key element in the PSHP program model, although in the funding proposal the emphasis was limited in this respect to relapse prevention and responding to crises. Instances of Therapeutic Alliance in case notes were typically related to attempts by the OTA to improve the level of engagement between the client and therapist to support the work of the peer workers.

> Support workers [peer workers] said therapist does not want to go to storage bins because [therapist] does not feel [therapist] has to. I am going to call [therapist] today to go to the storage area with support workers. [Client] is changing mind when therapist not around. Peer Support [PSHP] will not pay for gas to storage bins if [client] does not give anything away. (OTA Case note)
>
> Called [therapist], talked 30 minutes, and [therapist] is going to go to the storage bins. (OTA Case Note)

Updates and Check-Ins were the third most frequently occurring output, suggesting that the PSHP project staff and clients' regular mental health clinicians were in frequent contact, especially the OTA and referring therapist. Care planning typically occurred in the early stages of clients' involvement to develop the Peer Support Plan. While most records of this output related to the work of the OT in preparation of the Peer Support Plans or the OTA working with therapists to refine existing plans, there is evidence that peer workers took an active role in discussing and choosing objectives and activities with the client.

> Met [client] at the [library] to do a planning session at 12 noon…we continued to discuss plans for the next 2-3 months regarding sessions that could be related to the [training] modules. The following is a list of items we are considering: financial literacy, weekly schedule form (% of weekly activities), grocery shopping, search for a doctor (GP) and physiotherapist, guitar lessons, exercise class, …communication skills improvement, and read books on physical training and swimming. (Peer Worker Case Note)

Substance Use was not frequently recorded in case notes, appearing in the bottom quartile among outputs. This is likely a result of exclusion criteria for referrals to the PSHP project, which did not allow service to active users of substances in the interests of the peer workers safety. In most cases this output was associated with substance use by people in the client's social network. For one client however, the OTA connected with a client's therapist after the client revealed to peer workers that the client had returned to an old addiction.

> [Therapist] called me back from message I left…Said that [therapist] will try and find out what started [client] drinking alcohol again. I told [therapist] the workers were going to encourage [client] to go to an alcohol prevention [sic] program. (OTA Case Note)

3.2.5 Social Support Activities

Five output types were grouped under the heading Social Support Activities. They are summarized in Table 13 and Figure 8.

Output	**Description**
Social Activities	Include records of time spent with clients in a social environment like a restaurant or café.
Cultural Support	Includes activities related to integration into mainstream culture or supporting clients connections with their own cultures.
Family Issues	Include supporting clients in managing relationships and resolving issues with family members.
Exploitation Issues	Include records of exploitation or victimization of clients.
Advice and Mentoring	Includes records of peer workers providing informal advice based on lived experience and shared perspectives with the clients.

Table 13: Description of Social Support Outputs.

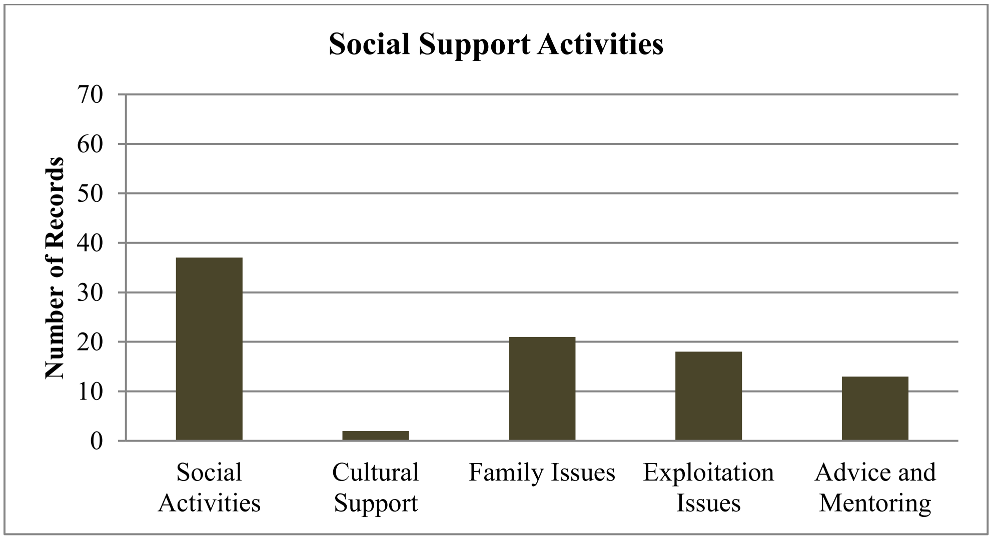

Figure 8: Frequency of Social Support Outputs.

Social Activities were in the top quartile among all outputs. While social recreational activities were technically outside of the scope of the project, expenses were covered for peer workers to go to restaurants or cafes with clients as a way of building connections and trust. Instances of Social Activities always coincided with other instrumental or clinical support activities. Peer workers appeared careful not to sacrifice the primary purposes of their engagement with clients for socializing.

> Picked [client] up at his place at 8:40 AM for a shopping trip…When we arrive at [store], [client] asks if we could stop for breakfast before we begin our shopping excursion. We talk about our strategy to complete shopping so we could be back at [client's housing] before 12 Noon. (Peer Worker Case Note)

There were only two instances of cultural support related to discussion of potential service access for a client. Family issues primarily related to supporting clients in managing their relationships with other family members. In one situation, a client was visibly distressed after talking to a family member on the phone, so peer workers provided advice to not talk to that family member if they were "emotionally abusive" (OTA Case Note). They also provided thoughts on how to approach time with family when relationships were tense by applying communication and self-regulation strategies.

> [Client] seems to describe relationship with family members as tenuous because of disappointments along with rather careless, inconsiderate moments with regard to [client's] visits which frustrates [the client]. Furthermore, [the client] appears to hold grudges which [client] does not attempt to fix with family members, causing lost time and difficult visits. We suggested tact in approaching a conflict with a statement such as "is there a problem" which neutralizes other vicious statements which [the client] might start with. (Peer Worker Case Note)

Helping clients manage family challenges was never considered as a possible role that peer workers would serve, but peer workers, with the support of the OTA, went beyond what a typical worker may have done in assisting a client through a very difficult situation.

> Pick-up the two bins, three chairs, three plates, and vegetable bins (and garbage bins) with staff vehicle. [Client] receives a phone call from [client's relative] as we are loading the vehicle at 6:45 PM. [Client's parent] has died. [Client] says they had a "love-hate" relationship which did not help their relationship. [Client] was quiet as we dropped off stuff at [client's] residence, then drove to [parent's residence]…we arrived at 7:30 PM. (Peer Worker Case Note)
>
> I told support workers [peer workers] to get [client] a card for the loss of [client's parent]. I also told them to get [clothes] for funeral. (OTA Case Note)

An informant advised the student researcher that in the tragic case of the accidental death of a client while in the PSHP project, peer workers and project staff gave photos the peer workers took of the client to his appreciative mother, in which he was well-groomed and -dressed, a substantial change from his appearance prior to participation in the project (former PSHP staff person, personal communication, 2015).

Exploitation Issues appear in the third quartile among all outputs. Two clients experienced difficulties related to homeless individuals who would come and stay in their housing for extended periods of time.

> [Client] has a homeless person living with. We will wait one week to see if homeless person is still living with [client]. If [homeless person] is, then I will call therapist next week. (OTA Case Note)
>
> [Client] still has a concern with [homeless person] coming over staying, eating [client's] food, smoking [client's] cigarettes, and asking for things to sell like tobacco and coffee. This person is stressing [client] out yet [client] still lets [homeless person] in even after months of [peer workers] telling [client] not to open the door. (Peer Worker Case Note)

When someone other than the client was in the client's home, peer workers were cautious and rescheduled visits. Visits were suspended in instances where it was clear that the unwanted visitor was using substances, which violated safety protocols for peer workers.

Advice and Mentoring fell into the second quartile, much lower than one would expect considering the importance of sharing lived experience as part of a peer-based program model. Nonetheless, there are some case notes in which the peer workers exercised diligence in recording this important aspect of service delivery. Two examples provided below are of peer workers sharing their experiential knowledge relating to managing loneliness and building communication skills.

> [Client] appears to be suffering from depression/loneliness. [client's] eyes continually welled up with tears as we discussed [the client's] uneventful week…we suggested that perhaps could focus on other things to occupy [client's] mind, enjoying [client's] time alone.
>
> Once [client's] residence looks manageable again, we stop to talk with [client] about the weekend and yesterday's activities. [Client] mentions a visit with [family member] for a half hour – leaving details aside that reveal [client's] probable limited communication skills…staff suggest to [client] that [client] turn events that happen in daily life into stories, for example, today's cleaning session. In this way when we ask about events in [client's] life, [client] can express details to the story from beginning, middle, and end, without feeling a lack of words for conversation. (Peer Worker Case Notes)

3.2.6 Service Access Activities

Three output types were grouped under the heading "Service Access Activities". They are summarized in Table 14 and Figure 10.

Output	**Description**
Submitting New applications	Includes assistance with submission of applications for housing, support, income, or other programs.
Submitting Formal Appeal	Includes letters and correspondence related to appealing policies, coverage, or decisions.
Connecting to Services	Includes activities related to referrals, linkages, or other support to connect clients with community or government services.

Table 14: Frequency of Service Access Outputs.

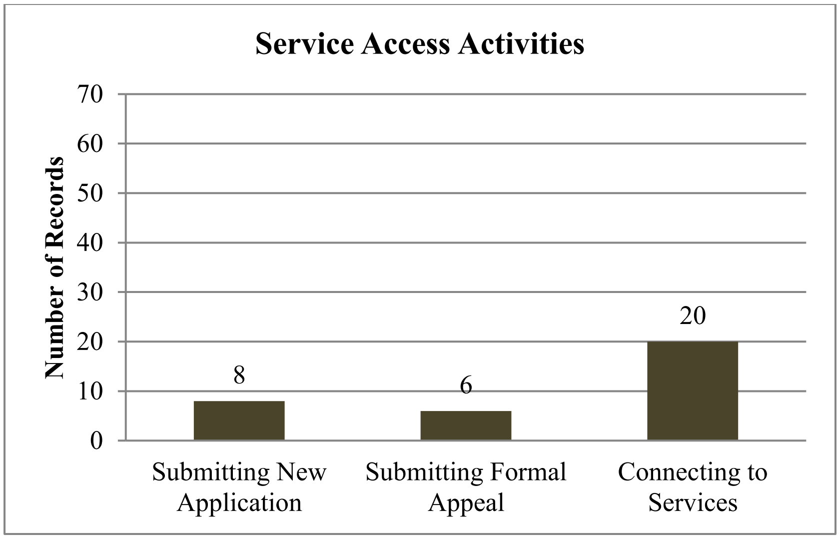

Figure 9: Frequency of Service Access Outputs.

Connecting to Services was near the bottom of the third quartile among all PSHP outputs. Food banks, income support programs, furniture banks, employment and education support providers, non-profit housing providers, and rent supplement programs were examples of connections made for clients by the peer workers. In some cases, these connections required a formal application. These were recorded under the Submitting New Application output. For two clients, applications were submitted by the OTA or a peer worker for subsidized housing provided by non-profit organizations. Similar to assisting with applications, the Submitting Formal Appeal output was related to securing program access on behalf of clients. For one client, a new medication was prescribed by a psychiatrist, but it was not covered under the AISH program. Peer workers worked with the OTA and the client's therapist to submit a letter (written by one of the client's peer workers) to AISH to appeal for coverage.

3.2.7 Social Inclusion Activities

Three output types were grouped under the heading Social Inclusion Activities. They are summarized in Table 15 and Figure 10.

Output	**Description**
Employment Support	Includes activities or discussions related to securing employment or employment support.
Volunteer Support	Includes activities related to connecting clients with volunteer opportunities.
Educational Support	Includes activities or discussions related to connecting clients to education or training programs.

Table 15: Description of Social Inclusion Outputs.

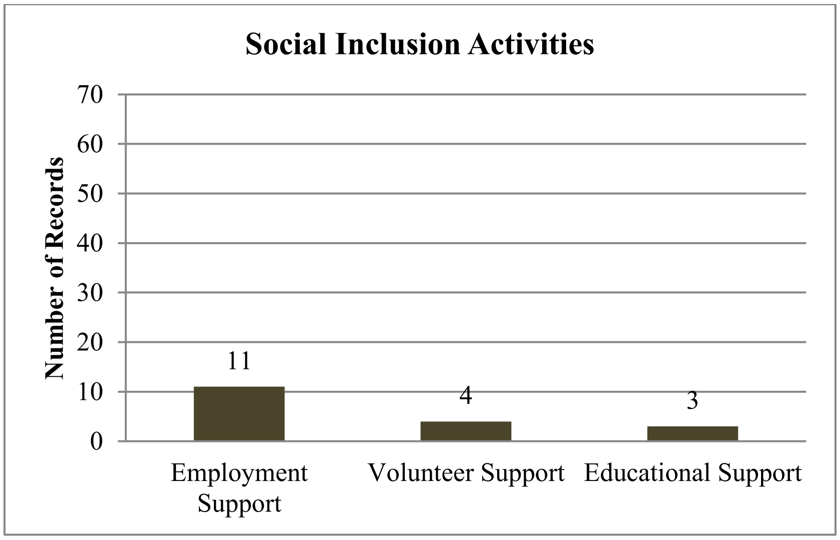

Figure 10: Frequency of Social Inclusion Outputs.

All three Social Inclusion outputs (Employment Support, Volunteer Support, and Educational Support) were in the bottom quartile among all outputs. Only two out of the four clients had efforts in these areas. While Peer Support Plans did not contain any objectives related to these outputs, clients themselves brought them up during visits with their peer workers. Peer workers would consequently follow-up with advice on selecting options and providing connections to resources in the community.

> We looked through some NAIT calendars. [Client] decided that [client] was interested in going back to school and becoming a fitness trainer. [Client] looked at the calendar and what was required. [Client] would have to go back and upgrade high school. [Client] found out this was the case for a lot of the programs that [client] was interested in. [Client] decided upgrading would be a good idea before going into a [post] secondary educations (sic). We decided that we'd look into these institutions more next time. (Peer Worker Case Note)
>
> [Client] does want a volunteer position, perhaps at the mall. We will get in contact with [coordinator] at On-Site Placement with a possible lead-in. However, a [contact at agency] claims [client] must be in good physical and mental health. (Peer Worker Case Note)
>
> We mentioned again [local restaurant] was hiring a dishwasher and [client] could negotiate hours and wages. [Client] was not interested. (Peer Worker Case Note)

There is no record in the client binders of clients actually pursuing any educational, volunteering, or employment opportunities that they discussed with their peer workers.

3.2.8 Peer and Clinician Contacts

Contacts made with or on behalf of clients indicated the level of intensity of the intervention and provided information on clinician engagement as a central component of the program model. Contacts were therefore divided into two main categories, client contacts, which included face-to-face contacts between clients and the peer workers ("peer contacts") and between clients and others (e.g. OTA, Coordinators, etc.; not necessarily face-to-face), and clinician contacts, which included both contacts (e.g. the OTA was able to talk to the therapist on the phone) and attempted contacts (e.g. the OTA left a message for the therapist to call back). The distribution of client and clinician contacts for each client is presented in Figure 11. Because the evaluation was limited to what was available in the client binders, email contacts were not included. However, there was no mention of email contacts in the case notes, whereas the OTA appeared diligent in indicating when a voicemail message had been left. This may suggest that email was not a frequently used method of communication with clinicians, but this could not be verified by the data collected in this study.

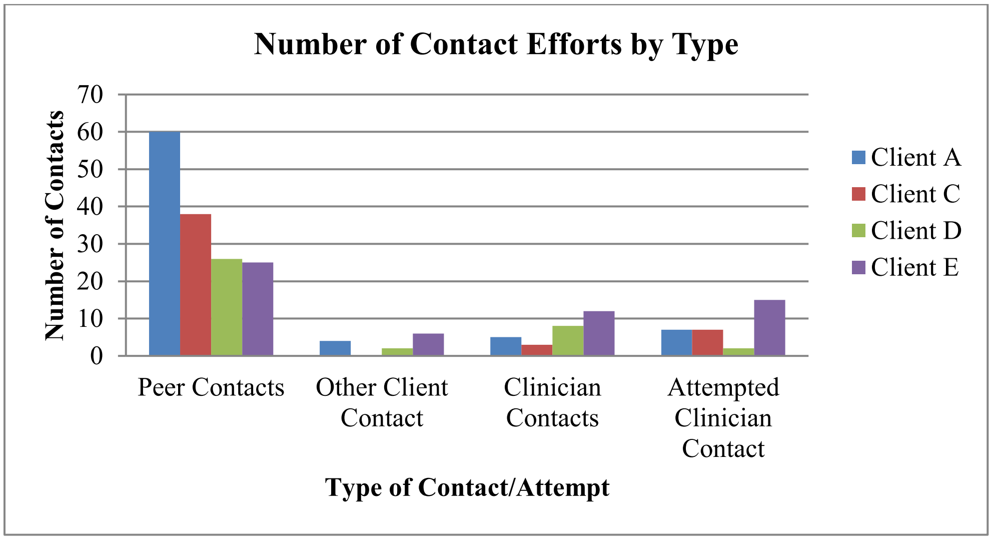

Figure 11: Number of contact efforts by type.

The number of contact efforts by type varied between each client. In terms of total number of peer contacts, one client received close to twice the number of any other client. Peer contacts were also averaged over the number of months that clients were involved with the PSHP project in order to compare the relative intensity of the intervention among clients. The time period used to determine this average accounts for intake and discharge processes in which visits would not occur, using the first peer worker visit as the starting point and the last visit as the end point for calculation. The average number of peer contacts for each client is presented in Figure 12.

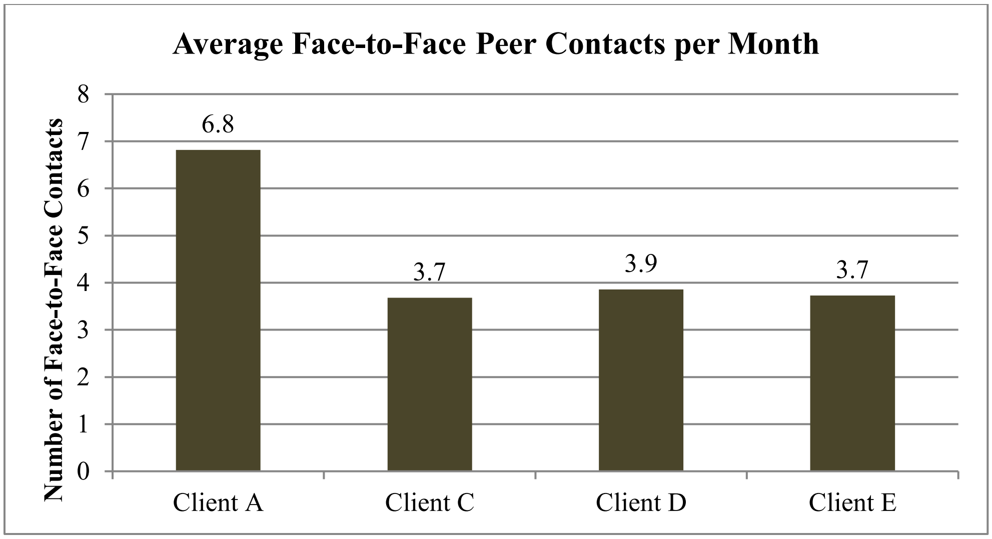

Figure 12: Average face-to-face peer contacts per month by client.

All but the same one client received a similar number of face-to-face peer contacts, averaging between three and four visits per month. The one client with exceptionally more peer contacts received almost seven peer contacts per month on average. Case notes suggested that there was an intentional ramping up of visits at the request of the client.

There were substantially more clinician contacts (including attempted ones) for one client than for other clients. When comparing attempted clinician contacts to completed contacts, only one client had more completed contacts than attempted ones. Across all clients, the ratio of attempted to completed clinician contacts was fairly even, although there were more attempted contacts than completed ones. Review of case notes suggested a number of reasons for missed connections between the OTA and the clients' therapists, but the perseverance of the OTA was not one of them. For all but one client, therapists changed or their phone numbers changed. There was no record in the client files of having received notification of these changes, and it would appear that the OTA found out about these changes through voicemail greetings or after calling a central number for community mental health services. In one poignant example, the

OTA tried for three weeks to reach a client's therapist because the client's needs and behaviours were becoming increasingly challenging and evidently outside of the scope or capacity of the PSHP project and the expectations of the peer worker role.

> Called [referring therapist] about [client's living conditions] and therapy. [Referring therapist's] mailbox was full. I called [referring therapist's] pager and gave callback number. (OTA Case Note)
>
> Called [referring therapist], mailbox was full. Called Edmonton Mental Health, they gave me a new number to call. I called and left a message for someone to call me back about client….I have called many times for now about three weeks. I will try again later. (OTA Case Note, four days later)
>
> I called [other therapist] who is now the therapist, back from maternity leave. [Referring therapist] is no longer handling [client]…[other therapist] will be contacting [client] within next week. [Other therapist's] first day was today. (OTA Case Note, same day as last case note)

Inexplicably, two months later, the therapist had switched back to the referring therapist. In another client's case, there was confusion regarding who was the active therapist for a client because the referral came from an OT with AHS. Initial care planning was conducted with this individual, but eventually it was clarified that the client's therapist had not been engaged. The first contact between the OTA and the client's therapist occurred six months after intake into the PSHP project. Regarding contact between the OT with the PSHP project and clients' therapists, there was only one instance where this was recorded, when the OT contacted a client's therapist regarding the client's claim that their confidentiality had been breached by sharing information at a team meeting.

3.3 Case Examples

In this section, examples of the types of activities performed by PSHP project staff are presented for each client with substantial participation in the PSHP project (4 of 5 client participants). Each case example highlights a key focus area for a client, with a narrative of the client's issues and consequent PSHP staff activities derived from the case notes. The case examples serve to show the diversity in approaches and types of services delivered for clients in the PSHP project. Additionally, the case examples offer a more cohesive picture of what service delivery looked like for each client, in order to supplement the presentation of disassembled service outputs across clients in the previous section.

3.3.1 Case Example: Social Support and Relationship Boundaries

For one of the clients, it was apparent from the case notes that the primary perceived benefit was the social support received from the peer workers. According to the case notes, the client was eager to go places with the peer workers, and on one occasion, invited them to a life skills group graduation party and introduced them "as his friends" (Peer Worker Case Note). Several times, the peer workers had to remind the client of the boundaries of their role as peer workers, re-orienting focus to instrumental tasks and support from the client's wish for social and recreational activities. The peer workers at one point considered visiting with the client five times per week because the client wanted to see them more often and there were not many other clients in the PSHP project at that time. The decision in the end was to visit approximately three times per week, although it appeared that visits afterward were less frequent than that.

The peer workers provided support for the client when the client's mother passed away, including driving the client to the mother's house. Case notes indicated that the peer workers may have also been engaging the client through the SSA's ESCAPE program, which matched people living with mental illness and provided money so they could participate in social and recreational activities together. The case notes suggested that a boundary was placed between

ESCAPE’s social focus and the PSHP project’s instrumental focus, and that the peer workers were aware of the need to maintain this distinction.

3.3.2 Case Example: Clinician-Peer Partnership

One client was referred to the PSHP project due to an impending move from a family member’s home to an apartment. There was a period of time that this client needed to use an emergency shelter while the apartment became available. The peer workers worked closely with the therapist to identify and address key needs during the client’s transition into an apartment, connecting the client to a furniture bank to acquire furniture, a television and DVD player, curtains, among other items. During peer visits, the client expressed feelings of loneliness that were attributed to the client’s lack of money. Although the client’s brief synopsis indicated that the client may have lived independently previously, at one point the peer workers discovered that the client had not been paying the client’s portion of the rent. The arrears had been accumulating over a period of several months, amounting to nearly $650. The peer workers advised the therapist about the Homelessness and Eviction Prevention Fund available at the time and asked that an application be made on the client’s behalf. The initial response was that the client would not become eligible until an eviction notice had been received. The peer workers continued to follow up with the therapist until the application had finally been made.

In the meantime, the peer workers drafted a letter for the client to submit to AISH to have the rental arrears covered, and to have the AISH amount increased to cover all of the rent. AISH approved the arrears coverage request, an “unusual” success as the peer workers commiserated with the therapist in one case note. The peer workers submitted an application to CRHC for the client to receive a rent supplement, as the client had to go to the food bank because the client’s income was insufficient to cover all basic necessities. Towards the end of the client's engagement with the PSHP project, the OT submitted an urgent request to CRHC on behalf of the client to approve the rent supplement because the client's finances were not sufficient to cover rent and other necessities. Although the client's engagement with the PSHP project ended before word was received regarding this request, the client included a housing subsidy in the list of income sources (Demographic Questionnaire) when interviewed by the student investigator.

3.3.3 Case Example: Advocacy

One client was very high functioning, able to manage all instrumental activities of living without any significant issues. The client had regular contact with family members and was actively engaged in attempts to eat healthy, exercise, and quit smoking. The client however required assistance in appealing to AISH for dental work that was required. The peer workers drafted a letter for the client and submitted it to AISH. AISH initially denied the claim, but then approved it after the peer workers submitted an appeal on the client's behalf. In another instance, the client was being transitioned from two antipsychotics to one new antipsychotic that had recently come onto the Canadian market. Unfortunately, the psychiatrist had made this decision despite the fact that the medication was not covered under AISH. The peer workers drafted a letter on the client's behalf requesting that the medication should be covered. The final case note for the client indicates that at the time of writing the medication was still not covered.

After a period of time, the peer workers began noting that a homeless man was staying with the client and using substances in the apartment. The client claimed that the "visitor" regularly exploited the client, staying for extended periods of time in the client's apartment and bullying the client to sell items for purchase of drugs. The client felt intimidated by the individual and was at a loss for how to address it. Eventually the client's sister and brother-in-law forced the individual out. The peer workers provided advice to the client on how to keep the individual from coming back, and even suggested enlisting the help of another PSHP client who lived in the building to get the client to stop the harassment. The individual stopped coming to the client's apartment for the rest of the client's engagement in the project. Based on the case notes, it does not appear that the peer workers had any direct interactions with the individual, but regularly reported to the OTA on the situation, who then conveyed the information in voicemail messages left with the client's therapist.

3.3.4 Case Example: Hoarding

One client was referred to the PSHP project because of issues regarding the cleanliness of the apartment in which s/he was staying. The client received the peer workers warmly and appeared eager to address the challenges that were threatening the client's housing stability. After several cancellations, the peer workers finally were able to visit the client at home. The seriousness of the situation became apparent: the client's living quarters were full of papers, cat food tins, and other materials. The client also indicated that there was a storage locker that was similarly full. The peer workers diligently supported the client in cleaning out as much garbage as they could, helping to clean and sort through it all. The peer workers purchased a book on hoarding and started their visits going through the book with the client, followed by sorting and disposing of materials. There were times when the peer workers were making multiple visits per week.

After a period of time, the client would get agitated whenever the topic of cleaning or getting rid of items came up, sometimes escalating to yelling. Moreover, the peer workers would return to the client's housing to find that space that had been cleared out had been filled with items that had been brought there from the client's storage locker in between visits. In addition, the client had placed a porta-potty in the living quarters because the washroom in the client's basement suite was not working. There were holes in the floor and the housing appeared to need other major repairs. The client lived with the landlord, and the two were connected through their church. The landlord was a senior who could not afford to make improvements to the housing. The OTA worked with the peer workers and the client's therapist to try to continue the progress that was being made. Towards the end of the engagement, the therapist met with the client and the peer workers at the client's home in the hopes of continuing this progress. Though the therapist was eager for the continued instrumental support provided by the peer workers, the client's behavior became very challenging and managing it was exceeding the scope of the PSHP project. It is important to note that the peer workers continued to work with the client despite occasional aggressive outbursts, and engagement finally ceased based on a decision by the OT and OTA.

3.4 Perspectives on the PSHP Project and Program Model

All clients remembered receiving services from the PSHP project. One client, who refused services soon after they started, recalled the experience of meeting the peer workers for the first time.

> One introduced himself, [gave] his name, says "Hi, I'm schizophrenic", [another] says "I'm bipolar", the other one was suffering from depression… "if you want to go for a walk, we'll go for a walk with you", and I was thinking, that sounds pretty strange to me. I don't know [what it would look like], the group of us walking down the street…(Client B)

The client acknowledged that the peer workers visited "once or twice" and that the client "kind of agreed to it", but in the end it turned out to not be something the client was interested in pursuing (Client B). For other clients who maintained engagement with the project for an extended period of time, there was good recollection of the modules used by the peer workers to train clients on household maintenance, grocery shopping, hygiene, among other areas.

> We did basically what we're doing now, talking about your life skills. We went through these booklets and I answered questions. They analyzed my household, how well I was keeping it clean in my apartment, how well I was looking after myself…whether I got a haircut, whether I shaved, whether I'm taking care of myself…went through the things and plus we talked like you and I are doing now, and went through a lot of good discussions. (Client D)

For the most part, clients recalled their experiences with the PSHP project as being beneficial in some way. For one client, the "good discussions" were a key aspect of the project that the client appreciated and regarded positively. This was echoed by another client, who appreciated the opportunity to talk to others about what the client was feeling and experiencing in life. In one client's case, however, there was a feeling that the relentless focus on instrumental activities and the use of the training modules was patronizing and did not account for the client's relatively high level of functioning and intelligence.

> It was just somebody to talk to [was] all I needed to do, and we went through all these courses and all these studies and…[it was] like I was back in school, going through all this stuff to assess my mental capabilities, when [it] was just a normal thing. For me, it was just minor, minor issues. (Client D)

For two clients, the excursions were the most memorable part of their interactions with the peer workers. One client remarked that "it was good to go get coffee somewhere" and that the PSHP project helped the client to learn and have fun (Client C). Another client enjoyed the public transit and shopping components of the project, especially the added benefit that came with the project budget for client costs.

> It was fun. It was cool getting on the bus and going to Walmart or going downtown and looking around…The people [made it fun]. And it was nice then to receive something that you didn't pay for. That's what they would spend some of the money on, like they'd have restaurant money. (Client A)

For another client, the biggest impact of involvement in the project was a confirmation that there were people out there who cared about the client and wanted to help: "I discovered there were some people volunteering and…there are actually some people there that care about me" (Client D). The client's comment regarding "volunteering" may suggest that there was not an awareness that the peer workers were being paid to provide the service. Nonetheless, this client did not consider the peer workers as individuals who had any special expertise that gave credibility to provide this kind of support to the client, and that the client in fact had more to offer the peer workers.

> And I think I got through to them as much as they got through to me, more so than the help they gave me, because they didn't understand their illnesses as much as I do. (Client D)

Despite the client's expressed preference for credentialed professional services over the experiential knowledge offered by peers, when asked whether there would be any value in having peers working to support others living with severe mental illness, the client quickly replied, "yes I think it would, anybody - even if they don't know anything" (Client D). The positive impact of the project was expressed by another client. When asked to clarify in what ways the project's positive effects manifested, the client responded that the PSHP project helped with "getting connected", "finding new branches", and "trying out different things"; "I was more independent after that" (Client A).

The pilot project's fairly sudden end left bittersweet memories for two of the clients. In one client's case, it was arguably the latent effects of the PSHP project – namely the social connection – that contributed the most to the client's overall experience of it and lasted beyond the client's formal involvement, albeit for a limited time.

> Well we all became friends after. The three of us. We'd hang out a little bit. But we all went our separate ways quite a while ago. I don't keep in touch with them. (Client A)

For another client, the end of the PSHP had a more practical effect on meeting the client's goals in the area of food preparation: "If I had went the week before, we would have went to Walmart and I would have had a microwave" (Client D). Thus, the loss of the project meant not only the loss of peer interactions, but also the financial assistance for purchasing needed household supplies available through participation.

Chapter 4: Results – Factors Contributing to Recovery and Independent Living

In this chapter, results are presented from the analysis of qualitative data from client and therapist interviews to address Research Question 2: *How do the expected outcomes in the PSHP project program model relate to each other, and what other factors not included in the original design contribute to recovery and independent living for people with mental illness?* The chapter begins in section 4.1 by integrating the concepts of independent living, skills and support, recovery, and social engagement – the main outcomes in the PSHP program model – based on analysis of the perspectives of therapist and client participants. In section 4.2, the constellation of factors relating to recovery and independent living that emerged from qualitative analysis are presented with reference to relevant participant interview data. Quotes reference participant data using a three-letter code: the first letter is either a T or a C for therapist or client participant, respectively, followed by a two letter abbreviation of their chosen aliases (e.g. T-DU, C-LW).

4.1 Interrelationships among PSHP Project Program Model Outcomes

The simplified version of the PSHP project program logic model presented as Figure 1 in Section 1.3 is adapted in Figure 13 below, presenting only the intended outcomes and their expected interrelationships.

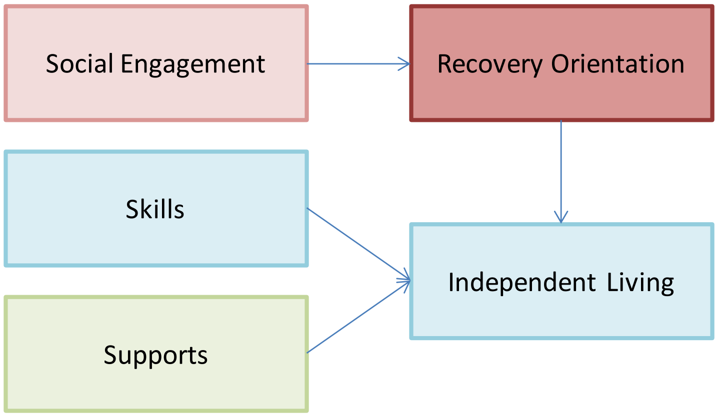

Figure 13: Positioning of outcomes in original PSHP project program model.

The integrity of the logic model was tested by the data collected in this study. At a very fundamental level, independent living, recovery, social engagement, and skills and supports appeared to be linked with each other, as evidenced by the perspectives of participants, particularly the therapists. This was highlighted by one therapist who recounted the success of a client who had made significant strides towards independence and recovery.

> Is there a relationship between independent living and recovery? I would think so. I think it all blends together, the stronger you are in being well and determining what you're doing. I've moved someone along from being in a group home into independent living over a three year period, and what she needed a couple of years ago and what she's doing now, is just [amazing]. She's now got a part time job. She attends a group, she's joined the local church. Three years ago, I would not have even believed [it]. So what's happening here? She's connecting out there, and less and less on us…She's just really feeling great about what she's doing out there now. The more independent she got, I think the stronger she grew. And from that group home to finding out she can manage, and she could take care of herself in an apartment. (T-CA)

In this example, four of the program model outcomes explored in this study were described as playing a part in this particular client's progress. Rather than being portrayed as a unidirectional process, the therapist appeared to reference key conceptual elements of recovery, evidenced by "being well and determining what you're doing" as well as "connecting out there", as being both a foundational contributor to independent living while also being facilitated by it. This was reiterated by another therapist, who went further in describing how recovery and independent living contributed to each other, but suggested that the former had to occur first for that cycle to begin.

> I don't know if you can say living independently can promote recovery, or the other way around. If you are in recovery, you're more willing or more able to live independently, and you want to be independent. But if you live independently, that may be able to keep you in recovery, but not [start it]. I think recovery is more important – it comes first, then independent living. (T-MA)

Even for those individuals who have strong independent living skills, an orientation towards recovery was considered a requirement to ensure one's needs could be managed and met on one’s own or with the support of others. From one therapist’s perspective, this was a key factor in housing stability, or more specifically, housing instability for mental health clients, even if they had strong independent living skills (T-PE). In other words, having skills or supports was not enough to promote independent living without having an orientation towards recovery. From another therapist’s perspective, having skills or supports was still deemed to be a key factor in independent living: half of that therapist’s caseload could live independently and maintain housing stability with minimal assistance, and a further 25% could maintain themselves in the community if they were in a supportive or family housing situation in which regular assistance was provided (T-DU). This further speaks to the dyad of skills and support necessary to promote independent living and recovery. This conceptualization of independence does not preclude the role of others in both social and functional capacities, which requires a departure from Western paradigms “because in this society we really emphasize independence and individuality, which is really counter to people being connected” (T-CO).

Social connectedness was described by one therapist as a key component of living independently, but it had its own requisite inputs, particularly for individuals who were isolated or otherwise socially deficient. To that end, social engagement was perceived to be an outcome of having the skills and know-how to develop and sustain supportive relationships.

> With this particular population it’s social connections…we all need to have the skills to have some kind of meaningful connections. You need to have the skills to initiate and sustain those, and also, to be able to figure out how are you going to make healthy connections…and meaningful relationships? (T-CO)

In essence, a person’s ability to live independently or have housing security was as much a product of their level of disability as it was dependent on the presence of strong social supports, especially when they served functional purposes.

> And also I think that what helps a person be able to live independently is to have a social network, [for example] a family that can assist them if they run into some sort of trouble, really just a support system and inner resources to manage... (T-GA)

In the end, the PSHP project outcomes examined appeared to have mutually sustaining relationships:

- Social engagement, skills, and supports contributed to independent living;
- Skills and supports were influenced by a person’s social network;
- Recovery orientation was nurtured by social connectedness and independent living;
- Social connections were promoted by having the skills and supports to initiate and maintain them; and
- Moving towards greater independence, including being able to make use of existing skills and supports, required some degree of recovery orientation.

Thus, it would appear from the perspectives of study participants that the PSHP project’s program model had some merit in its characterization of recovery orientation as “sustaining” independent living, however it did not identify a reciprocal relationship between the two outcomes. Additionally, it placed social engagement appropriately as a determinant of recovery orientation, but did not consider it as a contributor to independent living. In contrast to the findings, skills and supports in the program model were conceptualized as independent from rather than supplementing each other, and there was no connection between these constructs and social engagement. The relationships among these outcomes, as repositioned based on the results of participant data analysis, are illustrated in Figure 14.

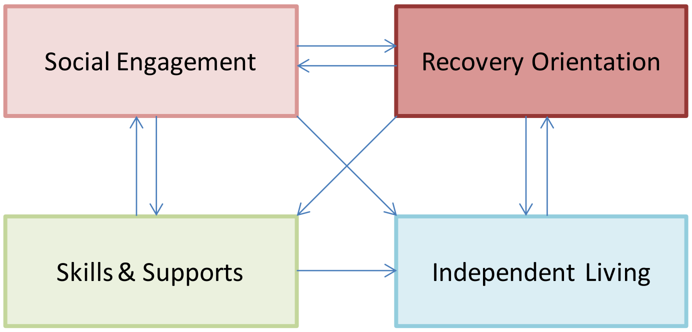

Figure 14: Repositioning of interrelationships among PSHP project intended outcomes

4.2 Factors Contributing to Independent Living and Recovery

As discussed above, independent living and recovery were perceived by participants to be interrelated facets of the same desired outcome for clients, with numerous factors contributing in some way to their achievement. There was significant complexity in organizing the factors because of the interrelationships among them and to other constructs that emerged from the analysis of participant perspectives. Nonetheless, they are presented in sections 4.2.1 to 4.2.3 according to the following groupings:

- Client characteristics and conditions that require special consideration in designing intervention and supports for recovery and independent living,
- What and how services are provided and the impact they have on achieving these client outcomes, and
- The social and environmental contexts of clients that play a role in facilitating or constraining their achievement of outcomes.

4.2.1 Client Characteristics and Conditions

In this section, factors related to how clients' personal capacities, backgrounds, and health conditions impact recovery or disability orientation are presented. These include cognition, personality, upbringing, history, functioning, symptomology, substance use, physical wellness, outlook, and self-esteem.

4.2.1.1 Cognition

Cognition refers to a person's ability to be "able to comprehend the information that they're receiving, to be able to rationalize it, and make informed decisions" (T-CA). Sometimes, therapists struggle to determine whether cognitive capacity is a product of illness severity or some other underlying impairment.

> You have to look at their cognitive ability and then the severity of their illness. Two different things going on. I have a client who cognitively is pretty limited and she's attached to a lot of misinterpretation of information and everything, and it's hard to tell which is the cause, the illness or her limited cognitive [capacity]. (T-CA)

In some ways, a person's intelligence is something that does not change over time (T-DU) and acts as a key strength for overcoming other challenges (T-GA). While some therapists regarded cognitive capacity as something entirely separate from intelligence, the level of cognitive impairment resulting from brain injury or other acquired or developmental deficiency can be a constraint on recovery. In the words of one therapist, "I would just say what does really limit people…would be damage – neurological damage…" (T-CO). Cognitive capacity can have a significant impact on a person's ability to navigate systems that are complicated and difficult to manage even for people without impairment. Moreover, it can also leave people vulnerable, unable to defend themselves against predators who seek to exploit them.

> They're taken advantage of easily, because either they're cognitively impaired, or they're intellectually impaired, and so they are taken advantage of in so many ways, it's ridiculous, by suspect landlords, neighbours claiming to want to help out, and they're taking their money. I've heard about that a hundred times, my clients are just being ripped off left, right and center. (T-GA)

From another therapist's perspective, a person's level of intelligence is a major factor in determining their capacity to live independently, going so far as to suggest that decision-making on the type of living situation required should be based on an intelligence test (T-JO). Thus, from therapists' perspectives, intelligence or cognitive capacity can be a major determinant regarding recovery orientation or independence for a person living with mental illness.

4.2.1.2 Personality

Personality was another factor that emerged from qualitative analysis as a factor contributing recovery or disability and independent living. In reference to independent living skills like cleaning and hygiene, there was debate among therapists regarding the extent to which performance in these areas could be attributed to learning of skills or personality types. Put simply, some people may have a propensity to be clean and organized, while others are less concerned with these qualities. Further, social orientation has an impact on how clients interact with their peers and clinician alike: those who are described as pleasant and easy-going tend to have better relationships as opposed to those who exhibit more challenging anti-social behaviours. Personality also impacts a person's outlook on life, how they view interactions with the health system and other dependencies, and also how they regard themselves vis-à-vis the general public, particularly in terms of perceived impact of stigma.

> Unfortunately I think the self-esteem [is affected] out there, and we know it's the stigma and the shyness and everything. For them to just go do it independently, it just doesn't seem to happen. Or they have a failure, they come back, they'll never go again. (T-CA)

From a negative side, personality can also tread into the clinical domain, for example with diagnoses of personality disorders. As one therapist noted, someone with "severe personality issues…is very different from someone who has got psychotic symptoms all the time" (T-CO) in terms of their ability to benefit from recovery-oriented supports and therapy.

4.2.1.3 Upbringing

Clients' childhood experiences were identified by participants as a key factor in determining a person's capacity for independent living and relative orientation towards recovery or disability. How those experiences formed due to interactions with parents and other family members can have a significant impact on the trajectory of a person, particularly if they are dealing with a disabling mental illness. Adverse childhood experiences and trauma can affect how a person develops early in life and their capacities later on in adulthood. For example, two clients reported having difficult childhoods marred by alcoholic and abusive parents. One of these clients spoke of the silver lining to this experience and the state of poverty in which the client's family was thrust, in that it facilitated a strong connection with the client's mother and in turn the lessons for maintaining a household with few resources.

> Basically from a very young age, we grew up living in poverty on a farm. Before I went to school, and after I went to school, I used to help mom make meals and cook… I learned how to cook when I was a child, and I used to help with the meals…[Dad] would make her go out and help in the fields too and do the farming, plus she had to look after six kids, make all the meals, and do all the laundry. I felt sorry for my mom, I was always mad at dad because he wouldn't let mom [be], leave mom alone to do mom's work. She had to help him do his too. (C-LW)

These experiences necessarily interfere with a person's ability to relate to others, to have normal interactions with society in general, and could potentially lie at the center of persistent affective symptomology.

> Well I've had [depression] since I was a child, because I was born in a dysfunctional family and so I was a depressed child, and I just stayed depressed. So I don't know when recovery ever took place. (C-CM)

On the other hand, growing up in stable family appears to have a long-term impact on a person's ability to live independently. Learning key lessons in the family home, including cleaning, cooking, and money management, can carry a person when mental illness or other disabling conditions create barriers to independence. From one client's perspective, time spent with the client's mother assisting with cooking and cleaning was instrumental in that client's ability to sustain daily activities of independent living despite active psychotic symptoms. When asked about the best way for people to learn skills for independence, one therapist responded that it was to "have a really good mother" (T-SA). Therapists suggested that learning skills in the family home was a key predictor of capacity for independent living.

> Well I think we were all brought up [by our] family. If you're from a stable family, you probably learned it from your parents or from the people you [were] living with growing up. (T-MA)

Therapists were unanimous in identifying money management skills as a major factor in determining a client's risk of losing their housing. With so little wiggle room when living on a fixed income, money management skills and personal finance principles and values derived from lessons learned in the family home are even more foundational in terms of ensuring community tenure and housing stability. One client stressed the learning of the "value of money" (C-LW) as a critical factor in that client's ability to live on meager income. Budgeting and financial discipline to pay for rent, food, and other necessities before spending on non-necessities or treats like alcohol or drugs were the secret to this client's success.

> You pay your rent, you buy food, clothing and shelter, is my motto, and then if there's any money left over, I'll buy a [piece] of marijuana or maybe a bottle of wine, once in a while. (C-LW)

4.2.1.4 History

For some respondents moving towards recovery from mental illness, the past is a powerful constraint on their ability to relate to others and normalize their place in society.

> It's just my experiences in life have depressed me, terrible things I've done in my life [have] made me loath myself and made me draw away from other people, fearing that they'll find out what I was. It makes me draw away and not get close. (C-CM)

This is especially the case for those who committed crimes or otherwise had negative experiences that foment ongoing guilt and shame. This can be magnified by depression, leaving the person in a constant state of isolation and self-alienation. In one client's case, it was fear that others would find out about a dark past that prevented social engagement, including activities that the client considered paths to quality of life like attending church or making new friends.

> I'm so shy and timid that [though] I want to go to a church, I just don't…you don't bring up your past because people are people and maybe some of them can't be trusted to not be offended by your past, the things you have done. (C-CM)

At a more tangible level, a history of eviction due to actions committed while in a state of untreated mental illness can have direct impacts on people's ability to live independently or access resources, including housing.

> … in this market it's hard to find a place. The vacancies are low…Nobody will give it to you if you have bad references, or you've been evicted from other places. No one will take a chance to let you move in if you are being evicted over there, you've been sued for so much money for damages and then paying it. (T-MA)

4.2.1.5 Functioning

The extent to which a person is considered 'high' or 'low' functioning is closely tied to their ability to perform instrumental activities of daily living. These include the ability to manage money, maintain and regularly clean their home, take care of their hygiene, secure transportation, and other routine tasks. From the perspective of one client, it was the ability to perform these instrumental tasks that indicated the ability to live independently.

> So I can cook a meal…I used to spend about $200 on pay day and I'd buy 30 pieces of meat for each meal…I've been managing myself living on my own, and I take care of my budget, I can look after my finances, and I make sure there's money… I make sure I have my coffee…my milk for my cereal and my coffee, and what I need to survive for groceries, and I clean my house on a regular basis. I take care of myself physically and emotionally, and as well as I can…I can live independently, I can go where I want to, when I want to… (C-LW)

In many ways, a person's functioning is dependent on their diagnosis and related symptomology, essentially determining whether they would be considered disabled by their illness. Further, symptoms can cause impaired thinking that leads to neglect of personal hygiene and illness management.

> You can have the skills, you can have the knowledge, but you've got to have the energy…there's still the perception too that a lot of people with some kinds of psychiatric illness are lazy. [But] you've got negative symptoms; you've got amotivation. (T-CO)

Level of functioning corresponds with being able to live independently and, in particular, maintain housing stability. In terms of housing, being able to fulfill the tasks of daily living was considered a requirement to be able to live in some affordable housing facilities. The connection between being able to function in daily life and recovery or disability orientation can weigh heavily on the aspirations of people living with severe mental illness, a fact that was not lost on one therapist.

> Unfortunately, sometimes it's a sad reality that they will never be able to and it hurts them. I think that they, somehow in the back of their mind, know that that's never going to happen, but they want it. (T-GA)

This viewpoint was reflected in the opinion of one client that being able to live independently provides a foundation for recovery "because [they] have the self confidence that they could look after themselves and take care of their own needs…[and] to be able to go out on their own" (C-CM).

4.2.1.6 Symptomology

Symptomology, or the course of a person's mental illness itself, impacts a person's recovery orientation. For some, having symptoms under control, or to be "well", was an important prerequisite for a level of functioning needed to live independently: "You have to be well enough to live independently and recognize what you need in terms of all the things of healthy living" (T-PE). As another therapist put it, "the diagnosis is largely equal to the level of recovery… it depends on the diagnosis what your future is going to look like." (T-GA). As with level of functioning, active symptoms can impact a person's ability to live in housing facilities, even those geared towards people living with mental illness.

> It's just being able to look after yourself, I mean [being] physically and mentally stable. If you aren't stable, if you're really mentally sick here, they'll want you to get help…Well, one guy was evicted from here because he was sick and he wasn't taking his medication, and he was disturbing other tenants, and so they evicted him. (C-CM)

Nagging positive or negative symptoms for people living with schizophrenia make it more difficult to imagine a life that is not dominated by these symptoms, as recounted by one client speaking about a former acquaintance with severe schizophrenia.

> …the voices would never leave her…Even with all the medication, she would still get sick…all she would tell me was how tormented she was by these voices in her head. (C-CM)

For one therapist, a diagnosis of schizophrenia was less of a sentence to a life of continuous torment; instead it appeared to manifest as a continuum of effects resulting in a diverse range of possibilities for recovery depending on the symptoms and the capacities of the impacted individual.

> Recovery for schizophrenia…is on a continuum. We have someone [who] was successfully working in this office…She took medication, she managed her voices, she got through her day, but there's always going to be those schizophrenics that even with the best medication and therapeutic management, they're always going to be delusional, they're always going to be paranoid, little bit suspicious…That's almost impossible to fix. (T-GA)

For therapists, the presence of psychotic symptoms or a diagnosis of schizophrenia appeared to be a red flag for the potential intractable, long-term disability that they could produce. Particularly for one therapist, having a severe and persistent form of schizophrenia all but precluded any possibility of recovery.

> The clients I worry about are the ones that are pretty chronically psychotic and they isolate, and they don't want anyone around. And those are the ones that all of a sudden will blow up in your face, in terms of caseload crisis…[in working] with the chronic mentally ill, recovery to us, is not a word that we believe in, too, in terms of true recovery…[i.e.] becoming an absolutely normal member of society. These people are never going to be that. (T-GA)

For mental illnesses other than schizophrenia, there was an equivalent range of relative severity and corresponding potential for successful management. While anxiety and bipolar disorder were considered fairly responsive to intervention and thus had the greatest hope of recovery, illnesses like post-traumatic stress disorder (PTSD) presented very difficult challenges for clients and therapists alike (T-GA). Hoarding, once included among the anxiety disorders, but now considered among the Obsessive-Compulsive and Related Disorders grouping in the Diagnostic and Statistical Manual of Mental Disorders (5th edition) (American Psychiatric Association, 2013), was considered another seemingly intractable phenomenon that frustrated therapists who had to deal with it. Hoarding tendencies have a very direct impact on a person's housing stability, as one therapist recounted in an extraordinary example of how severe mental illness can bore holes in even the most secure life situations.

> It is very difficult to deal with hoarding. I don't know how much we can do…they have so much stuff there, things are going to grow, like bed bugs or anything, the apartment is

> going to eventually be not good for human habitation. I had one guy…They called the health inspector to come and condemn the house, and move him out. So I went down, and the house was gone. But he wasn't a renter, that was his own house. (T-MA)

Additionally, concurrent personality disorders can also play a significant part in determining the overall ability for someone with schizophrenia to recover (T-CO).

In the end, the ability to manage symptoms and become more recovery oriented seemed to be a matter of individual learning of how they ebb and flow and then formulating strategies to maintain equilibrium as best as one can. From the perspective of one client, this was what recovery is all about: "recovery means to know, [and be] able to control [symptoms]" (C-TO). In other words, the meaning of recovery from mental illness came down to understanding unique symptomology and development of effective coping strategies, because symptom *control* per se was not an adequate way of describing the illness management process.

> It's very difficult to control [symptoms], but it's just a matter of…an ability to just take what comes at them, on this day. And sometimes the intensity is higher and sometimes the intensity is lower, but they have developed strategies and an ability to just cope with that. Just hesitant on the word control, because I just don't really feel like that's a very accurate situation. (T-DU)

This was reiterated by another therapist, who used an exemplar of a client who, despite having active psychosis, managed to live independently and avoid hospitalization, a key definition of recovery from this therapist's standpoint (T-MA). Inevitably, discussion of symptom management leads to discussion of insight as a key factor in this outcome. Without recognizing that one is ill, it is difficult to provide help, and without help, recovery is a difficult prospect: "I think that's part of their recovery is accepting help and knowing that they've had an illness, or they have an illness and they need all these things to keep them well" (T-PE).

While insight certainly applies to any type of psychiatric disorder, it has particular relevance to psychotic disorders like schizophrenia. From one therapist's perspective, it is impossible to turn one's attention to anything remotely related to recovery, such as gaining more independence or achieving personal goals, if a person is mired in the disturbed or twisted reality in their head.

> Insight is a big one, especially for psychotic clients. To me, that is a huge distinction…They think god's talking to them, they think there are demons out there…vs. the other person [who] is able to say "holy smokes, I need to go to bed, I'm not thinking well. I need to stop doing all these drugs"…A client with high insight and a client with low insight are a night and day difference…a client with high insight has a far higher ceiling in terms of being able to learn new skills and…selectively attend to [what] will allow [them] to live independently… [for] a client with low insight, they're terrified, paranoid, petrified, almost 90% of the day…they're always in survival mode…it's almost impossible to teach them…(T-DU)

The same therapist spoke of insight as something that could essentially override the impact of psychotic symptoms, allowing the person to live with them, but not be disabled by them.

> I got one guy [who] hears voices all the time…when [he's] watching tv and he hears a voice from the balcony, he's just like "eh"…he says I got to go to bed. So he's very, very, very insightful and he does okay…You wouldn't even know it if you saw him on the bus, just [a] friendly, friendly guy, but very, very sick voices coming from his head all the time. (T-DU)

In sum, symptoms and overall diagnosis play a key determining factor in terms of a person's likely orientation towards recovery or disability, however other considerations effectively moderate the extent to which diagnosis alone determines the path towards recovery.

4.2.1.7 Substance Use

Across all clients and therapists in this study, there was almost universal recognition of substance use and addiction as a major barrier to recovery and key source of impaired functioning.

> Addiction is a big, big problem. In triaging, if they see a client suffering from an addiction problem and a mental health problem, that client needs to be monitored. They need 24 care: meals provided, laundry, whatever, and it's all about managing risk in the community. They need to maintain their mental health…the providers need to supervise them, make sure it's done. (T-JO)

On one hand, there appeared to be consistent appreciation of the role that substance use plays in the lives of people who are bored and have little else to do. Unfortunately, when substance use crosses into a problematic behavioural issue, the negative aspects can overcome any positive effects (C-CM). In effect, for people who are socially isolated and generally marginalized by the rest of society, substance use connects them when there are no other means of connection left. One therapist commented how substance use is the basis of the strong sense of “community” among homeless people.

> Homeless people have an amazing community. It usually has an underlying element of drugs or alcohol, and some sort of thing…they tend to watch out for one another. They always know what the other guy’s doing. They’ll be the first to call the cops if someone’s in trouble. And it is a really tightly knit [community] – it’s like small town. (T-GA)

The overwhelming social isolation experienced by many people with severe mental illness is “greatly detrimental” (T-DU), thus substance use produces a less than ideal therapeutic effect in this domain when it allows a person to connect with others and venture out in to the community. In many respects, there are few other venues like bars where people can show up and connect with others with a shared interest (in this case, drinking). One therapist expressed the difficulty in juggling the pros and cons of substance use in this light.

> [They] really [need] more healthy options…not to get into the drug scene and stuff like that. I think that’s where a challenge might be. Unfortunately to feel that connection, some people…end up at the local bar and begin to get into a little trouble. I’m not saying that they shouldn’t go down to a bar…some of the people get very lonely, so they end up going to that, and it’s not just to drink, but you can sit there and be around all these people. (T-CA)

Notwithstanding the positives associated with the social life that substance use might bring, there was also clarity regarding how the social atmosphere generated by using substances was not necessarily a good one. The cocktail of social isolation, addiction, and poor social networks was considered to be a serious issue directly impacting one's ability to live independently and maintain housing.

> From my experience mostly my clients [are evicted because] they're partying, [and] then they have property damage. That could be the number one reason…They have an addiction problem and they are bored, they have nothing to do…people get together. (T-MA)

While not considered a particularly serious substance use issue among other possibilities like cocaine, heroin, or even alcohol, smoking tobacco has a widely accepted and well-documented negative impact on physical health. In addition to the short- and long-term health impacts, on a more immediate level, smoking can be a significant detriment to independent living through its cost and corresponding effects on the pocket book (C-LW). There are few drugs that have as polarized views on their potential positive and negative impacts as cannabis. One client "smoked marijuana for medicinal purposes, because I have a really bad back condition, and high stress levels, it helps relax my nervous system, keeps me calm" (C-LW). The client indicated that an earlier psychiatrist had relatively liberal views on marijuana use and accepted that the client used it to address physical and mental issues. However, a change in doctor resulted in a completely different viewpoint, one that the client described in an almost persecutory tone.

> And he started calling me down all the time, and he didn't tell me he was going to hospitalize me if I smoked marijuana. He totally disagreed with [previous doctor] and wouldn't understand…they did a blood test and found out I was consuming drugs, so they put me in the hospital and after a few days…I'm out of the hospital and back home here. (C-LW)

As a rule, the client was careful about sharing with others about substance use due to overwhelming societal views that tended cast any illicit substance use in a negative light. Further, this client was also careful about the financial considerations of substance use. In essence, there is a clear line to follow, namely the bottom line.

> You should be spending any money on groceries, not on a little half of crack-caine or marijuana or a case of beer. Those are not necessities, that's entertainment. But I don't drink most of the time because it's just not in my budget. I realize that. (C-LW)

This however does not change the fact that many people living with mental illness are greatly impacted by substance use and addiction. It holds such a powerful and insidious hold on people in its grasp, even among those who achieved some degree of sobriety: "it's a revolving door…a little stressor could just trigger someone back to using drugs" (T-JO). Thus, it remains a significant focus area when identifying the most important barriers to recovery.

4.2.1.8 Wellness

A person's general health and wellness was another area identified by participants as a key factor in determining a person's overall orientation towards recovery or disability. There was acknowledgment from one therapist that focusing on a person's mental illness could result in neglect of other aspects of their health, which could have similarly significant impacts on the person's ability to live independently and, ultimately, have direr consequences.

> Our clients have a shorter life expectancy than the average population, and that is something as well that needs to be systematized more. (T-CO)

One client spoke of the prerequisite of having basic physical fitness and mobility to be able to live in an affordable housing facility geared towards people living with mental illnesses.

> But you have to be able to do those certain things, and you have to be in physical health…a couple people had to leave here, but they waited till they found them other places, because they couldn't walk good anymore, and they couldn't go up and down the stairs. (C-CM)

For one therapist, the need to have some sense of an active lifestyle served a dual role in that it helped with physical fitness as much as it did mental health, and it was worth going beyond the typical role of a therapist to pursue it.

> And I had thought this isn't right that she's only 47 and she's really healthy, and so I started asking her what she used to do. And she told me she was a good swimmer. So I started taking her swimming, but we don't really have time. (T-SA)

Another aspect of wellness that was raised by clients and therapists was eating healthy food and avoiding junk food. For one client, the noticeable change in physical appearance and development of diabetes, possibly due to medications (T-CO, see quote below), was a warning sign that resulted in the client making substantial dietary changes.

> And I didn't eat healthy…two meals a day and cereal in the morning, and nothing till supper. And then I'd pig out and eat something at bedtime. But I changed over the years, I realized, especially once I gained all the weight. I started thinking about my health…finally gave up the syrup and I started using honey, and I started using artificial aspartame and Sugar Twin and all that stuff in my coffee. (C-LW)

One therapist commiserated with this view, highlighting the struggles that people with mental illness face due to their depth of poverty and the prevalence of sugary food products that are as inexpensive and available as they are detrimental to their health (T-CO). The client who had made dietary changes spoke of access to a dietician and consequent extra income to account for the added cost of purchasing healthier food to manage diabetes (discussed again under Income and Poverty).

> I saw the dietician after I was confirmed a diabetic, I got an additional $40.00 diabetic supplement for more groceries because I have to eat…fruits and vegetables and spend more money on groceries to eat healthy for my diabetes. It costs me more than an average single person would to eat. (C-LW)

The cost of food was noted by many therapists as a significant barrier to wellness due to the challenges of living on a low income. One therapist spoke of a client who not only struggled to afford food, but had an additional complicating matter of having to address the needs of a pet, often at the expense of her own health and housing.

> Then she had this little dog that died on her…She wants a pet, but she's living in a situation where they will not allow pets. Realistically she can't afford a pet… It's kind of sad, but realistically you can't say to them, "well you know how much cat litter

> costs?"…They just don't see that, but they'd rather go without food…so they become unhealthy in their eating habits, they become physically sick, and sometimes they end up in a hospital and then they lose their place. (T-PE)

While therapists and clients spoke more of issues relating to access to mental health clinicians (discussed under Clinical Supports), it was also recognized that having regular check-ups with a general practitioner physician was a key factor in maintaining physical health.

> I don't know if that can be built in somehow…going to see your GP on an annual basis, getting blood work done on an annual basis, and learning about how you take care of yourself, and have compassion for yourself…their physical health is neglected, I think because it's just one more thing you got to take care of, and also limited resources, like financial resources and poor motivation. (T-CO)

Thus, maintaining wellness through a proper diet, physical fitness, and access to primary health care can be a significant factor in determining a person's overall orientation towards recovery or disability orientation.

4.2.1.9 Outlook

A person's outlook was perceived to have some bearing on their relative orientation towards either disability or recovery. Outlook comprised aspects of faith and future orientation, ideally one that promises positive effects further down the road. For one client, the struggles of living on low-income were balanced by gratitude for what the client was receiving and steadfast faith that God would provide for the future.

> I live my life as honestly as I can and I'm thankful to God that at least in his own way, [he has] provided me a better way…on AISH and on a disability pension than my welfare would have paid. But at least I can afford to have a roof on my head, I'm not on the street. I have faith and [trust] in God most of all, that my dream will be realized some day…I have God guiding me every day…(C-LW)

One therapist commented on the importance of spirituality in this respect, drawing on the therapist's own personal beliefs regarding the importance of that kind of connection to steer away from negative influences and outcomes (T-CO). Another therapist connected the spiritual aspect of outlook to a contention that for those who are so inclined, involvement in church (discussed again under Sense of Belonging) “gives them some support and direction” (T-PE). This sense of direction for the future was regarded by another therapist as a key component of recovery orientation, focusing on the ability to set even small goals and work towards them.

> Just small goals, whatever it might be, like “I want to be able to (you know something simple) remember to take my medication every day”, “I want to be able to remember to eat my three square meals a day”, or something like that. Or it can be something even more like “I want to rejoin the workforce” or something like that. If they’re able to generate stuff that they want, the list of stuff they want, and are able to actively pursue those, one step at a time, I would say that’s good recovery. (T-DU)

One therapist noted how outlook was in many ways dependent on previous success, as exemplified by one of their clients who, in many ways, demonstrated an ideal pathway for recovery from mental illness.

> It’s just amazing to watch how that growth went, somehow she’s made herself. She’s just really feeling great about what she’s doing out there now. The more independent she got, I think the stronger she grew. And from that group home to finding out she can manage, and she could take care of herself in an apartment. (T-CA)

In terms of imagining a better future, one therapist raised the advantage that younger clients have in terms of regaining their foothold in society and pursuing goals towards normalization, contrasted with the disparate expectations with longer term or more severe illness. The same therapist also noted that this movement towards recovery for some clients helped therapists with their own perceptions and outlook on their work.

> To me, it’s quite an emotional issue…[We] put all our resources into recovery, and there are still the people that are so severely ill, that they don’t benefit from any of it. But, it’s certainly an extremely rewarding thing to participate in – for both the workers and the client – when they make steps towards recovery. (T-SA)

Interestingly, only one participant (T-JO) used the word “hope” to describe future orientation. Nonetheless, based on the perspectives of clients and therapists, having a positive outlook for the future and motivation to work towards a better life remain significant components in determining a client's overall orientation towards a life of disability or a path to recovery.

4.2.1.10 Self Esteem

A person's perceived self-worth can be an important indicator of recovery or disability orientation. The concept of self-esteem is interrelated with factors like other people's perceptions and the extent to which one feels marginalized by poverty or victimized by people with more power in society. In many ways, it is a product of societal factors more than it is some kind of intrinsic quality that is independent of external forces. As one client noted, it can impact the ability to make and maintain beneficial social connections.

> I was married once, that lasted six months. But I have such a terrible self image that I think it projects outwardly and people pick up on it. (C-CM)

Having a negative self-image can be a product of internalization of stigma, but it can also be caused by mental illness, especially affective disorders like depression. For clients experiencing depression, there is an obvious and evidentiary clinical effect on self-esteem that leads to a cycle of pulling away from people and becoming more isolated in life.

> I told sister [name] I'm worried that people are not going to accept me. She says, "you shouldn't think that because people probably aren't even going to notice you to begin with. And you shouldn't think that of other people, because you don't know what they're going to think of you." I just create all these negative images I guess. (C-CM)

One therapist spoke to these same challenges, highlighting the interplay between shyness, low self-esteem, and stigma in marginalizing and isolating people living with mental illness. Because of their sensitivity to external perceptions, real or imagined, people living with mental illness can face a daunting challenge to re-engage with society after numerous negative experiences.

> I think the self-esteem out there [is lacking], and we know it's the stigma and the shyness and everything. For them to just go do it independently, it just doesn't seem to happen. Or they have a failure, they come back, they'll never go again. (T-CA)

Living in poverty, sometimes compounded with clinically based neglect of physical appearance, creates a state of otherness in daily life simply because they look and act differently than the average person.

> It frustrates anyone, so [for] someone who's…a little sick, it's very, very hard [in terms of] how they feel about themselves and where they fit in. It doesn't help if you think everyone's staring at you, or your clothes aren't so good. The things that make them standout, the stigma stuff, definitely is a barrier for their self-esteem, living out their independent life…[like] the people who unfortunately smoke, or what they wear…or walking around with their voices. (T-CA)

Further, as discussed above, the propensity for people living with mental illness to be serially exploited can spur feelings of inadequacy and shame that further grind away at any remaining vestiges of self-esteem. In other words, it is difficult to remain confident when a person has repeated experiences of victimization.

> Very, very few clients feel the confidence and feel that they're smart enough to put up [a] good fight. They get browbeaten easily, pushed around easily. The clients just say I want to move, and a lot of them won't admit what's going on, because they're proud…they're embarrassed. [Interviewer: As anyone would be if they realized they had been…]…shafted, over, and over again. (T-GA)

On the positive side, most therapists spoke of the pride and self-esteem that comes from gainful employment and having an education. One client spoke very highly of the critical role that employment played in many domains in addition to self-esteem. From this client's perspective, having a job was a key factor in maintaining sobriety, social relations, and, of course, financial security.

> If you find a job that fits for you, it can help you out tremendously. It's a must. It gives you money, you socialize, meet new people, feel better about yourself. You're cleaner, and you feel like you accomplish something at the end of the day. (C-SC)

Having self-esteem means that one has a core capacity to engage positively with the world around them despite living with a mental illness, to be free from definition based on their mental illness and dependence on the mental health system.

> Independent living is the freedom of choice, determining your own health and what options you want to have to – what route you want to take to ensure that you're healthy… What do you want to do, and I still think it's still the same, recovery is allowing them to be out there and freedom from illness, and that the illness doesn't define them. That they don't have to be a professional patient, they don't have to feel like part of the system (T-CA)

One therapist expressed concerns regarding the expectation that every client will be able to achieve that level of normalcy, and "that there's a fine line between people being supported and then being pressured" (T-CO) toward this ideal. In the same vein, another therapist applied frank realism to what it means for a person with PTSD to be re-engaged in life.

> With PTSD, the indication of recovery is that you leave your house in the morning. You can work again. You're not stuck in your basement staring at a computer. You're not beating your wife. You're not drinking your face off every night. You're not triggered and you're not having nightmares. You're not avoidant of any stimuli that are associated with your trauma anymore, you can breathe through it. (T-GA)

Being able to "breathe through it" is a clear summation of the kind of self-esteem and confidence that people with mental illness need to take steady steps away from a disability mindset toward recovery and rejoining society.

4.2.2 What and How Services are Provided

In this section, factors are presented related to the provision of clinical services and instrumental supports within the context of the mental health system and the resulting impact on clients' orientation towards recovery or disability. These include housing, functional supports, clinical supports, medications, and system orientation.

4.2.2.1 Housing

Perhaps the clearest emergent theme from all clients and therapists was that housing plays a fundamental role in a person's relative orientation towards recovery or disability. The type of housing that one lives in appeared to be a consideration, with a clear differentiation between market (for-profit) and non-market (non-profit) types because, according to one therapist, "the underlying philosophy for the housing in extremely important" (T-CO).

For many therapists, the private housing market offered poor options for people living with severe mental illness, especially from the standpoint of trying to afford rent while at the same time living in poverty.

> The rents in the city are ridiculous. You probably do have an idea of some of the absolute shitholes people are living in…I'm talking 3-400 square foot flop, just one room with a saggy old bed and they're paying $650, $850 a month for the pleasure of staying there… I mean let's face it, a lot of our people can't afford the housing out here in Edmonton. (T-GA)

Another therapist commiserated with the physical state of many units in the rental market, decrying their general unsuitability for people living with mental illness.

> [Landlords] don't seem to adhere to any code that I would assume they should be up to. I hear [of] people [who] have infestations, other people in the building in various states of stability…lack of privacy, lack of hygiene, shared unclean bathrooms…very inadequate air quality, very poor air quality…it's rooming houses, and actually apartment buildings [too], they haven't been kept up to repair, or they haven't been upgraded. (T-CO)

For some people, the behaviours associated with uncontrolled symptomology are what put them at risk of losing their housing. In some situations, these people have the advantage of living in a private housing situation in which the landlord is understanding about the considerations required by a person living with mental illness.

> …they do seem to cause a bit of disturbance, based on some of their paranoid ideas. Those are the main things for eviction, and then the shouting out loud. I'm having one [client in this situation], thank goodness she's in a good housing situation right now, [with a landlord] who gets it. She talks so loud to her voices. They get a lot of

> complaints. But they understand, we try and calm her down, and [are] able to tell them that she's not dangerous (T-CA)

Nonetheless, many others are not so lucky. The need for relapse management that requires hospitalization puts some people in a position of not having housing security because of the interplay between insufficient support to promote medication adherence, eviction due to relapse, and the inability to pay for an apartment while in hospital (T-GA). This perspective was repeated by another therapist, who suggested that the system needed to do more in terms of financial support to intervene in situations where rent could not be paid due to a relapse, or if the person's health issues prevented them from being able to comply with the cleaning requirements for return of a security deposit.

> If you're not able to pay your rent because you've had a genuine relapse and you're in hospital, then there needs to be some kind of program like a compassionate "in-hospital rent" eviction prevention program, so they can just cover the rent for that month. It makes no sense…you get into the kinds [of] additional complexity of people losing their damage deposit because they're in no state to be scrubbing walls and stuff like that. (T-CO)

However, another therapist, while accepting that some clients do not succeed in housing because of factors out of their control, also acknowledged that in some situations the client should bear some responsibility.

> Some people are very irresponsible on purpose. They get prostitutes, they have big giant drug parties…then the landlord gets complaints and obviously wants them evicted. And there's other what I would call unintentionally irresponsible behaviour, like not paying rent, and because they don't budget well, and they have poor impulse control [when] they get paid… (T-DU)

One solution mentioned by a therapist was to get the rent money to the landlord before the client has a chance to spend it inappropriately, purposely or not. In this therapist's opinion, the biggest factor contributing to eviction was "not so much for [not paying] rent, because rent usually for my clients is paid by third-party. So rent is not a problem. Before they get it into their hands, already it's gone to the landlord" (T-MA). But even with external control over one's finances, living on a low-income leaves much of the rental market out of reach. Consequently, the landlords that often provide housing for people living with mental illness at once both fill this important need while leaving them in a state of vulnerability and risk.

> You have some slum landlords that take people in and they really don't care. I've crawled in and out of them many times, it's horrible. They take advantage of the clients and, because of their financial situation, [they] don't have much choice …a lot of these private places they charge an exorbitant amount and they really don't care about the person living there…even though they're aware of what's going on, sometimes they turn the other way until something happens to them… as long as the landlord gets money, nobody bothers to go and check to see what is it like inside, they don't inspect. (T-PE)

In essence, people living with mental illness are at a fundamental disadvantage in the market because they generally live on a low-income and, for "landlords…it's a money making business, so…it's that affordability thing: where [else] do they really fit in, in terms of what can they afford?" (T-PE). Because they lack a social support network of family and friends to advocate for them, many are left to live in deplorable and unsafe conditions with no recourse or capacity to pursue other options.

> She's stuck in this apartment…you're supposed to have a code, but half the time the door is open…what she tells me there are a lot of drug activities…and she's terrified, but she has no family to really help her…physically she's not well enough and really doesn't have anybody to help her move. (T-PE)

To make matters even worse, if they find themselves ejected from the housing market for all the reasons previously indicated – in some cases into homelessness – the door essentially closes behind them with little chance of being opened again, especially in a tight rental market.

> If they're homeless for a long time…you can pretty much 99 percent [guarantee] that [landlords] won't give it to you, if there are a couple other people [with applications], [they're] not going to take that chance. (T-MA)

Interestingly, there was no mention among client participants of similar stories dealing with private landlords, perhaps because three of the four clients interviewed lived in non-profit apartment units (the fourth had an ongoing rent subsidy). This portion of the housing market is very limited in size, with availability of units few and far between. With respect to the largest affordable housing providers, “the waiting list is like three years” (T-PE). For one client, living in non-profit housing provided by a charitable social services organization was a key factor in the client’s ability to maintain long-term housing stability.

> About 18 years approximately now I’ve been living here…I’ve got a good manager…he’s been pretty good at treating me good and I have my own [outside] door to use, so it’s not quite so much like an apartment. Plus the laundry’s free, there’s no extra charge, the utilities are worked in with the rent. I’ve got a reasonably good, a really good price on rent. (C-LW)

From another client’s view, living in similar non-profit housing meant that the landlord – a non-profit health service organization – “would have more patience with somebody who might screw up…whereas in a regular [for-profit] building they just might give you notice” (C-CM). This client explained how, in that building, behaviours that therapists spoke about as precursors for eviction in the regular market instead triggered intervention that did not result in displacement. Essentially, the non-profit housing provider requires tenants to be responsible for their own health, including having existing support (“workers”) and accepting help when issues escalate (C-CM). This sentiment was echoed by a therapist, who drew a line between non-profit housing providers and their for-profit counterparts in terms of their tolerance and understanding of the special needs of people living with severe mental illness.

> [Non-profit housing providers] are more understanding, and they’re willing to work with the client and the therapist to resolve [the issue], rather than just kick you out. The mainstream [major for-profit landlords]…are not tolerant with anything wrong, they will just [kick you] out. They are not understanding. Maybe there should be more education, or some more support with them, letting them know [tenant issues] could be the illness and [they should] give [tenants] a second chance. But you cannot control them. (T-MA)

As one client described it, these types of housing options offer above all else “a loving, forgiving attitude, understanding that people are handicapped and they need help and understanding, not a strict landlord that's just going to evict them because they smoked a joint, or hollered and screamed one time" (C-LW). Nonetheless, even the non-profit housing market is no panacea for people living with severe mental illness. First of all, for settings geared towards providing independent living for people living with mental illness, physical health issues are not so easily accommodated.

> You have to be able to do those certain things, you have to be in [good] physical health…a couple people had to leave here, but they waited till they found them other places, cause they couldn't walk good anymore, and they couldn't go up and down the stairs. (C-CM)

Furthermore, there are distinctions among non-profit housing providers in terms of their understanding of and capacity to address mental health issues. One therapist noted how an affordable housing facility, which had only cleaning and kitchen staff on site, managed to become a potential exemplar for providing a supportive environment through training from and close coordination with mental health therapists in Alberta Health Services.

> When we set this up first, there was a lot of anxiety with the staff, because they had never worked with mental health clients…we had some education for all the staff and one thing about the [affordable housing provider], they were really good about including even their kitchen staff, their cleaning staff. Everybody was able to come to these education sessions…they don't have any mental health training, but…they've really become quite aware of what everybody's doing, [they] just know how to have that interaction with them without being intrusive. (T-PE)

Still, another therapist recounted attempts to intervene in a serious situation involving a client who was living in a different affordable housing facility operated by a large social services provider.

> I called the police, they went to [affordable housing building], they had to argue to get access into her particular wing, which was locked. And they would absolutely not let them into the apartment to check out if there had been an incident without a warrant. And they wouldn't allow me to gain access at all. You know she could have been there deader than a doornail, she was not answering her phone…if you say as an organization that you want to provide a safe, crime free accommodation for people of very low income, you've got to understand that you have a very high mentally ill population in there…Their

> policies are such that very dangerous situations have occurred, with me personally on two occasions, because their rules are so rigid…if someone says "I know this woman is repeatedly suicidal, does ingest huge amounts of medications, and has almost flat lined this year at least 3 times", [and] I can't even knock on her door, you kidding me? …the rules get in the way and endanger people. (T-GA)

Additionally, even in settings in which there is an explicit focus on serving people living with mental illness, there are apparent limits to the extent to which erratic or disturbing behavior will be tolerated, as mentioned above, in non-profit housing settings in which no support services are available to tenants on-site.

> I had someone who had to leave because he just wasn't managing in his apartment, even though he's got all good skills. They felt uncomfortable with him being there, because there was some slow deterioration. But if there was something more [in terms of support] onsite for him or even somewhere where he could go temporarily and come back, there could have been something built in. (T-CO)

Aside from the lack of built in formal supports, independent apartment units can isolate people if they do not have a strong social network to relieve them of their loneliness.

> There was a guy here, he lived independent here, but he didn't like it so he ended up living in a group home, because he wanted, he needed to be around people. He couldn't stand sitting in his apartment by himself. So for some people…it's good if you have friends and family because then you're not totally alone. (C-CM)

It is this need for supports (both social and formal), especially for people with particularly severe and persistent mental illness, that places such a high demand on supportive housing facilities. As with the non-profit rental market, there are far fewer supportive housing facilities than needed to meet the demand. As one therapist indicated, among those non-profit options available to people with severe mental illness, many are defined as "transitional", which by definition precludes their utility in assuring long-term housing security for their tenants (T-CO). The concept of a "group home" is essentially the same as supportive housing; however, as the therapist implied, there are distinctions between types of providers in this segment of the housing market as well.

As before, the delineation largely rests on whether there is a for-profit or non-profit model underlying housing provision.

> I think some of the things that hurt our population, are some of the independent [for-profit] group homes that are not regulated and kind of run under the radar. I've had clients that have been paying upwards of $900, $950 a month to share a bedroom with another guy on a single bed, and [the group home provider is] only technically supposed to maintain a thousand calories a day of food stuffs…the huge rents, the ridiculous crowding, and then being fed a half a cup of cereal with skim milk in the morning. It's abusive. (T-GA)

To further complicate matters, one therapist spoke of a further distinction between regulated and unregulated group homes within the private market. The latter type appeared to be yet another problematic subclass of housing that, while offering much-needed shelter and purported support, also seemed to be better suited to making life worse for people living with mental illness as opposed to making it better.

> [Regulated] group homes…[are those] where they go visit the home, make sure it's safe, the environment is safe, and they have adequate staffing [and] these staff have adequate training. There are a lot of drawbacks with [unregulated] group homes…because of the lack of training…even for maintaining physical health. They take people off the street and they put them in these group homes to manage clients with mental illness, addiction problems, and that is wrong. (T-JO)

It is evident from therapist views on the arguably bleak state of housing options that many people living with severe mental illness are essentially forced to live in sequentially lower and lower tiers of inadequate, if not harmful, living situations. As one therapist stated, "when housing isn't adequate, the clients have no other choice but to go to these private group homes, and that's where the relapse occurs and more crime, more risk [happens] out in the community" (T-JO). Worse yet, there are those who do not even make it onto the lower rungs of the housing ladder. Instead, they are relegated to deplorable temporary accommodations that in some cases are provided to them by government due to a complete mismatch between the sometimes complex and challenging needs of so-called “hard to house” individuals and any of the options within the range of housing.

> They end up living in some of these dive hotels and motels, and for some reason the community lets them. These places survive and I don’t know [why]. Even Social Services, because there is no place to send them, that’s where they send them, to these places. There just is not enough [housing] available, and I think with our mental health clientele, some of them are really hard to house, just because of their mental illness and people don’t tolerate some of that behaviour. (T-PE)

In sum, housing plays a key role in determining the extent to which a person living with mental illness is able to pursue recovery or be mired in a disability mindset. While the client participants and some therapists appeared to have experience with housing environments that could offer foundations for favourable outcomes, aside from these few positive examples, therapists tended to paint a picture of a housing system that for the most part leaves people with mental illness at a great disadvantage for achieving progress towards recovery.

4.2.2.2 Functional Supports

The extent to which a person is engaged with functional supports can be a key determinant of whether they are oriented towards recovery or disability. As discussed earlier, while there may be deficits in functioning as a result of illness or other factors, these can be offset by availability of and appropriate access to the right services. It is evident from both therapist and client participants that clients are offered assistance and accompaniment on a variety of tasks that contribute to independence by programs and workers with a variety of names and titles that serve very similar functions. For example, on client received assistance attending appointments and going shopping by a “Community Support Worker”.

> She’d take you to your doctors appointments, take you for coffee. She would take me for clothes shopping and she was just always pleasant and you could talk to her…But now she’s the only one that does that job out of the office… (C-CM)

Many therapists referenced “Independent Living Skills workers” in terms of their value in assisting clients with significant difficulties to manage daily activities that range from social to instrumental. Therapists spoke very highly of their services and how important they were in helping isolated and low-functioning clients become more self-sufficient in the community.

> I have two ladies that have the ILS worker just exactly doing that, organizing their apartment, because they’re going to get evicted and they’ve got so much stuff in there. And that’s been a real task, because the stuff she helps them move out, she comes in the next week and they’ve got more stuff in there. So it has been an ongoing [task], but within that she’s also doing some teaching with them, just saying “look you really don’t need this” and teach them about health in terms of bed bugs and all that kind of stuff, that you don’t want to bring in all those things. They’re invaluable, we don’t have enough of them. (T-PE)

Besides ILS workers that are based within Alberta Health Services, other programs offered through contracted non-profit organizations were regularly accessed by therapists for their clients, offering a similar range of services to help with independent living.

> We also have [other services] that will go in and help clients with basic [skills]: “here’s how to cook a meal”, “here’s how to properly clean your fridge”, “I can take you out to get groceries”, “I can help you budget” …So there’s a lot of services already in place. (T-GA)

Among the many instrumental activities of daily living mentioned by therapists, money management was a key skill that heavily influenced the success of clients. As discussed above, paying rent is essential to maintaining housing stability and not spending money on drugs and alcohol can allow for sufficient funds to pay for a healthy diet. While ILS workers are able to assist with teaching budgeting skills and offer basic financial literacy, a program offering informal trusteeship went a step further, managing money on behalf of the clients. The program was mentioned by multiple therapists as a resource for clients who are “running out of money and they’re in debt all the time… sometimes it’s hard to convince them to do that, but once they’re on it they say ‘wow, at least [I] get a bit of spending money’” (T-PE). Services such as those discussed above provide a critical source of support for clients to be able to address their challenges, but they also contribute to the overall morale of the client as they become more stable, capable, and engaged. However, navigating the service system to find useful programs can be daunting, and the activity of finding support will itself require support.

> They need someone on their side, to believe that they can improve [and] keep improving…most of the time, they'll need someone to help them find appropriate housing and just to know what's out there, how to get help… they might know [what is available], but if they're afraid to phone or too disorganized to phone, they just might need some help doing all that. (T-SA)

While many services provide assistance to people living with mental illness, many clients and therapists spoke of the importance of helping people learn how to do tasks as opposed to having them done for them. One client referred to a living skills program that the client had attended while living in a transitional housing facility after having to move out of a relative's home. While the program did offer skill development, the client indicated that it had its limitations in terms of applying an assertive approach to achieving independent living goals.

> I took a couple classes there too. I even lived there just over a year. And they teach you some skills there for life skills…I felt though that they weren't strict enough, or that they didn't push us hard enough to become more independent. They kind of just left us to do our own thing…they tell you to keep your place clean. They don't check or anything like that. (C-SC)

While ILS workers can provide direct assistance with instrumental tasks, their most important role, from the perspective of therapists, was to help clients learn how to do those tasks for themselves. The latter focus requires a longer term of engagement with clients than the former.

> There are support staff like ILS workers that can be put in…long term to do teaching. That's generally how they learn, that's some of the opportunities around for people to learn the skills…it's not always easy to access that. (T-CO)

It appeared that ILS workers were in very high demand and short supply, but could generally be accessed if needed: "they can't give everybody an ILS worker, because there's limited resources...usually they get ILS support, but it has to be a good argument" (T-DU). The limited supply of ILS workers means that they can only be provided for short periods and for specific tasks. In the opinion of one therapist, this creates problems for people who require ongoing support with instrumental activities.

> We have to realize that some people will need x amount of support, probably indefinitely. I have one guy like that at the moment, and I've tried all kinds of things to have him learn buses, and through his cognitive limitations and…the scarcity of that resource, it's very difficult to put it in…I've spent freaking hours trying to get this guy bus training to go from A to B… He just needs someone to take him on the bus two, three times a week to a program indefinitely…he does better when he gets that because then that bleeds into other things. But when he doesn't get that, then it's like a domino effect. (T-CO)

In sum, the supports provided to address functional capacity are an important consideration in determining whether a person is able to live independently, and therefore also able to experience recovery. Without these supports provided by the mental health system, the many challenges in functioning that go along with mental illness would keep people in a state of disability rather than allowing them to pursue their potential and engage with the world around them.

4.2.2.3 Clinical Supports

The treatment and care provided by doctors, therapists, and other clinicians within the mental health system are obviously key factors in determining a person's course towards recovery or disability. Psychiatrists perform many defining tasks that set the course of a person's journey through the mental health system, including diagnosing the person and prescribing medications. Despite this key role, therapists and clients alike appeared to view their interactions with people living with mental illness as limited in quantity and quality.

> I only see my psychiatrist twice a year. Twice a year, for five minutes, twice a year. Just to get a prescription renewed and say see you in six months. (C-CM)

This nominal engagement and narrow focus on prescribing medications leaves some therapists with concerns about the ability of their patients to have a full understanding of the reasons for their treatment.

> And I tell him my problem, he utters not one word of health promotion or explains to me what's going on. All he does is write a prescription. What about the mentally ill who do not have a voice? (T-JO)

There was recognition from one client that psychiatrists have very large caseloads and thus leave clients feeling like they have a very superficial relationship with their primary medical provider, alienating them and making them feel like they are not being heard.

> And will [the psychiatrist] give me the time of day, I don't know, I don't hardly know. But you need that, anybody needs somebody – maybe not getting paid as much as psychiatrists are – but somebody there that will actually take the time to talk and help people. (C-LW)

Another client had the benefit of a therapist who would join the client during appointments with the psychiatrist. This continued until the therapist changed, leaving the client wondering about whether the treatment team was actually communicating behind the scenes.

> Like one worker I had [a few years before], she thought I wasn't doing well and she told my doctor, and I ended up spending six weeks in the U of A psych ward…that's what the workers are for. But now my new worker she doesn't go to my doctor; my old worker used to go to all my appointments, but she's retired. But [name], she's nice and that but she doesn't go to the doctor. Maybe she and the doctor would communicate, I don't know. (C-CM)

Dissatisfaction with the treatment team can impact the level of engagement of clients with the mental health system, which presents serious issues in terms of ensuring treatment continues and the well-being of clients is adequately monitored.

> A treatment team is a big thing too, because if they don't like their doctor or their nurse, or whoever they're seeing, that's when they kind of disappear into the [woodwork] and they're gone. (T-PE)

From one therapist's perspective, the hierarchy built into the medical model, in which doctors are at the top and all other professions are subject to their direction, can sometimes break down communication amongst the team and impair the ability to resolve issues for clients.

> Let's say [a client] hasn't been doing well for a while and worse since he got a new psychiatrist. So you have to have people, a few people on board, to address that…there is still this hierarchical control thing. From what I can see, a psychiatrist doesn't consult…different disciplines seem to be very open to getting input, I don't see that with the psychiatrists. You know if your guy's not doing well, have him see someone else. And that's got to be more than a discussion in the case conference with people who don't know who you're talking about. (T-CO)

Lack of communication can leave large gaps in care planning for clients. In some cases, these lapses can have a profound impact on the quality of care and the treatment of clients, as exemplified by a situation conveyed by one of the therapists.

> He became ill and went to hospital, and he had a struggle when he first got here, because he didn't have a therapist. And he had some real angry outbursts where he was threatening. And so he was hospitalized, and then we realized he was getting his injection at the hospital, and we did not realize he was not getting his injections, he wasn't going there. And nobody from the hospital communicated it to us to say, "you know he hasn't showed up for his injection". And so fortunately I knew the psychiatrist and she said, "well we were wondering", and then I said "well I can give him the injection here". (T-PE)

Among the types of clinicians that support people living with mental illness, psychologists were only mentioned in passing by therapists. This could be because they are not typically made available through mental health services, as suggested by one client.

> A psychologist or a professional counselor may [be helpful] possibly…. I've never talked to any of those people… [we need] professionals with a caring heart to talk to us, a sounding board for these schizophrenic people like me, that need somebody to talk to… (C-LW)

Psychotherapy appeared not to be considered for clients with schizophrenia, perhaps a natural result of the primacy of medications in typical care plans. One therapist suggested that psychotherapy was used for clients dealing with PTSD, as exemplified by the use of Eye

Movement Desensitization and Reprocessing for one of the therapist's clients; the therapy was so successful that the client was able to fly planes again (T-GA). Another client, who suffered from an affective disorder, received therapy from a psychologist while in hospital but was told that psychological services were not available as a part of community-based services (C-CM).

In addition to interactions with psychiatrists, therapists, and psychologists (or lack thereof), one client spoke about the value of working with a recreational therapist who proved to be a caring supplement to the treatment team.

> Occasionally I talked with her on the phone or sometimes met her, a couple times, and she was really good, and you know she was a lovely caring woman with a caring heart, and she would listen to me and actually say something that would make me feel better and help me. (C-LW)

In some cases, therapists will reach out to non-conventional partners to assist in reaching clients, particularly if there are cultural or religious considerations that have to be addressed to engage or provide care to clients. One therapist provided an example of a time when a clergyperson was consulted to help bridge differences in perspectives between the treatment team and a client.

> I have had some clients that I have had to work with a priest just because of their illness or whatever, and they really needed some redirection in terms of their feelings, because they feel that their illness is because they're evil, that's why they're ill. So that support [was] brought into the [care] in a positive way, and sometimes it works, sometimes it doesn't. (T-PE)

As suggested, sometimes assumptions made by therapists about resources that could help address clients' cultural needs do not result in positive outcomes. One therapist remarked about efforts to connect Aboriginal clients with culturally based programming without considering the different perspectives that non-Western cultures may have on the phenomenon of mental illness.

> There are cultural issues around that in terms of how things are perceived and experienced. I guess an example would be some of my First Nations guys, I ask them [about] this [Aboriginal healing] program, "do you want some kind of connection there?" Some people have agreed or wanted a contact, [but] sometimes it's an outright rejection

> saying “no I don’t want to do that because there are beliefs about my condition which I find frightening, that it’s spirits” – so people don’t want to go down that path. (T-CO)

While therapists noted some deficiencies in the way clinical supports are provided, clients were clearer on the gaps in care and what this meant in terms of the impact on their satisfaction with treatment and engagement with the mental health system. Issues related to communication, collaboration, capacity, and provider-driven care appear to get in the way of providing the best care to clients to move them from a disability orientation to one geared towards recovery.

4.2.2.4 Medications

The role of medications emerged as prominent factor in determining a person’s relative orientation towards recovery or disability, with a strong relationship to clinical supports, particularly the interaction among the various disciplines represented on the treatment team. “With psychosis, with depression, with bipolar disorder, and the funny thinking that goes along when they’re not well, medications can certainly reduce those episodes” (T-GA). Because of the central role that medications play in the treatment of mental illness, to some extent the effectiveness of the entire treatment team can be dependent on how well the medications work. In essence, without adequate symptom control, most other efforts to help clients are moot.

> In terms of people losing their place, sometimes they can’t manage because they’re not being treated adequately or properly. In order to be well, you have to have someone who is able to treat you with the right medications for your specific symptoms, and that’s not always the case. We get people over medicated, under-medicated. What are [the clients] supposed to do then? And then what are the staff supposed to do? (T-CO)

There was considerable recognition by therapists that pharmaceuticals were - at best - hit and miss, which can result in negligible effects for clients and, at the same time, cause side effects that leave them unwilling to continue with their regimen.

> It's unfortunate that med regimens are usually not very scientific to tell you the truth, they're no more scientific than just trial and error about that. "Try this", didn't work, "okay try the next one". A psychiatrist would never say that, but [if] they got a really bad first run and they just get really turned off, they continue to live life very symptomatic. (T-DU)

Therapists raised the issue of compliance with treatment as a significant factor in recovery or disability orientation. For the most part, the primary approaches to addressing treatment compliance include applying a different mode of drug delivery. A few therapists spoke about delivering drugs by injection, usually in long-lasting depots that can be provided in monthly or biweekly intervals as an alternative to daily pills that are easily forgotten or thrown out. Despite their value in this sense, therapists are still dependent on ongoing client contact (i.e. locating and meeting clients) to give the injections, to which another therapist appears to suggest that housing again plays an important part in facilitating medication administration.

> We do have a team at the clinic which is a team that goes out, they can go see the client every day, but when they go to give the injection, half the time they can't find them, because they're never in the same place. So that's the big dilemma, how do you fix that? I don't know, but there just isn't enough housing. (T-PE)

Despite all the concerns about medications from therapists, there was also general consensus that they served as the lynchpin for achieving success for clients. When they work, they provide substantial benefit for clients trying to overcome severe mental illness like schizophrenia. In the words of one client, medications may not solve the problem but they do have their benefits: "it might help keep you calm and might help you get to sleep at night, but it's not stopped the [hallucinations]…" (C-LW). In the end, with few other treatment options available or even considered, medications with all of their limitations are still the mainstay for helping people living with mental illness reduce the symptoms that disable them and start to make progress towards recovery.

> I think recovery again is greatly impacted by inadequate treatment, and by that I mean the medications aren't good enough, and there aren't other types of treatment explored or made available. (T-CO)

Thus, there appears to be a significant role played by medications in terms of promoting either a recovery or disability mindset. Based on participant perceptions, medications can be considered essential to addressing symptoms and promoting mental health for clients, but only if they are prescribed appropriately and there are supports for clients who need assistance with treatment adherence.

4.2.2.5 System Orientation

A major factor completely extrinsic to characteristics of people living with mental illness is the nature of the mental health system upon which they rely, and how its orientation, patterns, and makeup affect the quality of care and treatment that clients receive. There was considerable evidence from therapists and clients in this study that services available through the system were generally inadequate to meet the needs of people living with mental illness. From the perspective of one therapist, the real test of the efficacy of the system is captured in the hardship endured by clients in trying to access it: "Looking beyond housing, we're talking about doctors, nurses, psychologists…Our clients should never have to struggle to meet their needs, those services should be readily available, always" (T-JO). Perhaps a major reason for why the system is perceived as inadequate is because the primacy of clinicians and medications in treatment plans may obscure the simple fact that, at the most basic level, people need "adequate support" (T-DU). Providing adequate support entails adopting and allowing for an assortment of approaches based on the individual needs of clients. In many ways, this points to the concepts of client-centered care and client choice in the services provided to them.

> I would say people need a variety of options. so maybe it's people going into an independent apartment, whether it's spending time at a transitional skill building housing place, [or] whether it's attending groups. I would say it's in a number of different ways that they need to access things, because not everything's appropriate for everyone. (T-CO)

While new programs are often added based on emerging evidence and changes in clinical practice, this does not necessarily mean that the range of options is increasing. As one therapist noted, funding limitations in the mental health system sometimes make the question of introducing new programs a matter of "or" instead of "and".

> I still think there's a bit missing. We used to have…a life skills group. *Used to have*. It was [there] for years, and then with this sort of system of change where things keep changing within the system, but things remain the same, one thing that got axed was the life skills program, because it was perceived to be not evidence based…and basically outdated. So [they said it] didn't really do anything in terms of building skills, but most of us on the front line disagreed with that, because sometimes I feel that people go to the WRAP and the WOW [but] maybe they need something before that…it seemed like the life skills got thrown over so these things could be funded, which I think is unfortunate. (T-GA)

With limited options to consider when supporting clients, there was a sense from some therapists that they were not so much working towards recovery, but stabilization. This affects the attitudes and approaches of therapists as they pragmatically aim for disability mitigation as a treatment goal for the most severely affected clients, instead of raising the bar towards recovery.

> But a lot of my clients don't get to [recover completely], that's not to say that no clients do that, some are able to, it's just that I deal with some of the worst ones again, and so my guys don't usually get even close back to that level…But they go about maybe midway and that's where I keep them there, and I keep them there with supports that we were discussing, go forward with [informal trusteeship], or [a] new living situation like supportive housing, or [community supports]. (T-DU)

By keeping clients at the "midway" point, not only is the possibility of recovery being precluded in the minds of therapists, but the origin of client dependency on the system becomes clearer as a manifest result of the way it is oriented. In essence, by not having a full complement of services available, it is difficult to apply flexible approaches that can be applied in an individualized way to promote and reinforce client recovery.

> When services are limited and labeling happens, I get words like "they're too dependent"…they [need] a little gentle guidance [in] figuring out what they want, and everyone wants something a little different, and [they all] need [something] a little different. And they're all at different stages in their illness, and in their development. So it has to match that. (T-CA)

In some cases, the fact that clients are not responding to treatment or programming was viewed as a fault of the client, not the system. Consequently, the problem of mismatch between service delivery and client need is sometimes solved by creating and enforcing rules that have little to do with service quality for clients and more relevance to protection of programmatic structure.

> [There's] a feeling like they cannot meet the needs of the client, that the client's needs are too high… there can be other things put in place, [but] I often find that places will not do additional steps. Or if you do that for one, then we have to do it for everybody, this kind of thing. So sometimes simple problem solving things cannot be put in place, because of inflexibility. (T-CO)

Despite the lack of comprehensiveness in the variety of services available in the mental health system, there was still acknowledgement that there are many resources that can address client needs. From one therapist's perspective, the problem is that these services can be very difficult to find in the extremely complex system structure, so many clients are completely unaware of them unless they happen upon them by coincidence or serendipity (T-DU). The difficulty in finding out about services is compounded by the cruel irony that many of the most essential services, like income and housing, often have lengthy application processes and convoluted pathways that appear completely counterintuitive to the cognitive and motivational challenges experienced by so many people living with mental illness. Even therapists, who have professional training and are embedded within the system, appeared frustrated by the burdensome processes associated with accessing essential supports.

> The system can be quite confusing and difficult to navigate, like, for instance, if….they've been living with an illness for their entire lives. AISH would be a first step for me in terms of securing a monthly income….That can be a very difficult process. Housing is also a very, very difficult process. As far as I'm concerned, it's probably the most difficult process to deal with…[a] maze of information, they need forms and places to go…I would be overwhelmed by looking at it quite frankly, if it wasn't for the fact that I do it all the time. So this is easily overwhelming for them, so I don't think they would be able to do it without support. (T-DU)

In the end, there was a sentiment among participants that the system was oriented to be unapologetic about its convoluted nature, with clients "pressured to [think to themselves]: 'look, everyone can learn to deal with this, so let's just get on with it, you're not the only one'" (T-CO). As one therapist remarked, long-term guidance and supported access would do much to help clients get the services they need, but this is not generally available in a system that expects people with mental illness to navigate it despite their challenges.

> But for someone who's getting out there, they need to know who's around them: bus service, sometimes transportation, they might need orientation to that; where to go get their AISH, the first time; the bus passes, how to do all that…I think [we need to be] walking people through things at their pace. And [for] what they need, I don't think you can say, "we only do it once, and if you don't learn, too bad." That's been a barrier. (T-CA)

It is not surprising that the barriers to accessing services and inflexibility on the part of the system can leave some clients disengaged. Nonetheless, from the perspective of one therapist, the mental health system demands obedience from people with mental illness despite its failings.

> With the issue of what's called non-compliance… the term is inherently hierarchical…because it basically means you're not doing as you're told. [For] people if they're non-compliant, it could well be for a number of reasons, and those reasons are not properly addressed. (T-CO)

Compliance with treatment usually requires most clients to attend regular appointments located within centralized community mental health clinics. For some clients and in certain situations, therapists are able to offer home visits, "like during crisis obviously we have a lot of services that we can put in place, like, for example, I go out and see clients" (T-GA). This flexibility was acknowledged by other therapists, albeit with an admission that the practice is far from what is usually within a therapist's capacity and availability.

> I have gone out to people's houses and assisted with that. Usually that has to do with a crisis situation, because they're getting evicted and I don't want them to be arrested. I have done it, but I don't usually make time for it, if I'm being honest. (T-DU)

Having limited capacity to meet clients presents challenges in terms of maintaining regular contact. Client engagement and therapeutic alliance are negatively affected by this lack of contact, especially if appointments are missed.

> If they're in the community, it's a little different in that they have to reach out more to get those services…if you don't see them for three weeks or whatever, you may miss some things, and they'll miss your appointment, and it just goes that way. (T-PE)

Nonetheless, having clients come to clinics for appointments creates an artificial environment in which it is difficult to fully understand what is going on in their lives and provide adequate supports. As one therapist demonstrated, visiting clients in their homes provides a much richer set of information for the therapist to appreciate the contexts of their clients and develop meaningful care plans. Further, without someone to check on how clients are doing, clients can fall into a state of isolation and neglect.

> If [therapists are] just only seeing [clients at] in-clinic appointments, you have no clue what they're doing in that environment. I had a psychiatrist that actually does do home visits with me. And he says the same thing, he said "wow, this is something, sitting behind a desk and interviewing somebody, they come in dressed because they want to be appropriate. But you go and see them at home and it's a totally different thing, and it's an eye opener". But the sad thing is that there isn't somebody to check in…[for] a lot of the clients that have home care, at least there is that person that lays eyes on them, and then they can say, "there's something…this person is just acting odd, this is going on." Other than that, they're kind of lost souls. (T-PE)

That some clients become "lost souls" due to the inability of the mental health system to reach out to them is evidence of a pattern of neglect that is experienced by many clients. It appeared from therapists and clients alike that there were numerous factors that could contribute to neglect of people living with mental illness. In one example, a therapist spoke of the tendency for the system to view lack of crises as a positive outcome for clients and a basis for not applying a more assertive approach.

> I'll give you an example: right now I have a woman in a group home who's got schizophrenia and severe anxiety, and she doesn't make any waves and sometimes I think we have to make sure that that's not what we call success. I go there every two weeks, give her an injection, because she's far too anxious to take any DATS or anything. But, I just think that a negative byproduct of the recovery drive is that if people don't make waves, they're just going to be kind of forgotten. (T-SA)

On the other hand, even people who appear to be doing well in terms of living independently can find themselves essentially ejected from the system except for nominal contact for the purpose of ensuring compliance with their medication regimen.

> I'm concerned when I hear about that phrase, "independent living". I can hear social isolation. "You're doing well now, out you go. Boot. Are you taking your medicine?" (T-CO)

This sentiment was shared by one of the clients, who expressed feelings of despair and isolation because the client's therapist determined that the client was doing well enough to not require contact.

> She knows I'm looking after my health and I'm doing okay living on my own. So she's just too busy with other people and she doesn't give me the time of day. So I virtually got nobody to talk to. (C-LW)

A therapist noted how providing services that required expenditures received considerable scrutiny and monitoring even when they were essential to achieving positive client outcomes. On the other hand, there was a feeling that if services were not being provided despite being needed by clients, there was not a similar level of concern on the part of the system.

> They have to look at the budget, I understand that. [For example,] we can order taxis for people. You know you've got to justify why is this person always taking this taxi, but if you're not doing stuff like that, then nobody knows that you're not doing anything. (T-SA)

From the client’s viewpoint, there was little interest on the part of the system to work with people who were entrenched in the lifestyle of chronic mental illness with little desire or potential to regain a productive and engaged role in society.

> They’re more interested in young people and helping them, maybe curing them or getting them out into society, but not my age. They know I’m not going to be changing, I’m not going to be going into the workforce…I think their expenditure of time and manpower – I’m just guessing – could be used better on somebody else maybe. (C-CM)

There is no question that the mental health system does indeed serve a variety of needs for people living with mental illness. However, unless clients are in a narrow window of having just enough (but not too much) need to require services, they can fall out of the system. As a factor in contributing to recovery or disability orientation, the positioning of the mental health system certainly seems to be biased towards the latter.

4.2.3 Social and environmental contexts

This section presents factors related to the roles played by social relationships and interactions with environmental contexts in facilitating or constraining recovery orientation. These include family, social network, community, housing, perception of mental illness, security and vulnerability, income and poverty, and self-esteem.

4.2.3.1 Family

The relationships that people with mental illness have with family can be an indicator of their progress towards recovery or state of disability. For most people, family plays an important part in their lives; for people living with mental illness, the relationship with family can be affected by the course of the illness and (self-)alienation.

> Well you know family's important, but some of them don't have family, or their family has been really dysfunctional and so they have nothing to do with them. (T-PE)

For one client, there is a very practical need for contact with family members: "well, if some people don't have any family, like me, if I was to die nobody would know it until you smelled body, in the hallway" (C-CM). This client's interactions with family were the client's primary sources of social contact, offering connections in an otherwise lonely existence.

> I should be glad that my sister…will phone me and she tries to encourage me to go to a show with her and I always say no…But I'll contact her on the phone. So she's my only, other than the mental health lady, [person to] talk to. Oh I have an aunt who phones me every night of the week. Talks to me for ten seconds…she doesn't want to talk to me, because I try to say something and she just cuts me off by saying, "well I just phoned to say hi and I love you and I'm thinking about you, so I'll phone you tomorrow". (C-CM)

Another client spoke positively about the relationship the client had with the client's mother, although even that relationship had been strained due to differing views regarding mental illness and the client's experiences.

> There's even my mom, I talk to my mom, but she doesn't understand and she doesn't really believe me. So that just frustrates me. But my mom, when I talk to her about this stuff, well I just give up, because she doesn't believe…like a lot of people don't, they don't understand…what [the symptoms] do to me. (C-LW)

One client portrayed a different picture of relating with family members, in this case relatives who themselves live with mental illness. In the position of being the one with more stable housing and income, the client was a source of instrumental support for the relative, whether the client desired this relationship or not.

> My [relative's] been staying with me for a while. And she has a mental illness. And it's been very difficult on me and she's been here for a while. So I do struggle with that…[before she moved in] I was doing fine, I was just on top of the world. When [she] got evicted, she couldn't pay the rent, that's kind of where things got kind of bumpy. I had to help her move, and adjusting to another human being's attitudes and conversation, and the way they live their life – differently – was pretty stressful. I asked her to leave a couple times now. I don't know when she plans on getting out of here. (C-SC)

The same client provided another example of a situation in which interactions with family were less than positive. From the client's perspective, they served not only as a trigger for the client's own battle with substance abuse, but also as a frequent blight on the client's attempts to achieve personal goals and maintain steady progress towards recovery.

> My [relative] was living in [another city]. I was doing really well here. I wasn't smoking or drinking, and then he moved back here about four months ago. And he always asks me to buy him liquor and stuff like that. And I did it a few times and then one time I was just "I may as well have one too" and then it's been a downward spiral from there. That's one example of someone keeping you behind: family members. I don't have a big family, I'm just saying the handful I do have, I could find that they keep me behind. (C-SC)

One therapist commented that "most people aren't going to have a mother that's going to come over and teach them to cook and clean, [but] I actually do know people that have had that" (T-SA). A client discussed how connection with family members was sometimes difficult, but had improved over time. In this client's case, a close family member played a key role in supporting the client in maintaining life in the community, offering some instrumental and moral support from time to time.

> My [sibling] takes me [to a restaurant] every week. [He] lives in Edmonton, and my [other sibling] lives in [another city]. [He] knows everything about my medications and schizophrenia. Before he didn't believe [in my illness], but now he does. He changed a few years ago [when I] lived with him for 6 or 7 months four years ago. [Now I] don't need help from him, but he helped me move and I gave him a key. I try to call my [other sibling], but [her spouse] answers [and doesn't let me talk to her]. (C- TO)

Two of the clients who participated in the study had each been married at one time; one client had adult children at the time with whom contact was still maintained. For these two clients, as opposed to the others, there was discussion about the desire to have a spouse or significant other, and the challenges associated with achieving that goal.

> Waiting day after day, well week after week, month after month, year after year, wondering when my life is going to start, and I'll have somebody to talk to…I wish I had my wife, somebody to love and I'm going to hold and share my life with. (C-LW)

One client was pragmatic about the chances of finding a spouse at the client's stage of life and in light of the client's current circumstances and mental illness. As with housing, people living with mental illness can feel excluded from the regular "market" of potential significant others, left to try to connect with others who share a similarly unfortunate station in life.

> Yeah I kind of wish I was with somebody…Well I guess what I more lean towards is somebody, not necessarily mentally ill, but who had sort of a life of nothingness. I mean somebody who's had a productive life and nothing wrong with them, and went through normal stages of school, university, husband and wife and that, they couldn't relate to me probably and I would have a hard time relating to them. (C-CM)

Among the therapists, there was agreement that family could play a critical role in assisting people living with mental illness both from a social perspective as well as in an instrumental sense. One therapist indicated that family support can manifest itself through the imparting of valuable life lessons while the person was in the family home: "if you're from a stable family, you probably learned [independent living skills] from your parents or from the people you lived with growing up" (T-MA). As important as that preparatory role can be, the same therapist provided a more current and active role that family can play in promoting therapeutic alliance and contributing to treatment and care.

> Usually if they're not well their family can force them to call me….Or their family will force them to call me and if I don't hear from them [or] from the family, either they're okay [or] they're not okay, so I need to check into that one. (T-MA)

In sum, connections with family can be indicators of the extent to which a person living with mental illness is oriented towards recovery or disability. While family relationships are generally considered positive and desirable by overcoming isolation and instrumental needs, in some instances they can be a detriment or abusive, and thus hinder recovery.

4.2.3.2 Social Network

The factor “social network” refers to connections with non-family members as a distinct form of social interaction from those with family members. In terms of the role that social connections play in orienting a person towards recovery or disability, one therapist appeared to indicate that lack of a social network could have a very direct and negative impact despite progress in other areas.

> They’re fearful to say that [they’ve recovered], because then they think that maybe they won’t get services…you see that more when people have issues around attachment, “I don’t want to be doing too well right, because then I’ll be by myself again”. (T-CO)

To a large extent, having some sort of a social network is essential to any recovery-based treatment. In the words of one therapist, “it’s more than half, maybe 60 percent, of recovery… people who are more sociable…would be less liable to be fall behind and get sick” (T-MA). As such, helping a client develop some sort of social life is critical to overcome social isolation. For one therapist, addressing social isolation was a paramount area of focus in terms of treatment planning to help clients towards recovery.

> One of my main treatment goals with one of my clients is to prevent social isolation because it’s highly detrimental. [For] somebody who sits in their room all day and stays away, while that might be comfortable for some people, the difference is some people want to be there vs. other people who do want to go out but feel inadequate towards going out…So those are two completely different people, but social isolation is just a horrible life direction when it comes to recovery based treatment. (T-DU)

From another therapist’s standpoint, it is critical that clients “know that somebody cares about them and that they can contact somebody, or [even if] they don’t have a lot of contact, they have regular contact” (T-SA). While many people living with mental illness, due to lack of other social contacts, may regard interactions with workers and clinicians as respite from social isolation, one client was quick to dismiss formal support relationships from other types of social contacts.

> They just assume and assess me as mentally ill, and think I'm imagining all this stuff, and I don't have an actual person just to go and talk to once in a while, that'll sit and listen to me, like you're doing, and relate to... As your friends, no matter who you relate [to], [you] have to want to love and help them, as much as they're helping you…those [are] factors in life, [and] the most important thing of all is love. (C-LW)

In essence, having a social network other than formal support workers was deemed by therapists and clients alike to be an important aspect of recovery.

> I think the big thing is support and having a support system, and that's where a lot of people fall apart, [the] lack of support, [or for] some of them, friends – friendships. In [housing facility] a lot of them have made friendships and they have their people that they like to socialize with. [If] they're living in their apartment in the community, sometimes it's a little difficult for them to socialize, because if they don't know anybody they might not go out…if they don't have family to come and get them, that's another thing. (T-PE)

From another therapist's standpoint, it is not the quantity of members of the social network that matters as much as the perceived benefit that the client receives from interacting with them and what else they have going on in their life (T-CA). For one client, the impact of loneliness and isolation were palpable. In many ways, trying to build a social network was a primary goal in the client's mind, but there was a lack of clarity on how to approach the task of making new friends.

> I don't know how to make a friend like the ones I met in the park [when younger], they just congregated there and we just hit it off. With a couple of them, I hit it off and I don't know [how] it happened, it just happened. But now at this stage in my life, where do I go to [make friends]. No, maybe I won't have friends, but I could at least have some kind of dealings with people, I'd hope. But I don't know where or how. (C-CM)

From the experiences of two of the clients, there were efforts made to build social networks, with varying degrees of success and perceptions of the potential utility of further efforts. One client made an effort to reach out to others in the housing facility as a means of strengthening the client's social network.

> I keep to myself most of the time, but…I have [made] friends [with] several, well three people in the building here that have been here since I've been here, just about. And other people that come and go – come and go. So each new person that comes next door to me or whatever, well I get to know them, help if I can and become friends with [them]. [I] try

> and become friends with everybody in the building and I know everybody in the building. (C-LW)

The other client had a very different experience with neighbours in the client's housing facility, instead deciding that the social interactions were not of value and more wearing on the client's patience than offering an outlet for support.

> I used to associate a lot with my neighbour next door…I found that our conversation was just repeating over and over again, and the same negative things in how our lives were so miserable, and then finally I just thought well I may as well just end that… I thanked him for all he's ever did for me, and I still have nothing against him…he was really good to me for all these years, he used to take out my garbage out all the time. He used to cook meals for me, he used to go to the store and buy things for me…he does it for other people in the building…he's just that kind of guy. He's a sociable [person]. (C-CM)

Nonetheless, the same client did recognize a need to engage with others in some way. Instead of reaching out to people in the building, the client made some preliminary efforts to create some avenues for potential social interaction in the broader community, albeit limited by the client's own perceptions of social barriers that could preclude positive social interactions.

> I don't really feel comfortable out in public, but I have to get over that because I enjoy going to [shopping centre] on a nice day, they have tables outside the [coffee shop]. I go inside, buy a coffee or a bun, then I just sit outside and watch the people. I kind of hope somebody sits down, but nobody's going to. And I'm afraid to go up to somebody and talk to them, because I think they're going to look at me and say, "leave me alone". If you were sitting by yourself at a table, would you want some stranger to come by and talk to you? You might feel a little uncomfortable. (C-CM)

For both clients, building their social networks was not considered something that could be pursued with a shotgun approach. Preferences were clear and appeared to constrain the types of people they wanted to meet. For one client, sharing similar religious beliefs was an important basis for social connection: "I would like a friend to talk to but, it would have to be somebody that was very religious as I am… anybody that doesn't believe in God is not somebody I can talk to, because they don't understand" (C-LW). Another client similarly spoke of a faith-based group meeting in which the client had participated many years before, saying, "it's just nice you know, we talk about values [because] we have the same Christian values" (C-CM). A therapist noted how involvement in a faith community served a client well in terms of allowing him to develop a supportive relationship from his perspective.

> They go to church, [and] they get friends they feel they get support from, from their church. One guy told me that he had a friend among the church [attendees], and he talked to him every week, so that can make him feel that he's being heard and if he needs something he can turn to him and talk about it, kind of "semi- support"…(T-MA)

One client spoke about how meeting people who were Christian resulted in daily social activities with like-minded people, and a strong sense of enjoyment from being part of the group and sharing in activities together.

> I met some people that were Christian. And we went to their place every day, every second day have coffee, read the bible, play guitar and sing songs, and just talked and have fun. (C-SC)

Aside from faith and personal values systems, one client also indicated that social preferences may not always align with the same-gender approach (men with men, women with women, etc.) often used by programs that assist with social connections.

> I don't know why, I'm just intimidated by [same gender]. I find [other gender] just easier to get along with. It's not a boy-girl attraction thing…something turned me off at some point, who knows…that's what I mentioned when they said they'd have somebody come over here and play cards with me, I said "yeah but they'd have to be [someone from other gender]". And that's the last I heard from them. (C-CM)

With regard to formal programming that helps people build their social networks, one therapist pointed to programs offered by Alberta Health Services and its contracted agencies specifically for people living with mental illness. Evidently, there was recognition on the clinical side that ameliorating social connectivity was a matter of addressing an identified barrier to recovery and other clinical outcomes.

> I refer many people to groups, many to Pathways, Prosper Place, everywhere…most people inherently want some form of connection, no matter how sick they are. There are

> those hard, hard cases, that basically don’t live on this planet, actually, but I think most people inherently want connection, human connection. (T-GA)

This sentiment was reiterated by another therapist, although with the caveat that not all people are oriented towards creating social connections.

> I mean some people really like to have activities and go out and do things, some people don’t. I think we can offer those things to them, but [therapists] also have to recognize some people just have never really been social, that’s just not their thing. And they just as soon [would] read books. (T-PE)

Moreover, another therapist commented about the lack of availability of services when clients appeared to need them the most: “no evening socializing [opportunities]. The days are long, I still think if you had social connections in the evenings, you don’t feel so lonely” (T-CA). This gap in social opportunities can translate to less than optimal opportunities being considered, as discussed earlier under Substance Use. The example one therapist gave of a client who had been mired in negative social connections due to cocaine and alcohol abuse could be attributed to a need for social activities after daytime program hours. In the case of this therapist’s client, he was able to make use of his outgoing personality to rebuild a more positive social network that he has been connected to for a long period of time, largely the result of connections made in group programming.

> In his case I think he’s always been a social being, he’s always been a very pleasant nice person. So people are drawn to him, but his major stumbling block was the cocaine. And once he got rid of that, he naturally flocked towards the community and friends…[for] seven years now, he still mentions the same friends…In groups, we don’t encourage people obviously to really become good buddies…but it happens, and some of those interactions go on through time and are very supportive. (T-GA)

Another therapist agreed that the relative benefit or detriment of a person’s social network, if they have one, is a function of their abilities to engage socially and the people they have around them due to their environmental contexts.

> They also learn off the people they associate with, and some of them have good [social] skills, some of them have bad skills. That's the downfall of a lot of these people, it depends on who they socialize with…a lot of them do come from really bad environments [in which] they learned to survive. (T-MA)

It was this entrenchment in bad environments that prompted one therapist to comment on the challenges that clients have when they are removed from those settings and offered a new, positive milieu in a supportive housing facility. These difficulties revolved around getting "them to socialize appropriately. Some of them didn't [learn that], they came from really bad stuff, and now they have to learn some social skills to come to the dining room" (T-PE). Nonetheless, it was suggested that a change in setting can relieve people of detrimental social interactions and produce much better opportunities that impact other aspects of a person's life. As with family, social networks can have an impact on a client's orientation towards recovery based on their characteristics and capacity to offer positive and supportive engagement. That said, feelings of loneliness, existing negative social contacts, and a lack of social skills can impair a person's ability or motivation to overcome challenges to establishing good social contacts – outside of formal support workers – in their lives.

4.2.3.4 Sense of Belonging

The concept of "sense of belonging" emerged as an important theme from therapists and clients alike. The term is being defined for the purpose of this study as the underlying basis for sustained social connections, the framework upon which the social network is rooted and people feel a sense of belonging that reinforces the relationships around them. Even housing, which can be considered more a part of the physical environment than the social one, contains elements that support social connections, as described above and by one client: "some people might feel more secure [in housing for people with mental illness] feeling they're with like-minded people with mental illnesses" (C-CM).

Several therapists applied a health promotion lens, pointing out that a feeling of social inclusion was a key social determinant of health. This was exemplified by one client participant who had a non-mainstream cultural identity and a very limited social network: the client would go daily to the ethnic grocery store to eat and enjoy the company of others who shared a similar background (C-TO). One therapist in particular identified this need for a sense of belonging as equivalent to other basic needs like food and housing.

> It's a problem across the board, but with this particular population it's social connections…because social life is that social determinant of health. It's basically about social inclusion, however way we talk about a social life like going to the gym, or hanging out with your friends, [or] being on a computer, all of those things. Your social life is [important] because we're social beings… you need food, you need secure housing, you need to be part of a social network and milieu. (T-CO)

As discussed under Social Network, group programs and activities offered to people living with mental illness serve as the main way that the mental health system promotes community and social connection. However, for some people, these places are less social opportunities but instead reminders of their marginalization and the fact that their primary social identity is often defined by their mental illness. Thus, as with one client, some choose to avoid these options for multiple reasons, even when struggling to make social connections in other ways.

> I don't know how to go about [meeting new people] to tell you the truth. Well, I can go to this Pathways group, but I went through a tour through it and I don't really want to go. I notice they sit around a lot in there, and some of them play cards or sometimes they play bingo and that, or they go outside and smoke and that. (C-CM)

For another client, experiences have been more about social exclusion as opposed to inclusion, despite efforts to make connections and find a sense of belonging.

> I just didn't feel like I fit in at all there…I found this a lot of places I go. I just don't find myself fitting in. So I do a lot more things independently now. (C-SC)

This idea of “not fitting in” was expressed by a therapist in relation to the challenges that some people feel when they leave inner-city environments to live in housing in other parts of the city.

> If you move someone to the west end or south side from the inner city, the people that they meet, they communicate in a certain way. They present themselves in a certain way, and you know people in these so called “normal” areas of the city, look at [our clients] and go, “ugh, that guy’s different”. (T-GA)

One therapist spoke about the need for a concerted focus towards overcoming differences and combating stigma (discussed under Perceptions of Mental Illness) based in the concept of community building.

> [We can help] by giving people a welcoming environment, where they don’t feel stigmatized…[by offering] community events, activities, that they can attend or participate in, to the extent that they wish or are able…I think community gardens are a fantastic way to go, [for] which, from my perspective, there’s a spiritual aspect to it. (T-CO)

Among therapists and clients, there was one type of community in particular that figured much more prominently than any other, namely faith-based communities or churches. Despite the system’s need to approach community building from a secular or, at the very least, non-denominational standpoint, there was a plethora of information provided by participants looking at the issue from this perspective. One client expressed that having a sense of belonging was fundamentally based on sharing values and beliefs with other people in a community.

> Well, it’s ways to be with people who have similar beliefs…and talk about things. Sometimes they talk about things that are troubling them, and so it’s a way to air out troubles and that, just listening to all the people with different things [they] have to say. (C-CM)

In addition to providing spiritual direction, involvement in a church also provided a much-needed venue for engaging with other people in order to start building social connections.

> They do a lot of social things, which are good…one of the ladies that goes to this church, after mass they have a social where people can come and just have some cookies and tea. And she really looks forward to that. (T-PE)

One client spoke very positively about being involved with several churches, primarily because of all of the activities the client was able to engage in with other people.

> Well when I was going it was great, it's like being on top of the world. I hung out with the Mormons throughout the whole summer last year. It was really fun, we [played] games and sports. And when I was in another church we were really having a good time [playing] games and stuff like that. (C-SC)

Nonetheless, as with most aspects of life with mental illness, perceptions of marginalization and alienation can be quite powerful. One therapist noted that a client had stopped going to a church social group because "they were very clique-y, so it was hard for her [because] she is a little odd in her appearance" (T-PE). With regard to the stigma associated with mental illness, another therapist had never heard anything about clients being excluded from participating because of their health issues or disabilities (T-DU). Similarly, another therapist commiserated from the standpoint of someone who attends church regularly that, in general, churches were intended to be welcoming places by virtue of the values espoused by the Christian faith. In essence, it was part of the faith and the belief system to welcome newcomers with open arms, especially those facing hardship.

> Well, the church is supposed to be open, they don't screen you whether you have a mental illness or you have physical [issues]. I don't see any hindrance, any obstacles for people going to church. I don't see that in my church anyway, [because] that's not happened in my church. Everybody can come, everybody's welcome to come. We don't have any kind of problem – either physically or mentally ill, they all come in to worship. It's okay. (T-MA)

One client indicated a desire to be associated with a welcoming church while at the same time expressing some concerns regarding the difficulty of navigating the various denominations and types of churches under the Christian faith. Specifically, the client noted challenges associated with trying to find the right congregation, especially when one subscribes to the core values and beliefs but not to the nuances of ritual and practice that vary among groups.

> I'd like [it] to be a non-denominational [church], because I don't want it to have their set of rules in this church. They're all Christian but they kind of are different, I don't like that. So I [would] like one that wouldn't have its own little [things]…[but] all churches have their own thing. And I'd like one that sort of accepts people of all walks of life. (C-CM)

Therapists seemed to be frequently addressing the need to help clients find connections based on faith, and many relied on resources available through the mental health clinic to provide some guidance when requests were made by their clients for assistance.

> Some clients [hold religion] very, very central to their core identity…If the client brings that forward I try to nurture that as much as I can. We have resources that are available at the clinic, most of those are unfortunately only Christian resources, but if they do identify any sort of church, or synagogue, mosque, whatever it might be, I'll certainly encourage that, and work as best as I can with it. (T-DU)

On one occasion, the spiritual support resources available through the mental health clinic were able to help a therapist who had a client who was engaged in a spiritual group that apparently would have taken social inclusion to an extreme and potentially dangerous level.

> There was one situation with one of my clients, actually I was really glad I involved [spiritual support resource] at the clinic here. She just knows more about the churches around the city than I know. As I said, if somebody brought religion to the table, then I was fully endorsing it, it was like "good, good let's use that, let's work with that". Because he was talking about religion so much I consulted with [spiritual support resource] and she was added to the treatment team for this client, and it turns out the church that he was going to is – for lack of a better word – a well-known cult…she knew it right away…I had no idea. That was a challenge in that regard and [with] my own ignorance, I didn't know [any better]. How am I supposed to know these things? (T-DU)

Of course, for those who do not subscribe to a particularly religious belief system or lifestyle (Christian or otherwise), there are few if any other options that have the social inclusion opportunities that are available through participation in a faith community. As a result, sometimes they are suggested as options by therapists, but clients may have strong reasons to not want to pursue these routes to overcome social isolation.

> I have been suggesting to one of my guys recently that, because of the loneliness, he try to find a faith community, but he was adamant “no”, and is very articulate about this, because he feels that religion has been used for oppression, and, you know, [he’s] totally right. But then he won’t explore perhaps there’s a couple of churches which are geared to diversity and change. (T-CO)

As much as churches and other faith communities offer so much potential for people living with mental illness to feel a sense of belonging, they also can present risks, especially for people who have high levels of religiosity combined with active delusional symptoms.

> Some of them go to church and they understand what’s going on in terms of the religion. And then there’s some that it’s not good for because, they may become ill, they become really incorporated in this delusional stuff… And you have to be careful because you don’t want to impose anything on them because some of them are pretty vulnerable and impressionable. (T-PE)

On a similar note, one therapist recounted how a client’s involvement with a faith group was a tremendous support for her, but presented significant challenges when her beliefs conflicted with those of others in the housing facility in which she lived (T-PE).

In sum, churches and faith-based groups are very useful avenues for people living with mental illness to seek social inclusion as a part of their journey towards recovery, providing a sense of belonging to a community with shared values. However, for people who are not religious, have other values systems, or are especially vulnerable or socially unprepared, moving from feeling marginalized by disability to social inclusion can be a much more difficult process with far fewer opportunities to pursue.

4.2.3.5 Security and Vulnerability

A key factor that emerged was the ever-present danger that people with mental illness face in the broader community. There were numerous examples of situations involving exploitation, abuse, and vulnerability of clients that emerged from both therapists and clients. For many people with mental illness, the prevalence of abuse in their lives has been continual, presenting a significant challenge for therapists and others who need to account for the impact of trauma on individuals (T-PE). One therapist talked about a client who had finally been doing well in a supportive housing facility after serially losing housing and experiencing violence at the hands of her social network in the inner city. Despite efforts by therapists to try to intervene and stabilize people in these situations, the effects of trauma can be long-term and cumulative, making progress on recovery a feat of assertive persistence.

> So it's just a juggling act with some, some people just to work with them so that you can keep them well enough to work with them, otherwise, like her, she just fires you and then she disconnects with everybody, and then she ends up somewhere – gets beat up, taken to hospital, losing your place…and that's happened to her so many times… (T-PE)

Further, as discussed in the Cognition section, some clients have limited capacity to make decisions in their own best interests, either due to developmental, acquired, symptomatic, or medication-related neurocognitive impairment. This leaves them vulnerable to unscrupulous individuals who try to take advantage of them, some of whom unfortunately are also the ones who are supposed to be caring for them.

> I do see the people I work with to be vulnerable adults, and by virtue of having a condition which would impair – either some of the time or at periods of time – judgment. So safety I think is definitely protection from others, whether those are people in the community or people who staff facilities. (T-CO)

Many people living with mental illness experience concurrent addictions, as discussed in the Substance Use section. This puts them into contact with (and in a state of co-dependence on) dealers, fellow customers, and ill-intentioned associates who at worst may try to exploit clients or at the very least present a continual temptation to spiral deeper into substance abuse.

> I used to have problems with one guy especially… some of my friends have brought other people here, street people here. Had trouble with a couple [who] wanted to do their hoots here, I said no…I [know all that] having a hoot of crackcane does is make you want to have another hoot, and then you start wanting to take the money out of your bank account you got for groceries to buy another gram of crack cocaine. (C-LW)

For this client, being situated in an inner city neighbourhood with high rates of homelessness, prostitution, and addiction introduced an array of unwelcome people who found their way into the building.

> I told [manager] a couple times that I had hookers coming here when I first moved in here, and [neighbour] got busted next door, he was having a whole bunch of hookers smoking crack in his place all the time. And they'd come over to my place, the hookers, bumming cigarettes all the time…So when he got busted and got kicked out of here, then I had hookers for a while here, until they finally at that point they were moving down to 118th Ave and not this area. Or just ordinary street people were coming, I had my door open all the time, they'd ask "can I come in and have a hoot?" (C-LW)

In the end, people living with mental illness find themselves disproportionately surrounded by "people preying on the weak" (T-DU) due to living in poverty and with so many vulnerabilities. This situation is so pervasive that one therapist described the phenomenon as an almost systematic pattern of abuse, primarily financial in nature.

> There's so many things seem to be colluding against them. I don't want to sound like a conspiracy theorist. It's not a conspiracy, there's a lot of money to be made off people who have less. (T-CO)

As discussed in the Housing section, landlords in the private market benefit handsomely from the limited choices available for people with mental illness. The commonality of clients living in terrible conditions or otherwise being exploited in the housing market suggests an intentional blindness to the injustices perpetrated on such a regular and predictable basis.

> I think our city is mistreating mentally ill people. You know they are the dregs of society, they are the ones that are easily taken advantage of, and landlords know it and they go for it. It makes me sick. (T-GA)

People living with mental illness are "lonely and afraid" (T-SA), isolated from family and friends to protect them and constantly needing to be on guard about who might be trying to exploit or harm them in some way.

If it were not enough that so many of the people in their lives had ill intentions, many people with mental illness find themselves vulnerable even in the places they go for sanctuary and belonging. One therapist spoke of the challenges in connecting clients with some faith groups because sometimes, nefarious motives belie their benevolent appearances.

> I'm concerned about some of them preying on these individuals because they're very vulnerable…I think sometimes they invite them for the whole day, they feed them…they think it's great, and then there's an ulterior motive where maybe they have to give them a bit of money, or something. It's just what I perceive with some of them, so you have to say "well I'd be a little cautious". (T-PE)

In sum, people living with mental illness experience an almost structured form of serial exploitation that places them in a state of continuous vulnerability. Being isolated and living in poverty appeared to be key contributors to increased risk of being targets of abuse and victimization. If having a recovery orientation necessitates engagement with the world around them, the issue of their lack of security from or powerlessness against predators is certainly a critical barrier.

4.2.3.6 Income and Poverty

The fact that so many people with mental illness live in poverty is a critical factor in determining their relative orientation towards recovery. As exemplified by the client participants in this study, some are unable to work, dependent on income support programs. The level of support received through AISH has increased from previous years, helping recipients to be able to afford essentials, especially if they are able to make additional money through paid work.

> [The AISH increase to $1588] certainly has increased some people's quality of life. They can just have nicer things…they may feel that they have a satisfying life. They work, maybe part time and they have clothes that they like, and they have a place to live that they like. (T-SA)

Unfortunately, for many clients, the prospect of working is not within their capabilities, so the potential of extra income for a higher quality of life is out of reach. For one client, going on AISH was a necessary evil that required acceptance of a diagnosis that the client refuted. Further, it also required succumbing to taking medications that from the client's perspective had both negative and positive effects.

> To make a little better living on my own, I can't do [it], I've tried and it's not possible. So I agreed that I need the medications to help me sleep and…I agreed to that point, [that] the [disturbance], well you call it a "mental illness"…is stopping me from being able to work. So I need to be on AISH, on income support, and I need that medication to sleep, because I got addicted to it right away…(C-LW)

As discussed in the Functioning and Functional Supports sections, poor money management skills are prevalent among clients. This makes living on low income that much harder to achieve critical securities like housing and food, particularly when their financial management and literacy supports are not in place.

> Some people they're just not going to get over that impulsivity when it comes to spending. They can learn what a savings account is and how to budget, and how to save for a rainy day, and how food is important…[but] they get their hands on the money and they just spend it…you can tell that they learned a lot, because you're discussing it with them, but is that successful money management? (T-DU)

Notwithstanding the ability to manage money appropriately, one client made it very clear that the only reason why survival was possible was because the client had an affordable rent as a result of living in a non-profit housing facility. Thus, affordable housing essentially made income support through AISH sufficient for living, compensating for the inability to supplement the benefit with employment income.

> No I wouldn't [be able to manage]. If I didn't have the low rent I have, to be able to buy groceries and eat healthy and pay my phone bill…I wouldn't be surviving. (C-LW)

One client spoke about the challenges with maintaining a healthy diet to deal with diabetes and other health issues, and how increases in income support were all but negated by the increases in food prices and the high cost of dietary supplements.

> Potatoes and canned vegetables, whatever I need for $200. Now I'm spending about $400. Plus, plus I'm spending $75 – 100 at the health food store for Stevia and probiotics, and Metamucil for my diabetes and my sugar levels. With this it seems like I used to have more money when I was making less than what I do now. (C-LW)

Aside from essentials like housing and food, income also plays a key role in the ability to live an active life and participate in the broader community. Social participation can be precluded by the inability to afford it.

> And I have enough money to eat every month. I don't have any financial capability to just go and do things. It cost money to go out for coffee, or go sit in a restaurant, or eat a meal. I can't afford that kind of lifestyle. (C-LW)

Similarly, the cost of virtual connectivity, via the internet and media, in effect encloses people with mental illness if they are in a state of poverty.

> It's $145 dollars with telephone and tv bills, plus this Fall I got my cell phone so that's $35. $175, $180, and I went through my first years here with just a tv with rabbit ears, and I didn't have a a tv bill. All I had was just whatever it was $15, $20 for my telephone. (C-LW)

In sum, there are many issues that affect people living in poverty, including income support benefits, the cost of living, and the cost of social engagement. Living in poverty, an experience shared by many people with mental illness, thus reinforces barriers that promote a disability orientation and keep clients disconnected form the world around them.

4.2.3.6 Perception of Mental Illness

The impact of people's perceptions about mental illness, particularly negative attitudes or 'stigma', emerged as a key determinant in a client's relative orientation towards a recovery.

Stigma appears to have a foothold in social institutions. One prominent example is the way that the justice and law enforcement systems reinforce prejudices against people with mental illness. Four of the clients interviewed had interactions with the justice system, with one referencing a criminal record (C-CM) and another recounting time in jail (C- TO). Even with pardons, access to employment and even volunteering opportunities remain limited due to criminal records, thus preventing people with mental illness with significant justice system interactions from engaging the broader community to aid in recovery.

> I liked talking to the elderly people because they seem…nice and pleasant. But I have a criminal record and I can't volunteer anywhere. I'd like to volunteer at a seniors place, but I can't, I was told, they can't take me because of bonding reasons or whatever. (C-CM)

With or without a criminal record, people with mental illness face further limitations on social participation as a result of biases in the justice system. One client spoke about being denied entry by border security in the US because of the presence of the client's anti-psychotic medications (C- TO). Another client referenced how travel is restricted if one had a history of mental illness, even with a pardon for past criminal activities, due to information sharing between law enforcement agencies on a person's psychiatric history.

> I could never leave the country, even with a pardon. I watched a show on W5, even if you don't have a record, but if you have a mental health history of suicide, they'll turn you back at the border of the States…the RCMP gives the information to the Americans and then we're considered potential dangers or threats. (C-CM)

The media was considered a central agent in the persistence of stigma, promoting a biased public discourse on the subject that alienates people living with mental illness.

> What you read in the newspaper, the media, gives all of us some kind of [false] information… there is that stigma that they're ax murderers or whatever. That's the kind of thing that you have to dispel, that myth. (T-PE)

The system further adds to prejudices by creating policies that in effect assume that people with mental illness pose a danger. The potential of violence perpetrated by mental health clients has promoted the adoption of ’work alone‘ policies by service providers that protect workers who do home visits through mechanisms such as frequent check-ins (Canadian Centre for Occupational Health and Safety, 2016). These may have utility from an occupational safety perspective, but the underlying assumptions were not lost on one client.

> Every ten minutes they would be phoning her asking her “are you okay, are you okay?” She says “well they do that because I’m in your apartment”. I understood it but at the same time I was a little offended by it. (C-CM)

Moreover, clients can find themselves being judged through the lens of mental illness for every behavior, with the inability to express emotional responses without them being interpreted as a symptom or sign of relapse.

> I was [not] having a mental health crisis. I was just mad at life. It’s a normal human emotion, there again. The anger emotion is an emotion every human being has. That doesn’t mean you’re mentally ill because you get mad. (C-LW)

One of the chief problems associated with continuing stigma is the impact it has on people who are unwilling to accept diagnoses of mental illness because of the prejudice it affixes to them from that point on. For one client, the prospect of moving from non-profit housing provided by a mental health organization into a seniors residence was viewed as a way to get away from the stigma: “if I move into the seniors place, that’ll have nothing to do with mental health…” (C-CM). Another client spoke about the stigmatizing role of diagnoses and the client’s own rejection of the labeling, despite acceptance of the underlying medical rationale.

> I may have a medical condition I will call it, but I would not call [it] a mental illness or schizophrenia. [The] psychiatrist might be right in some things in their assessment of people, but they’re wrong in calling people schizophrenic…I’m not a schizophrenic and I don’t appreciate being called one. (C-LW)

In the end, people with mental illness simply want to be viewed no differently than others living with a range of other illnesses, and be able to pursue the same goals as everyone else in society. In other words, clients just want to be "normal", having normal goals living normal lives.

> For some people it's employment, [for] some people it's moving out of a group home into an apartment…Some people want to have a car, some people want to have things that they see other people have. They would feel more recovered, more normal. (T-SA)

The mental health system itself plays a role in perceptions of mental illness in society, but has been criticized for not doing enough to push the anti-stigma agenda, both internally and externally. One therapist raised this not as an issue of undefined roles, but competing responsibilities in an overloaded system.

> Because of the demands on mental health services, not much attention is placed on…education and health promotion. And it should be in a national service framework [to] provide education [and] health promotion… (T-JO)

In many ways, combating stigma by changing the frame of discourse from disability and dangerousness to recovery and normalcy is one of the most essential steps in supporting clients to adopt that orientation themselves.

> So whatever word you want to attach about it…it's still what it means to the person…whatever the word recovery does, that is the person's ability to go out there…I think recovery and in terms we're using it nowadays, is more around those social forces [that support] living and integrating in society, and it's sort of the last piece of mental illness, that stigma piece…recovery is starting to look more like the anti-stigma campaign, more than wellness to me. (T-CA)

As a way of combating stigma, one client offered advice to others a matter of speaking up against the practice of labeling: "don't let the doctor condemn you, or feel condemned, because a doctor called you a schizophrenic and you're mentally ill" (C-LW).

With ever-present negativity with respect to public perceptions and discourse about mental illness, clients seeking recovery find themselves in a difficult position of trying to reconnect with society while being pushed out of it. However, the conversation still leaves out those with severe mental illness, with justice system prejudices about propensity of violence intersecting with high profile incidents reported in the media. In the end, changing society's view of mental illness remains both an extremely discouraging barrier and a powerful avenue for clients to be able to adopt a recovery orientation.

Chapter 5: Discussion and Conclusion

In this chapter, the results from the previous two chapters are discussed within the context and framing of the two research questions guiding the study. The research questions were as follows:

(1) How and to whom was the PSHP project delivered, and to what extent did PSHP project delivery address factors related to achieving recovery orientation, independent living, and other intended outcomes of the PSHP project program model?

(2) From the perspective of participants, how do the expected outcomes in the PSHP project program model relate to each other, and what other factors not included in the original design contribute to recovery and independent living for people with mental illness?

The chapter begins with section 5.1, re-examining the program logic model for the PSHP project and expanding it to incorporate other recovery-related factors that emerged from analysis of participant interviews and client files. These factors are discussed as interacting elements in a multi-domain system, represented as an ecological framework called the *Recovery Wheel* to answer Research Question 2. The Recovery Wheel framework is supported in the discussion by drawing on literature related to the factors in each of its domains. The results from the analysis of PSHP project delivery are discussed in relation to each of the domains in the Recovery Wheel to address Research Question 1. Also related to Research Question 1, client participant recollections of their participation in the PSHP project are discussed in section 5.2, followed by an examination of the role of peer workers with respect to the discussion in sections 5.1 and 5.2.

This chapter closes with section 5.3, which presents the limitations of the study, suggestions for improvement of study design, and considerations for future research, followed by a conclusion summarizing the key findings of the study (section 5.4).

5.1 Understanding Recovery as a Multi-Domain Construct

In section 4.2, a revised logic model was presented based on the results of analysis of client and therapist interview data related to factors that contribute to recovery and independent living, two key intended long-term outcomes of the PSHP project. The revised logic model is presented again in Figure 15 below.

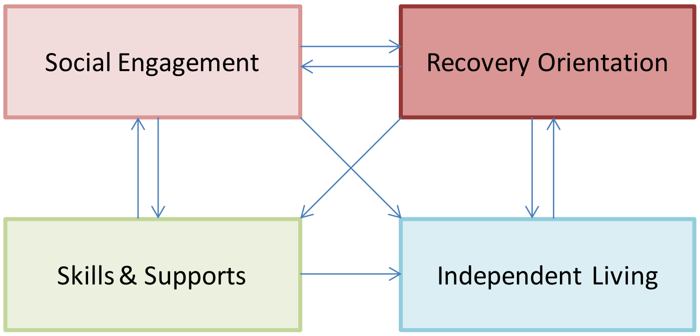

Figure 15: Repositioning of interrelationships among PSHP project intended outcomes.

This revised logic model diverges considerably from the linear model initially conceptualized for the PSHP project, suggesting reciprocal and sometimes circular interrelationships among the intended outcomes. It is evident in the analysis that there is only one outcome that essentially encompasses all the others initially described in the PSHP project and that guided this study, namely recovery orientation. Based on analysis of participant interview data, factors involving a person's characteristics, their immediate social environments, service systems, and society in general, appear to combine and interact to either facilitate or hinder recovery.

For example, symptoms of psychosis that respond to medication and thus are well controlled can free people from a disability mindset (T-GA). However, some people have persistent, arguably treatment-resistant voices, but learned to manage them to the extent that their intrusion into daily life is not overwhelming (C-LW). On the other hand, some people do not outwardly exhibit symptoms, but are essentially disabled by their medication (C-TO). For some in this situation, the extent to which they have people checking in on them may determine whether overmedication is detected and someone is able to resolve the issue with the psychiatrist (T-PE). This is further complicated by the orientation of the mental health system towards short-term crisis response and long-term nominal maintenance (T-SA), as evidenced by the twice yearly, 5-minute psychiatrist visits mentioned by therapists and clients alike (C-CM, T-CO). This approach is generally lackluster in supporting and empowering people with histories of chronic, long-term disability, many of whom have underlying intellectual or cognitive impairments (T-DU) and require easy and comprehensive access to instrumental support to make up for functional deficits (T-MA). Their low level of functioning leaves them in a state of vulnerability to financial exploitation and neglect by housing operators (T-GA), ever-deepening their poverty and social exclusion. Stigma and apathy prevent this sad reality from driving real change in how society or institutions treat and support people with mental illness (T-JO).

Thus, there are numerous factors that seem to intertwine and have some impact on the level of disability, or, on the other end, extent of recovery, but none absolutely determine either. This speaks to the need for a more sophisticated framework for understanding how recovery can be achieved and the factors that may contribute or get in the way.

5.1.1 Theoretical Foundation – Ecological Model

In their report *Perspectives of Indigenous Participants in the Housing First Program*, Bodor and colleagues (2011) conceptualize healing and recovery as a balance among the four directions of the Medicine Wheel in pursuit of “the good life”.

> From a Western perspective, housing stability of formerly homeless individuals and families is a first step towards individual self-sufficiency in society. From an Indigenous perspective, housing stability of formerly homeless peoples is a starting point from which Indigenous people can get onto the path of *miyo pimâtisiwin*, the good life — a journey

> of healing into balance between physical, emotional, mental and spiritual aspects of self in relationship with other beings (p. 20).

Being on the path to *miyo pimâtisiwin* is in line with common conceptualizations of recovery as both a direction in which one is oriented as well as a state of being that is not so much an end as an ongoing process to be nurtured (Leamy et al., 2011). Moreover, the implication of balance among different aspects of people and the world around them fits well with the way in which the factors that emerged from analysis interact with each other to promote or constrain this 'journey of healing'.

From a theoretical perspective, the First Nations medicine wheel offers an ecological framework for conceptualizing recovery. Applying an ecological approach "can incorporate constructs…that focus on psychological, social, and organizational levels of influence… along with consideration of environments and policy in the broader community" (Sallis et al, 2008, p. 466-467). In many ways, the interactions among factors emerging from the data to promote a recovery orientation appear to fit the four core principles of ecological models of health behavior as described by Sallis, Owen, and Fisher (2008). First, it is evident from the perspectives of participants that there were as many extrinsic factors as intrinsic ones in terms of making life easier or more difficult for people living with mental illness. In many ways, the factors that emerged from analysis coincide with the socio-ecological model of health promotion proposed by McLeroy at el (1988) and can be considered relevant to its conceptualization of ecological domains, namely intrapersonal (developmental history, skills), interpersonal (family and friendship networks), institutional (social institutions, rules and regulations), and community processes or factors (laws and policies). Secondly, factors appear to affect each other in all domains, either compounding or cancelling their respective effects in complex interactions. Finally, key influencers, from a person's own characteristics, like cognitive capacity and upbringing, to external factors, like the structure of the mental health system and societal prejudice, have a bearing on their likely orientation, as emerged from the analysis of participant interview data. Consequently, achieving recovery appears to be dependent on a constellation of factors for which multiple interventions in multiple domains are required, and whose interactions are fundamentally complex and interrelated. Thus, applying an ecological model can help to understand what factors should be considered in program design and system re-orientation in the interests of promoting recovery for people with mental illness.

5.1.2 The Recovery Wheel Ecological Model

For people with mental illness, factors in each ecological domain determine to what extent a person is oriented towards a disability or a recovery identity. The net outcome – i.e. from the compounding or cancelling of interactive effects at all levels – may provide guidance regarding whether an individual is oriented more towards a disability identity or towards a recovery identity. The indigenous medicine wheel approach has advantages that could bridge some of the connectivity deficiencies inherent in Western linear thinking and pervasive in extant models. Figure 16 illustrates a model based on the medicine wheel for connecting the different ecological levels, encompassing the multiple factors that emerged from analysis.

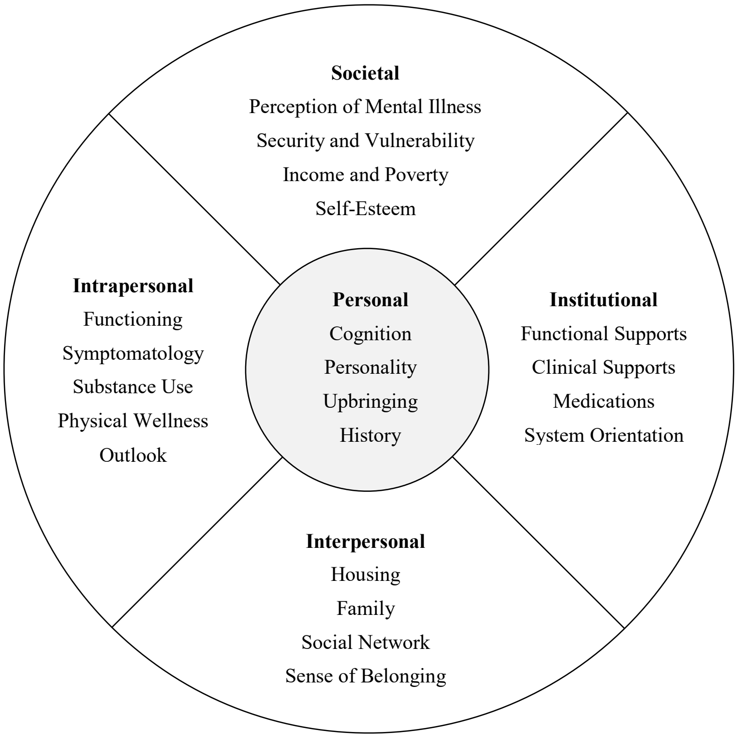

Figure 16: Recovery Wheel Ecological Model

The personal domain of the framework consists of factors that are essentially static, forming the hub of the Recovery Wheel. They are built into the essence of the person, from intrinsic traits and dispositions to extrinsic impacts from the family environment in childhood and the trajectory of their lives. Considering these qualities as purely static does not account for the ability of people to overcome aspects of their personal history and traits, but that is an endeavor in which success may be more exception than rule. Four factors emerged in the personal domain based on the perspectives of participants: cognition, personality, upbringing, and history. The semi-permanence of these aspects, and the extent to which they tend to define a person over the long-term, are what position them at the core of the wheel instead of the intrapersonal domain.

The intrapersonal domain includes factors that are intrinsic to the person, albeit affected by externalities and subject to change over time. This contrasts them against factors in the personal core of the wheel, in that they are aspects of a person that can be altered for better or worse, and thus could be the target of appropriate interventions. In essence, the intrapersonal domain shapes how people think about themselves, the world around them, and the future. The intrapersonal factors include functioning, symptomology, substance use, physical wellness, and outlook.

The interpersonal domain of the Recovery Wheel includes aspects that relate to a person's immediate interactions and relationships with people around them, namely their family and non-family ('social network') relations. Two components not traditionally included in this ecological domain have been incorporated, namely housing and sense of belonging. Because people living with severe mental illness who are dependent on the mental health system are often relegated to seeking housing exclusively through the rental market or social housing providers, the concept of housing becomes more of a personal relationship as opposed to typical considerations of housing as a factor within the physical environment. In many ways, the landlord-tenant relationship is a special one, akin to family in some respects. For example, a landlord can enter one's personal space, albeit with 24-hour notice (Residential Tenancies Act, RSA, 2004), a privilege afforded few others, even family and friends. Further, one's tenure is essentially bounded by the extent to which the personal relationship with the landlord is positive, or at the very worst neutral. If the relationship sours, the likelihood of being evicted grows tremendously. Thus, the relationship of a person to their rental housing is a brokered and personal one, not solely a manifestation of the immediate physical environment. Sense of social belonging is another factor that has been included in the interpersonal domain of the Recovery

Wheel, and this aspect was included in the community level of the socio-ecological model (McLeroy et al., 1988). Social belonging essentially governs a person’s primary relationships and interactions with family, friends, and acquaintances within their social networks, in addition to society and the broader social milieu in the community. In this context, it is appropriate for social belonging to be included in the interpersonal domain.

The institutional domain includes factors that are largely based in the system of supports and treatment that people with mental illness access to address their needs. In some respects, the mental health system and its various clinical and functional supports can be perceived as a monolithic and imposing structure while also providing indispensable support for people who can engage with it. In this light, the institutional domain of the Recovery Wheel includes the many roles of the mental health system, including functional support, clinical support, medications, and the values and biases that underlie its framework (‘system orientation’).

Finally, the societal domain of the Recovery Wheel includes factors that correspond with the ways people living with mental illness are impacted by the larger societal factors around them. Its aspects are ethereal and omnipresent with little if any capacity for a person to effect change in this area without external, society-level intervention and systems-level change. At the same time, these factors have significant effects on the lives of people living with mental illness, in many ways governing their ability to relate or interact with their social networks and the broader community. Four factors emerged in this domain: income and poverty, security and vulnerability, perceptions of mental illness (which includes stigma), and self-esteem. While self-esteem could be considered a factor more intrinsic or intrapersonal in nature, it is deeply rooted in the relationship, perceived or real, between people living with mental illness and the world around them.

5.1.3 Situating the Recovery Wheel within other Ecological and Recovery Frameworks

The Recovery Wheel departs from the socio-ecological model of health promotion proposed by McLeroy and colleagues (1988) by splitting their intrapersonal level into the personal domain (at the hub of the wheel) and the intrapersonal domain of the wheel. The interpersonal domain is essentially consistent with the socio-ecological model, but includes factors that were not considered in the health promotion model. The institutional domain of the Recovery Wheel is reserved for the mental health system as the predominant institution or organization affecting people living with mental illness. The societal domain of the Recovery Wheel has closer association with Bronfenbrenner’s (1994) exosystem and macrosystem levels, as they pertain to institutions, belief systems, opportunity structures, and hazards.

With regard to recovery frameworks referenced in the literature review for this study (in section 1.5.3), the Recovery Wheel incorporates many of the components included in other models, but differs in its focus in some critical ways. In essence, the Recovery Wheel speaks to factors that *promote or constrain* recovery, as opposed to defining the recovery process or its hallmarks. For example, the CHIME framework (Leamy et al., 2011) of connectedness, hope and optimism, identity, meaning in life, and empowerment, serves as a way of defining the recovery process from the perspectives of people living with mental illness. Other frameworks (Onken et al., 2007; Davidson et al., 2007; & Drake & Whitley, 2014) address a variety of areas, but tend to omit factors at the individual level (personal and intrapersonal domains). Connections between previously published recovery frameworks and the components of the Recovery Wheel are presented in Table 17 below. In the table, factors from the Recovery Wheel are presented side-by-side based on the student investigator’s perception of best fit with components described in section 1.5.3, which were derived and summarized from the studies referenced.

Recovery Wheel	**Leamy et al. (2011)**	**Onken et al. (2007)**	**Drake & Whitley (2014)**	**Davidson et al. (2007)**
Personal				
Cognition				
Personality				
Upbringing				
History				
Intrapersonal				
Functioning		Re-authoring (coping, healing, wellness, thriving)		
Symptomology				Managing symptoms
Substance Use				
Physical Wellness				
Outlook	Hope and optimism	Hope, Awareness and potentiality		Renewing hope and commitment
Interpersonal				
Housing			Safe and private housing	
Family	Connectedness	Social functioning	Meaningful relationships	Engaging in meaningful activities
Social Network				
Sense of Belonging		Social connectedness	Normative life processes, Social connectedness	Linking to the community
Institutional				
Functional supports		Social opportunities		Addressing basic needs
Clinical supports		Choice among meaningful options	Empowering relationships with providers	Ensuring care continuity, Being supported by others
Medications			Input on medications	
System orientation		Choice, Self-determination, Sense of agency	Agency in treatment decisions	Focusing on needs not diagnoses, Peer-based delivery, Individualized planning
Community				
Perception of mental illness	Identity	Stigma		Viewing people as citizens, Addressing discrimination, Overcoming stigma
Security and vulnerability			Protection from victimization	Assuming control
Income and poverty		Integration	Employment and income, resulting in self-esteem	
Self-Esteem	Empowerment, Meaning	Power, Meaning		Becoming empowered

Table 16. Comparison of factors in Recovery Wheel versus those in other recovery frameworks.

The frameworks in the literature tend to include factors external to the individual, with the exception of hope or positive outlook, and some reference to physical and mental wellness. For the most part, special attention is paid in these frameworks to institutional and societal levels, likely a consequence of the authors' focus on the ubiquitous issues of stigma, social marginalization, and mental health system deficiencies. In many ways, the Recovery Wheel fills a gap in existing frameworks by paying attention to the individual-based factors (personal and intrapersonal domains of the Recovery Wheel) that ultimately serve as the starting point for any interactions with the external environment. Neglect of these factors in other recovery frameworks, while arguably avoiding defining people according to illness and biomedical perspectives, can also be interpreted as an invalidation of the real struggles people with mental illness face in terms of clinical phenomena and life circumstances. Because the participants engaged in this study were mostly therapists with only a few clients contributing data, the clinician perspective may have influenced the emergence of these factors, although client data tended to provide support for them as well. In the end, discussion of the factors that emerged in each area of the Recovery Wheel sheds light on how to promote recovery orientation among people with mental illness.

5.1.4 Discussion of Personal Factors in Recovery

The factors that emerged in the personal domain necessitate special focus to acknowledge their long-standing effects and, by their nature, the limits they impose on intervention modalities at other levels. In many ways, they act as a foundation for other levels, either confounding or facilitating their respective roles in promoting recovery.

5.1.4.1 Upbringing

Upbringing was identified as a key factor impacting clients in two particularly salient respects. The first is through the potential for early family life to impart living skills that are carried into later years. For some clients, their initial training for fulfilling tasks of independence such as cooking, cleaning, and money management was gained from their parents. These can be carried into adulthood and act as a key buffer to support housing stability and independent living in the community. The second effect is through the long-term impact of adverse childhood experiences, including family dysfunction, abuse, and witnessing lateral violence, on mental illness in adulthood and corresponding functional and clinical outcomes (Rosenberg et al., 2007; Chapman et al., 2004; & Anda et al., 2006). In a study by Stumbo and colleagues (2015), 94% of their sample reported adverse experiences either in childhood or as adults. Three of the clients interviewed (C-CM, C-SC, C-LW) expressed that this characterized their early lives and had an impact on them. Clinicians assessing people's capacity for independent living or need for skill development could learn a lot from their upbringing in planning for how best to support them on their recovery journeys.

5.1.4.2 Cognition

There appeared to be a fundamental nature to the impact of cognitive impairment caused by developmental or acquired brain injury, or even mental illness itself (Vohringer et al., 2013; Tsitsipa & Fountoulakis, 2015), in terms of its potential to be an almost irrevocable barrier to achieving outcomes like recovery or independent living. Perhaps the most frustrating aspect of cognitive impairment is that clinicians are essentially powerless to address it from a medical model (Goff et al., 2015), but it has such insidious effects in all areas, notably the potential for victimization and the ability to conduct instrumental activities. Moreover, medications themselves were noted as causes of cognitive impairment, a phenomenon well-understood as a frequent (and often dose-dependent) side effect of antipsychotic medications (Tandon, 2002; Gardner et al., 2005). In contrast to the challenges of having low intelligence or cognitive capacity, people with higher intelligence may be better positioned for recovery orientation, as they may have more confidence in their ability to overcome challenges, as was the case with C-LW. Cognitive elements like intelligence, motivation, and working memory have been associated with educational level and literacy (Alloway & Alloway, 2010; & Farsides & Woodfield, 2003). Further, higher cognitive performance has been associated with greater insight and positive self-evaluation (or self-esteem) in psychotic illness (Cooke et al., 2007), as well as employment tenure (and therefore, arguably, financial self-sufficiency) for people with severe mental illness (Gold et al., 2002). On the other hand, lower intelligence has been associated with increased risk, persistence, and co-morbidity of schizophrenia, depression, and anxiety (Koenen et al., 2009). However, higher intelligence produces its own challenges for care, in that programming and services geared towards those who require more intellectual engagement appears to be largely non-existent.

5.1.4.3 Personality

Personality appears to be largely ingrained in heredity (Bouchard & McGue, 2003) and, in adults, is largely stable across the lifespan (Andersen & Bienvenu, 2011). Thompson and colleagues (2003) refer to recovery styles that are seen as personality traits that are also stable across time: an integration recovery style incorporates the experience of psychosis into wider life experience, while a sealing-over style isolates the experience of psychosis, considering it a disruption; the latter group has been shown to have better outcomes over the long-term (Thompson et al., 2003). Even with depression, which by its nature effects affect and temperament, some personality traits change with recovery while others are more enduring (Peselow et al., 1994). Having a personable and positive attitude impacts a person's overall outlook and sense of self-efficacy (Franz et al., 2014), although this might be a reciprocal effect. A more "dour" personality, on the other hand, may promote social withdrawal as a result of less positive interactions with others, as expressed by C-CM.

5.1.4.4 History

For people with histories involving the legal system or other regrettable actions committed while acutely ill, these can reduce willingness to 'get out there' and meet new people for fear of what others will think if they find out about their pasts. Mezey and colleagues (2011) suggest that the stigma of being an offender combines with the stigma of living with mental illness to create serious barriers to recovery and independent living. Interestingly, being labeled as "forensic" is not associated with higher levels of self-stigmatization, but histories of incarceration or homelessness are (Livingston et al., 2011). It is unclear from the literature if personal history interacts with personality traits. This appears to be the case for C-CM, although the three other clients who were interviewed expressed similar reservations in some way.

5.1.4.5 PSHP Project Delivery in the Personal Domain

In many ways, the PSHP project was not built to address most factors in the personal domain. Explicitly within its criteria for referred clients, it excluded people who had lower cognitive capacity because there was an expectation that clients would learn new skills from the peer workers. Certainly, based on the clients who participated in the study, there appeared to be a more intellectually capable group served by the project, although it is possible that other clients may have been served who had lower cognitive capacity. Further, in the criteria used to solicit referrals to the project, people with histories of violent behavior were excluded from participation. It is unclear to what extent a criminal record may have played a part in determining eligibility, although it would appear that at least four (out of five) of the client participants in the study had a criminal record based on their interview data, with one indicating involvement with forensic mental health services. Nonetheless, in the delivery of the project, histories of clients were not discussed in the client files and thus not a focus of the peer workers' efforts. Similarly, there was little regard for the upbringing of clients, especially within the context of deciding on the right type of intervention for them. A case in point in this regard was the experience of Client D, who had learned independent living skills and attitudes from the client's early years at home, but was subjected to regular training modules that appeared to grate on the client's patience.

There was mixed evidence of the project's ability to serve people with challenging personalities. In the case of Client B, services were terminated by the client because there was no interest in participation. While it was not mentioned in the client's file, the client acknowledged having a self-deprecating personality that was likely the root of the client's unwillingness to participate. Moreover, internalized stigma may be at the core of some people's expressions of isolationist personalities, and may feed into reluctance to participate in programming like this. The PSHP project should be able to help individuals who may be shy or socially abrasive as a stigma-defense mechanism, as they are likely the ones who are at greatest risk of isolation and abandonment. On the other hand, the PSHP project did demonstrate some capacity to work with individuals with challenging personalities. Client E acted aggressively and insulted the peer workers when they were more directly addressing the client's hoarding issue, but the peer workers continued to serve the client until the OT decided to end service.

5.1.5 Discussion of Factors in the Intrapersonal Domain of the Recovery Wheel

Factors emerging in the intrapersonal domain of the Recovery Wheel are mostly psychological in nature, aside from the concept of wellness, which may be regarded as a subjective outcome of physical health. By placing these typically primary elements of recovery to one side of a larger framework, it stresses the interrelationships between these factors and others that lie outside of the psychological sphere.

5.1.5.1 Functioning

It is evident that clients' level of functioning is a significant factor in determining their path towards recovery. To some extent, programs that were mentioned by therapists, like Practical Supports and ILS, are geared more towards lower functioning individuals who require significant assistance with instrumental tasks. Some clients indicated areas in which they desired assistance such as food preparation and cleaning. However, in light of their higher functioning level, it is unlikely that they could access lighter assistance, particularly at times when symptoms are more prominent or medications are causing amotivational side effects. In essence, there is a state of limbo for clients who are higher functioning, but not so high that they require no assistance at all, ever.

While therapists speak often about individualized supports, the system is clearly not structured in a way to individualize assistance to help higher functioning clients. For lower functioning clients, the lack of adequate supply of supportive housing leaves many of them unsupported and at risk of eviction because the level of support they require is simply not available. They would also not be able to live in affordable housing programs that require the ability to perform instrumental tasks by oneself. There appears to be a ‘sweet spot’ for level of functioning that could allow for adequate support, but none of the clients in the study, and few mentioned by therapists, appear to fit this mold. Ultimately, functioning is a key consideration in ensuring that clients have the right supports available to promote recovery, but those who are either too high or too low functioning appear to have challenges in accessing this.

5.1.5.2 Substance Use

Substance use is clearly an important factor in recovery, in that it seems to serve both positive and negative roles. There is a clear evidence-base on co-occurring disorders and the challenges they present to treatment modalities and provision of supports (Drake et al., 2001; Tsemberis et al., 2004; & Dixon, 1999). Therapists were unanimous in raising addiction as a major barrier to recovery and an ongoing and predictable negative outcome in clients’ lives. However, the more salient point emerging from the study is that substance use is as much part of the lives of people living with mental illness as it is with the general population. With frequent conflation of the concepts of substance use and addiction, there is often a sense that any substance use should automatically be considered problematic, especially in the case of people living with mental illness. However, results of the 2013 Canadian Tobacco, Alcohol and Drugs Survey suggest that use of alcohol, tobacco, and illicit substances is fairly common in the general population (Government of Canada, 2015). There is apparent dissonance between the idea that recovery is a normalizing process, while at the same time people are forced into a sobriety-only value paradigm that does not exist in normal society.

For C-LW, there was a constant fear of eviction as a result of smoking marijuana, not to mention the client's experience being hospitalized for use on one occasion. As described by more than one therapist, use of drugs and alcohol is inherently part of many social activities, particularly for those with few other social options. Harm reduction approaches have been applied in Housing First programs and inform shifts away from zero-tolerance policies in affordable or supportive housing settings (Pauly et al., 2013). Incorporation of harm reduction within the mental health system is important so that psychiatrists and other mental health professionals can reconcile with the lived experience of their clients. This will be difficult, especially for psychiatrists, because of the ongoing battle regarding the linkage between drug use (most notably marijuana, but also stimulants like cocaine and methamphetamine) and schizophrenia (Arsenault et al., 2004; van Os et al., 2002; & Callaghan et al., 2012).

5.1.5.3 Symptomology

A paradox emerged among clinicians who, on one hand, seemed to group diagnoses according to how disabling they are, and, on the other hand, suggested that specific symptoms were more telling of prognosis. Therapists' negative opinions regarding the likelihood of recovery from paranoid schizophrenia and PTSD were juxtaposed against stories of individuals who overcame these apparently intractable illnesses to achieve independent living and return to gainful employment and normalcy. Further, even having active hallucinations and delusions, the focus of most treatments for schizophrenia (Kapur, 2003), does not necessarily make them disabling, as most therapists spoke of clients who lived with active symptoms and managed to live rewarding lives. For two client participants (C-TO and C-LW), voices and delusions were part of their everyday lives, and they had learned to cope with them and, to an extent, mitigate the effect that they had on their lives. Although some therapists seemed to suggest that depression was not as difficult to manage as psychotic or personality disorders, Resnick and others (2004) found that severity of depressive symptoms was strongly and negatively correlated with low recovery orientation. Thus, there may be merit in looking at how clinicians manage depressive symptoms for individuals with other co-occurring disorders as it may be a key to recovery.

5.1.5.4 Wellness

Physical wellness emerged as a significant factor in recovery, albeit one that appears to receive little consideration by the mental health system. Access to primary care physicians was described by some therapists as a necessity, but examples shared by the participants seem to suggest that this is not commonplace. It is alarming that, despite a high rate of physical ailments like diabetes among people with mental illness (Prince et al., 2007), the finding that cardiovascular disease is the leading cause of death worldwide for people with schizophrenia (Azad et al., 2016), and the propensity for some medications to cause illness (Newcomer, 2005), connecting clients to clinicians and programs to support healthy living is more of an afterthought than a central part of the care plan. In the end, people living with mental illness need much more attention paid to their physical health and corresponding resources to support their wellness in order to promote recovery.

5.1.5.5 Outlook

It is not surprising that people’s perceptions of their future, or outlook, would emerge as a factor in recovery, as hope is frequently included in recovery models in the literature (Leamy et al., 2011; Onken et al., 2007; Davidson et al., 2007). What is surprising, however, is how few times "hope" was referenced directly by either therapists or clients. Semantics aside, it is clear that having a positive outlook was identified as a key component to recovery in therapists and clients alike. This entails having some goals or aspirations for the future, including both secular and religious types. On the other hand, having a poorer outlook may be a consequence of living with an affective disorder: Schrank and colleagues (2014), in exploring the interrelationships among symptom types, hope, self-stigma, and insight among people with schizophrenia, showed a stronger negative connection between depression and hopefulness than any other variables tested in their study. Aside from clinical correlates to hopefulness, having money in the bank was what made some clients positive about the future. Thus, it would appear that outlook is as dependent on other factors as much as it is, in and of itself, an influence on recovery orientation.

5.1.5.6 PSHP Project Delivery in the Intrapersonal Domain

There is considerable evidence that peer workers addressed many of the factors in the intrapersonal domain of the Recovery Wheel in their work. Functioning would appear to be the factor that was most directly relevant to the PSHP project delivery model, in that most of the activities were related to addressing clients' need for independent living skills training in specific areas. Nonetheless, there was no formal assessment referenced in the case files, thus it would appear that people were referred to the project even if they did not need skills training. Utilization of a tool to assess independent living skills could be a simple way for peer workers or others to assess the level of functioning of an individual. In Client D's case, the peer workers offered living skills training on cleaning and money management despite the client having indicated that those skills were learned from the client's upbringing in the family home. Notably, the peer workers recorded that Client D’s hygiene and apartment cleanliness improved drastically after several visits, suggesting that there was some effect, albeit likely motivated more by pride than new skill development. Nonetheless, the focus on instrumental skills training may have benefited lower functioning clients more than those who were higher functioning and more capable in daily living activities.

There was a fair amount of diagnostic diversity even within the small sample of client participants, with mental health issues like hoarding, schizophrenia, affective, and possibly even personality disorders represented. This suggests that the PSHP project design could potentially serve people with a fairly wide array of symptomology or diagnoses. Even though it was not an intended target for PSHP project delivery, symptomology was often discussed among clients and peer workers, as there were many case notes in which clients discussed what they were experiencing. This ranged from peer workers discussing problematic psychotic symptoms with Clients D and C to going through a hoarding book with Client E. In fact, Symptom Issues were the second most recorded PSHP project output after Cleaning. In many ways, it is not surprising that peer workers did not avoid conversations on a central aspect of their shared experience, namely the symptoms of severe mental illness. While the presence of symptoms is notable through a clinical lens, the impact of those symptoms is experienced and interpreted by the person themselves. Because of the fundamental subjectivity of this factor, it may be beneficial to view the person from outside the clinical sphere, with potential merit in exploring how peer workers could apply their lived experience to address clients’ self-perceived impact of symptomology on recovery.

Wellness was often addressed by peer workers, with regular application of a 1-to-10 scale regarding how a client was feeling that day. This accounts for the fact that Health and Wellness appeared as the sixth most frequently reported output by peer workers. The workers paid close attention to how clients felt in both physical and mental terms, on multiple occasions suggesting changes to daily routines or contact with psychiatrists to modify medication dosing or types. That said, there appeared to be little attention paid to general health in the referral process, and it was not an area for which peer workers received training or connections to other services (e.g., primary care networks). While there may have been an expectation that AHS would handle any kind of health or medical issue, it is clear from the findings of this study that there are often disconnects between mental health and physical health resources.

Substance use, while it apparently did not preclude referrals, appears to be an area that was not handled directly (less than seven mentions in case notes) and peer workers were more or less unprepared to address it. It is unknown to what extent the peer workers may have shared this kind of life experience as well, although due to the high proportion of people with mental illness who use substances, it is unlikely that none of the peer workers would have had this background. Again, this was an area for which the workers were not trained, and no linkages were made either, other than support from the OT/OTA in notifying therapists if substance use was becoming a problem for the client. As the PSHP project was delivered at a time when integration of mental health and addiction services was still in its infancy in Alberta, it is important to consider how a peer-based service could incorporate both application of lived experience and harm reduction to address client needs. As most addiction services and related peer support (like Alcoholics Anonymous or Narcotics Anonymous) follow an abstinence focus, not to mention the risks associated with connecting active substance users in a service provider-recipient relationship, this is an area that will be difficult to explore without significant changes to the current paradigm. It will be challenging to transcend the dominance of ideological perspectives in integrated mental health and addiction care to test alternative approaches based in harm reduction and normalizing attitudes towards drug use, including allowing active substance users to engage in peer or service relationships.

Finally, it is unclear whether hope and outlook were an explicit focus of the intervention, as there was no record of conversations regarding optimism for the future. This is one area that the program logic model assumed would be incorporated into the delivery by virtue of peer-based delivery. One client (Client A) did speak to the impact of getting to know people with mental illness who were living successfully as an inspiration to expand this client's horizons, yet this result did not appear to come about through any focus and intention on the part of the peer workers. This would be consistent with the challenges associated with attribution of subjective recovery-related outcomes with mechanisms of action of peer support. As with other factors in the intrapersonal domain of the Recovery Wheel, peer workers did not receive any specialized training or connections to explicitly address hope and outlook for clients.

5.1.6 Discussion of Interpersonal Factors in Recovery

Factors that were placed into the interpersonal domain of the Recovery Wheel involve connections between people and their immediate social surroundings. In some respects, the interpersonal domain contains those elements of individuals' lives that keep them from being isolated or marginalized in the community, and ultimately sustain them on their journey towards recovery.

5.1.6.1 Housing

Housing emerged as a well-developed factor in the Recovery Wheel, covering a variety of issues that impact people's chances of achieving a recovery orientation. The private housing market is essentially inaccessible for most, with just a small slice of units barely affordable to those on disability benefits (e.g., AISH). Combine this with landlord requirements for criminal checks, rental references, and credit scores, and the market appears hostile to people with mental illness, particularly because they do not measure up against other applicants for already limited spaces. As a result, many are left at the mercy of landlords who take them in, paying considerable amounts of money for very poor living conditions. As with the private rental market, privately run group homes were identified as yet another example of systematic financial exploitation of people with mental illness due to a lack of other options through the health system or the community sector.

The various forms of non-profit housing were regarded positively by both therapists and clients, as they were considered more supportive (even without on-site support services) due to their organizational mandates and philosophies. This translates into a tendency to pursue help rather than eviction as recourse when issues arise. Further, non-profit housing serves as a critical avenue for social connection and a sense of community with fellow tenants. Nonetheless, non-profit housing units are so limited that they hardly register as a viable option. Further, many have expectations of clean criminal records, zero tolerance of substance use, and limited staff understanding of mental illness or capacity to respond to it. Any affordable housing provider should expect that a significant number of people with mental illness will be living in its units, thus they should be able to work more effectively with clinicians to facilitate support. Education of housing staff can serve to complement and enhance clinical supports by adding another level of compassionate observation to identify signs when clients are not doing well.

5.1.6.2 Family

People's families emerged as an important consideration for promoting recovery orientation, primarily in the context of their capability in providing supports. Key elements of support include moral support, companionship to overcome isolation, and checking-in assist therapists in engaging their clients in treatment. Unfortunately, family also emerged as a major stressor for clients, with examples of exploitation, abuse, or simply being mired in shared addiction. On the other hand, mobilization of family members through education and active engagement in the care plan could reap benefits for clients and introduce an important ally for therapists trying to pursue treatment goals. Griffiths and Sin (2013) similarly highlight the potential of sibling support in promoting recovery for people with mental illness, particularly through active education and caregiver support (e.g., through a Sibling Network). Unfortunately, stigma and marginalization play an important role in mediating family relationships and preventing the creation of new ones. Some clients stressed the loneliness of living with mental illness and the difficulties in finding an intimate partner. Studies have shown that being married increases performance on various recovery measures for people living with depression, bipolar, and schizophrenia (Meyers et al., 2002; Wingo et al., 2010; & Sibitz et al., 2011), thus there may be benefit in supporting them in developing intimate partnerships to promote recovery.

5.1.6.2 Social Network

Social connectedness is frequently referenced in recovery frameworks (Leamy et al., 2011; Onken et al., 2007; Davidson et al., 2007; Drake & Whitley, 2014). For many people living with severe mental illness, their social situation is more about disconnectedness due to relationship loss, marginalization, and loneliness (Baker & Procter, 2015). For many clients, there is no one else in their lives except for clinical staff and support workers. Having friends promotes a sense of interdependence and reciprocity, people who will listen without turning what is said into a clinicial assessment. Therapists and clients alike characterized substance use as mostly deleterious, but it also served as an avenue for social connection. In the end, positive relationships to replace the negative ones (e.g., if substance use and social engagement turns into abuse and dysfunction) need to be built on shared values, experiences, lives, and interests – well beyond simply having a mental illness. There is a very limited range of opportunities offered by the mental health system for clients to connect with others at any level other than shared status as recipients of care. Further, resources are limited for helping people connect to social-recreational activities and venues outside of the system. Even internet access, which provides virtual ways for people (including those with mental illness) to engage with others (Torous & Keshavan, 2016), remains out of reach, largely due to the cost of computers and service (Huang & Su, 2009). Thus, the ability to engage in new social relationships may be deeply connected to income and poverty for people with mental illness.

5.1.6.2 Sense of Belonging

It can be difficult for people with mental illness to feel a sense of belonging, but it is a critical factor for recovery. People with severe mental illness may not easily integrate with regular society, appearing different due to behavioural struggles or poverty. On the other hand, community-building programs geared towards people with mental illness (e.g. day programs) may not be appealing. Almost all participants regarded faith communities as a powerful tool for connecting people with mental illness with others who share similar beliefs and values. Griffith and others (2015) suggest that 80% or more of individuals with psychotic illness turn to religion as a coping strategy, and consequently rely on churches and other faith groups for help. Shah and colleagues (2011) suggest that faith communities help people with mental illness by strengthening self-worth, reducing isolation through communion with others, offering connections for practical support, and building a social support network. Rogers and Stanford (2015) go further in suggesting the use of church-based peer support groups that offer an avenue to connect with the larger faith community as a vehicle for recovery. For non-religious clients, opportunities for meaningful social connection and a sense of belonging are not so clear. In this context, Duff (2016) describes how "sociality may…be regarded both as an indicator of recovery and as a practical means of achieving it…[with] sites like cafes, libraries, bookshops, and parks…availing opportunities for social interaction…in which sociality [is] normalized" (p. 67). Further, housing can be a venue for community to be created; even people with limited social drive can remain disengaged but not isolated.

5.1.6.3 PSHP Project Delivery in the Interpersonal Domain

The PSHP project again was not intended to directly address most of the factors on the interpersonal domain of the Recovery Wheel, although stability of the clients' housing situation was certainly an important target. For housing, the fact that Managing Tenancy was in the top ten of PSHP activities suggests that the peer workers were actively examining the housing situation of clients and providing advice on ways to address it. This is an important area of support in that housing emerged as a critical issue for people with mental illness in terms of recovery orientation. Interestingly, all five clients indicated that they had been in their current housing situation for three years or more. Further, three of the five client participants were housed in non-profit housing at the time of the study. It is unclear from this study to what extent being in non-profit housing may have supported their housing stability, or how the circumstances of the other two clients (one in a private rental unit with a rent supplement, and the other living in a house with an elderly landlord) contributed in their cases. Nonetheless, non-profit housing is an important variable that warrants further exploration in the context of supporting housing stability, particularly in terms of adopting peer support as a layer to support skill building and offer service linkages for tenants, as the PSHP project appeared to do.

It seems paradoxical that the PSHP project had such an explicit boundary around social support considering typical application of peer support in other contexts usually is very heavy on that front. It can be understood from the peer worker notes that there was direct messaging regarding separation of their roles and responsibilities within the PSHP project and doing anything that resembled socializing or leisure. This further impacted the ability of the peer workers to act as bridges between clients and potential sources of community, because there was ultimately a firm barrier that prevented connection on any other level other than service provision. For Client A, who acknowledged becoming friends with the client's peer workers, there appeared to be a stretching of this mandate as the peer workers were granted permission to visit with the client multiple times per week, and many of those visits were excursions to restaurants or cafes. In fact, this appears to have been a common practice for peer workers, in that Social Activities were the fifth most frequently recorded activity in client files. In most cases, it appears as though the peer workers administered training modules at restaurants and cafes as a way of staying within program boundaries. Aside from these implicit social activities, peer workers were able to connect with their clients (and others) through the social-recreational ESCAPE program that was offered concurrently by the SSA. In fact, ESCAPE served as an alternative avenue for peer workers and clients to engage outside of the boundaries of the PSHP project. This was likely an asset to PSHP project delivery because peer workers and clients who wanted to spend time with each other outside of the PSHP project could do so through this other program.

For Clients A, B, and D, strong religious or spiritual leanings could have been avenues for connections to faith communities that may have been successfully facilitated through a peer relationship. Because this was not considered in the design of the PSHP project, it would have to be relegated to other programs' responsibilities like ESCAPE or the spiritual group at AHS mentioned by Client B. Other means of having a sense of belonging within peer contexts appear limited, and client participants tended to only report some involvement in AHS-run programming with very few mentions of anything offered by CMHA or SSA. There is a strong sense that even these options may not appeal to many clients who do not want their social connections constrained to programming defined by mental health status.

The extent to which the PSHP project assisted with family issues is a finding that warrants further exploration. Three clients had records in their case files indicating that peer workers engaged to address various issues related to client family members, including victimization and abuse, and there were more records of addressing family issues than explicit components of the PSHP project model like Connecting to Services. The accompaniment provided by the peer workers for Client A after the death of the client's parent was certainly outside of the scope of the PSHP project, but their involvement was supported by the OTA. The OTA also contacted Client D's family when efforts to get a predatory acquaintance out of the client's apartment were going nowhere. Advice provided by the peer workers to Clients A and C helped them deal with difficult family relationships. In some ways, this reflects T-MA's sentiments regarding the value that family involvement adds to client care provision: it is likely that peer workers found themselves engaging in family issues because it was a necessary step to address problems that emerged in clients' lives. More needs to be done to understand how peer workers can engage family members in an intentional way, and how training and support could be provided to assist them in doing this for their clients' benefit.

5.1.7 Discussion of Institutional Factors in Recovery

The institutional domain of the Recovery Wheel includes factors that are based in the mental health system's direct role in promoting recovery. To a large extent, the positioning of the system with respect to its clients, and its consequent ability (or inability) to address the functional and clinical needs of people with mental illness, have an impact on whether people can live independently and pursue recovery-related outcomes.

5.1.7.1 Functional Supports

Services available through the system appear to be key mitigating factors for deficits in functioning, particularly with respect to instrumental tasks like cleaning, meal preparation, grocery shopping, and budgeting that are essential for maintaining housing stability. Supports are available to assist with money management, transportation, and other needs, but navigation of the system can be so complex that people need support to do so. ILS workers are noted as important resources for supporting clients, but some therapists indicated limitations in accessing them. Gabrielian and colleagues (2015) regard functional support as an essential component of care plans for people with co-occurring cognitive limitations, but services appear to be provided as short-term interventions as opposed to long-term support. Particularly relevant to this population of higher need clients is the need for more supportive housing options in which skill development can take place. Functional supports can essentially cancel out functional limitations using an approach that supports placement in real-world community settings (like housing) and then plugs in training and supports to maintain it (Corrigan & McCracken, 2005).

5.1.7.2 Clinical Supports

Clinical services figured prominently as a factor contributing towards recovery. Psychiatrists were singled out for their typical focus on medication management and the short and infrequent time clients get with them. There was also criticism of their ability to work with other members of the interdisciplinary team, including therapists. Ironically, psychiatrists may choose community-based practice to engage more substantially with clients and be part of an interdisciplinary team, but can be constrained by the limited time they have to engage in much beyond medication management due to administrative structures (Carpenter-Song & Torry, 2015). Regarding the clinical team, there were numerous recounted instances in which medications were not provided, appointments were not kept, and clients consequently fell through the cracks. Moreover, clients appear to have little power to change their providers if they are dissatisfied with the services received, but the PSHP client files showed plenty of examples where clinicians changed without any evidence of notification. Moreover, the concept of an interdisciplinary team appears to be misleading, in that there was little mention of any other professionals other than therapists (i.e., nurses) and psychiatrists.

Clients expressed a desire talk to psychologists about their experiences and receive insightful advice based in some degree of expertise. Psychotherapeutic approaches have shown some promise in promoting recovery through “enhancement of clients’ abilities…to see themselves facing a myriad of challenges, and then deciding how to meaningfully respond to those challenges” (Lysaker & Roe, 2016, 121). The past experiences that clients had with other professionals like psychologists or recreational therapists were regarded positively, but attempts by clients to request access to other clinicians, especially psychologists, were usually met with rejection. In the end, clinical supports essentially provide what the system is willing or able to offer as opposed to what people with mental illness want or feel they need.

5.1.7.3 Medications

Having effective medications to address symptoms with minimal side effects emerged as a key factor in recovery. On one hand, medications were identified as essential tools for dealing with symptoms and reducing relapse, but on the other hand, they were described as at-best imprecise or at worst “primitive” (T-CO) and “not scientific” (T-DU). There is considerable evidence supporting medications for treatment of severe mental illness (Tandon et al., 2008; Gardner et al., 2005; Chakos et al., 2001, Jones et al., 2006), although there are no ‘magic bullets’ that reliably address all symptoms across all client subgroups. For example, Crawford & DeLisi (2016) found significant differences in responsiveness to treatment between men and women living with schizophrenia.

Long-acting injectables administered by clinicians have an advantage over self-administered oral pills especially for people who have adherence challenges, a sentiment supported by the literature, albeit mostly in studies not employing randomized controlled trials (Suzuki, 2016). Considering adherence to – or ‘compliance’ with – treatment, in particular ensuring clients are taking medications, is a major issue for treatment of schizophrenia that has been well-studied (Sendt et al., 2015), it is difficult to reconcile this with evidence of overmedication (Ahmed et al., 2007) and apparent ignorance of adverse effects that have substantial impact on the well-being of clients. As discussed with respect to the personal and intrapersonal sides of the Recovery Wheel, the fact that medications can cause poor health (Lieberman et al., 2005; Gardner et al., 2005) and cognitive impairment (Tandon, 2002; Veselinovic et al., 2013) suggest that they require more intensive management than semi-annual psychiatrist visits.

5.1.7.4 System Orientation

Fundamentally, the supposed adoption of recovery-oriented principles in the mental health system contrasts with the deficit-oriented viewpoints of therapists who remain skeptical of recovery as a possibility for most of their clients. This mirrors the findings of Schrank and colleagues (2015) that “in clinical practice, low expectation and therapeutic pessimism may be unhelpful for service users…[who are perceived] as challenged and disadvantaged…[which] may reflect limited understanding of current conceptualizations of recovery” (p. 52). Therapists often spoke about providing adequate support but it appears that the measure of adequacy is typically determined by clinicians rather than by clients. Empowerment and a sense of agency are critical elements to promote recovery (Leamy et al., 2011; Onken et al., 2007; Davidson et al., 2007; & Anthony, 1993), but there appears to be little evidence that the system has the capacity to make this happen considering the resource limitations experienced by clinicians and the evident hierarchical approach applied with clients. At the provincial level, a review of mental health and addiction services determined that they account for only 6% of health spending, far less than the 9-13% recommended by the Mental Health Commission of Canada and the World Health Organization (Alberta Mental Health Task Force, 2015). Ultimately, an under-resourced mental health system can only commit resources for people who present with a specific need profile, and can do little for people who do not actively engage it despite well-documented challenges associated with treatment engagement and therapeutic alliance (Davis & Lysaker, 2004; & Kvrgic et al., 2013).

5.1.7.5 PSHP Project Delivery in the Institutional Domain

Of all areas in the Recovery Wheel, the institutional domain is the most explicitly connected to the PSHP program design, and this is evident in the frequency of outputs noted within the case files. Cleaning and Money Management were both in the top five of PSHP project outputs, and peer workers received considerable training in these areas. While there were other areas of functional support that were included in the PSHP project design, like taking transit and connecting to mainstream services, these figured less in peer worker activities and foci. For Client E, activities conducted by peer workers to clear the client’s home of clutter as a result of hoarding were considered to be Cleaning; this may have inflated the number of outputs recorded in this category. Further, having a set of modules and receiving special training on teaching cleaning skills and on financial literacy probably elevated these focus areas considerably as well. Nonetheless, both of these areas were regularly mentioned by therapists as key issues that get in the way of housing stability and independent living, so there is also the possibility that the peer workers put so much time into these areas because they were the most prominent issues facing the clients. As programs like Practical Supports and ILS are highly subscribed by therapists for clients in need of functional supports, this is a component of the PSHP project that could be considered well-supported.

Notably, peer workers addressed medication issues on a regular basis, having frank conversations with clients to help them understand that some of their physical and mental health issues could be attributed to side effects or dosing problems. In all cases where peer workers engaged in this sort of activity, the onus was placed on the client to raise the issue with their psychiatrists or therapists. Again, no training was provided to peer workers on medication counseling, nor was it ever intended to be a focus area, if not considered out-of-bounds for fear of interfering with clinician accountabilities and expertise. However, much like symptomology, taking medications, and managing their positive and negative effects, is a foundational shared experience among people with mental illness. Thus, it should be expected that peer workers will engage in these sorts of discussions, so there should be guidance and accepted pathways for addressing medication issues. To some extent, this may present as a very controversial issue from the perspectives of clinical and peer boundaries. It is difficult to negotiate between perceptions of expertise on the matter: in essence, who has more knowledge about medications, the doctors prescribing them or the people who have to take multiple pills every day for their entire lives? If the PSHP project was designed and delivered to be an alternative avenue outside – rather than as an adjunct to therapist support within – the mental health system, there may have been a different emphasis on managing the impact of medications that may have strained peer worker and clinician relationships.

The role of the PSHP project in addressing clinical supports is slightly complicated, in that on one hand, the OT/OTA position essentially added dedicated occupational therapy resources to the clients, but on the other, the interactions between the OT (as opposed to the OTA) and either the therapists or the clients were extremely rare. In a sense, the peer workers were the ones actually delivering services within this clinical modality, having been trained by the OT and working closely with the OTA to plan and debrief on client support. This may have been a strength of the PSHP project design, in that embedding peer support under the direction of other clinical disciplines, such as social work or nursing, may have resulted in a very different focus and, perhaps, some sense of duplication or conflict with existing services provided by therapists. Couching the PSHP project within the context of occupational therapy may have been fundamental to adding a key element to the existing care team and contextualizing the peer workers in the eyes of therapists as more than just sources of social support. In the context of peer support being applied as a clinical service, it may be important to consider the gaps being addressed for clients and provide clinical oversight (or sponsorship), training, and support for peer workers under a professional discipline that lends credibility and utility to their roles.

The PSHP project appeared to have a profound effect on the way the mental health system worked with clients, addressing many of the barriers identified by therapists and clients in interviews, such as lack of communication, diminished agency on the part of clients, and limited capacity for clinicians within the system to engage with clients on a regular basis. Updates and Checking In were the third most recorded outputs in the client files, which suggests that keeping therapists abreast of client circumstances and peer worker efforts was a high priority. Additionally, there is significant evidence that peer workers worked closely with their clients to define what issues were affecting them the most, developed care plans according to their wishes, and utilized the OTA as a conduit to escalate problems that needed to be resolved by therapists. A considerable amount of time was spent on supporting Therapeutic Alliance: as a PSHP project output, it placed in the top ten most frequently recorded activities. Related to this, the fact that the OTA spent so much (recorded) time attempting to contact therapists to address emergent and critical issues among clients begs the question of what would have happened if there was not a resource like this to persevere despite at times baffling inconsistency and irregularity among therapist responses. This finding that clients could essentially be abandoned through shuffling of caseloads, without any apparent communication or assistance in maintaining connections with services, requires further exploration to determine the extent to which this may or may not be a common experience among clients, and the factors that may ameliorate or exacerbate it. Nonetheless, the provision of peer workers added a significant number of client contacts, with most receiving approximately one face-to-face visit (often in their homes) per week, far more than the 10-minutes-per-year psychiatrist or monthly therapist in-office visits. Again, the interface between the peer workers and the therapists via the OTA served an important role in augmenting the intensity of support for clients, in many ways offsetting the structural and philosophical deficiencies evident within the mental health system.

5.1.8 Discussion of Societal Factors in Recovery

Factors that emerged in the societal domain of the Recovery Wheel capture the overriding power of discrimination against people living with mental illness and the consequent marginalization that keeps many people living in poverty and outside of mainstream culture. Without addressing these larger systemic issues, one can only expect limited and exceptional instances of recovery despite efforts at other ecological levels, and ongoing vulnerability and social exclusion will continue to be the norm for people with mental illness.

5.1.8.1 Security and Vulnerability

Victimization of people with mental illness occurs from all angles, including housing providers, members of one's social network, family, and random strangers who target people with known vulnerabilities. There is a growing literature base on violent or criminal victimization of people with mental illness (de Mooij et al., 2015; Meijwaard et al., 2015; Teasdale et al., 2014); they can have between 6 and 23 times the risk of being a victim of crime than the general population (Teplin et al., 2005). Further, rates of revictimization are higher for people with schizophrenia and bipolar than people experiencing substance use disorders or depression (Teasdale et al., 2014); both disorders also are associated with significant cognitive impairment (Vohringer et al., 2013), which suggests a relationship that requires study. Claycomb and colleagues (2013) found that 70% of participants in their study had experienced financial victimization in the past month, with 35% indicating that they ran out of money because of it. One area that figured prominently among therapists was the matter of exploitation by unscrupulous landlords. This is an issue in which the literature is silent, although Drury (2003) found that "despite the variation in accommodations, all clients, through diverse combinations of behavioral dysfunction and economic hardship, lived in predatory environments…at the mercy of slumlords…" (p. 198). Richard Warner (1997) speaks of an altogether familiar circumstance for people living with mental illness in the early days of deinstitutionalization in the 1960s, when, for those people without the opportunity to move into nursing homes, the only option was "substandard inner city housing that [was] overcrowded, unsafe, dirty and isolated…a captive market for unscrupulous landlords" (Bassuk & Gerson, 1978; in Warner, 2004, p. 87). The results from this study suggest that Edmonton has its own stories in this vein. Without security and sanctuary, ideally through safe and supportive housing (Duff, 2016; Davidson et al., 2007; Drake & Latimer, 2012), clients have little hope of ever moving forward from dependency to recovery because of the constant risks they face from others who appear to be waiting to victimize them in a myriad of ways.

5.1.8.2 Income and Poverty

People with mental illness are widely recognized as being more likely to live in poverty, largely because of their inability to engage in the labour market and consequent dependence on social assistance for income (Wilton, 2004). For many, this is a state of both absolute and relative poverty, in that people with mental illness are at once deprived of the resources to meet their basic needs as well as what is needed to support social participation and well-being (Williamson & Reutter, 1999). Moreover, it leaves them vulnerable to a cycle of stigma, victimization, and further poverty (Perese, 2007). In many ways, the client participants in the study are fortunate to receive AISH, which provides significantly more income than if they were to receive Alberta Works. According to Tweddle and colleagues (2013), the AISH amount is almost twice the Alberta Works' disability benefit amount, but both are well below the median income levels of people living with disabilities in Alberta, at almost a half (48.6%) and a quarter (26.3%) respectively; even with AISH, people only receive 93% of the Low-Income Cut-Off figure. While the AISH amount increased from $1188 to $1588 in 2012 (and at the time of writing, the current rate), Alberta Works rates have stayed the more or less the same since 1993 (Kolkman, n.d.). Not only does this affect the ability to acquire housing, but it also impacts acquisition of other essential needs like food. The Vital Signs report on food security published by the Edmonton Community Foundation and Edmonton Social Planning Council (2013) suggested that the weekly cost of food to go up by 58% over that time period. While many people with mental illness want to work to garner more income, many cannot due to a combination of structural and personal factors like marginalization, inadequate treatment, substance abuse, and housing instability (Hall et al., 2015). Thus, many clients are in a vicious cycle of being deprived socially and health-wise while on social assistance, which precludes them from seeking or finding employment, which further marginalizes and disables them.

5.1.8.3 Perception of Mental Illness

There is considerable literature on the concept of stigma of mental illness, particularly related to schizophrenia (Thornicroft et al., 2009; & Crisp et al., 2000). Stigma persists despite efforts in recent years to engage in positive public discourse around mental health and illness (Coverdale et al., 2002; & Reavley et al., 2016). Media depictions of people with mental illness are overwhelmingly negative, emphasizing links to dangerousness despite limited evidence-based associations and painting a picture of an erratic and frightening stereotype (Coverdale et al., 2002; & Reavley et al., 2016). Fazel and colleagues (2009) deflect any perceived risk from psychosis, suggesting that people with schizophrenia “may confer no additional risk over and above the risk associated with the substance abuse” (p. 12). Similarly, Markovitz (2011) points to stressful life events, limited access to comprehensive support, and living in impoverished and socially disorganized communities, as key influences on violence risk. Living in high poverty communities increases the likelihood of victimization, which has been identified as an important risk factor for violence (Hiday et al., 2001).

Involvement in the criminal justice system is a common experience for people with mental illness, with one study showing one quarter of participants having been arrested in the previous ten years, two-thirds notably for non-violent crimes (Cuellar et al., 2007). Skeem and colleagues (2011) suggest that correctional policy itself promotes additional arrests, convictions, and incarcerations due to stigma that results in more conditions and heightened monitoring upon release. Having a criminal record "limits social opportunities, such as jobs, housing and social networks…which, to some extent, serve as protective factors…reducing the risk of violence" (Douglas et al., 2009, p. 42). In this way, the role of stigma in constraining recovery is more than ethereal, having direct impact on access to housing (Corrigan, 1998; Corrigan, 2004; & Newman & Goldman, 2009) employment income (Corrigan, 1998; Corrigan, 2004; Bond et al, 2001), and mental health services (Corrigan, 2004b), all significant factors that contribute to recovery. From Corrigan's (1998) perspective, stigma's effects interact at multiple levels, impacting the person living with mental illness, their proximal social network and community, and society itself, having a devastating impact on self-esteem, outlook, and opportunities for social participation, which ultimately present barriers for recovery.

5.1.8.4 Self-Esteem

Self-esteem is fundamentally linked to the self-perceived identity of people with mental illness. The interaction between stigma and self-esteem is strong, even controlling for depressive symptoms, demographics, and diagnosis (Link et al, 2001). Low self-esteem left to continue its decline unchecked results in demoralization, a key predictor of suicidal ideation that remains largely unaddressed by clinical care (Clarke & Kissane, 2002). Suicide is a well-known risk associated with schizophrenia: suicide is committed by 5-10% of people with schizophrenia

(Palmer et al., 2005). Yanos and colleagues (2010) suggest that suicide risk (among other social and clinical effects) can be attributed to reduced self-esteem resulting from an illness identity that internalizes stigma-related feelings of inadequacy and incompetence. As such, clients should be supported in developing a positive identity defined by empowerment and agency that will facilitate recovery (Yanos et al., 2010). In this context, Margetic and colleagues (2010) have shown a strong relationship between a person's self-directedness, i.e. "defined personal goals…as well as a higher level of self-determination and autonomy" (p. 605), and the extent to which stigma is internalized or resisted. Corrigan and Watson (2002) describe three groups of people with mental illness with respect to the interaction between stigma and self-esteem: people who legitimize stigma and manifest low self-esteem and self-efficacy, people who view stigma as unjust and respond with "righteous anger" (p. 47) and use it, and people who are indifferent to stigma or the perceptions of others. For the second group, strong identification and association with peers becomes a powerful tool for empowerment and collectively becoming "righteously indignant about the negative social identity and discrimination bestowed upon them by society" (Corrigan & Watson, 2002, p. 44).

5.1.8.5 PSHP Project Delivery in the Societal Domain

There were some factors in the societal domain of the Recovery Wheel that were addressed by the PSHP project, and others that were not. Income and poverty were not explicit targets of the intervention, but they were addressed to an extent by peer workers' applications for rental subsidies, additional AISH income, and medication coverage, all of which directly address the issue by increasing the money available for clients. For example, the fact that peer workers were successful in securing an increase in AISH to cover Client C's rent shortfall was a feat of sorts.

At the time of the client's participation in the study, Client C indicated that a rent subsidy was (still) being received. In Client C's case notes, the peer workers wrote that the client "associates happiness and freedom with having money". In effect, having income is the gateway to recovery, at least from the second-hand accounts of peer workers.

It should be noted that all client participants were receiving AISH at the time of their participation in the study, and in all cases the disability benefit was supplemented by either pension earnings (four clients) or part-time employment (one client). Thus, they may have been in better financial positions than other PSHP project clients on Alberta Works or otherwise receiving less income. Peer workers recorded filling out paperwork to appeal benefit eligibility decisions, suggesting that therapists did not have to fit this critical, but time-consuming, responsibility into their already overloaded schedules. Special training on filling out AISH and rent subsidy applications and filing benefits appeals could have improved the peer workers' effectiveness in helping clients receive their respective entitlements. Training aside, many of the peer workers could do more than empathize with clients experiencing poverty, and the strategies they had learned could be put to good use in mentoring others.

Much like many other factors, there was no anticipation that the PSHP project would uncover victimization of clients, nor was there any expectation that it would figure so prominently among the activities of peer workers. Although the frequency of outputs addressing Exploitation Issues was less than many others already discussed, they were still within the third quartile, mentioned more times than Shopping, Public Transit, or other activities explicitly included in the program model. In two situations, a "homeless person" was staying with clients, suggesting that they may have been targeted due to their relatively greater resources, including disability income and housing, and because of their mental illness. While it not possible to generalize this experience to other PSHP clients, such a high proportion in the study sample warrants further exploration on prevalence of victimization among people with mental illness. Moreover, the clients who participated in the study did not suffer from serious cognitive impairment and appeared to have at least average intelligence; it could be assumed that clients who do not share these strengths may experience victimization more frequently. It should be noted that without the peer workers visiting clients in their homes, there may have been no knowledge of these circumstances, and the impact of victimization on self-sufficiency and self-esteem may have been improperly attributed to other putative causes or not noticed altogether. Since this appeared to be a high frequency activity, peer workers could certainly benefit from training and support to build on their own strategies to overcome exploitation.

For an intervention couched in concepts of recovery and peer support, there was no evidence of any direct interactions with clients regarding societal perceptions of mental illness, in particular internalized stigma. In fact, Client B’s refusal to participate in the PSHP project, on the client’s own account, was largely due to stigma. To an extent, the project failed in terms of working with the client to overcome ingrained perceptions of mental illness to view the peer workers as helpers as opposed to a “pretty strange” group of mentally ill people. This study did not employ any tools for examining internalized stigma among the clients, thus it is difficult to make any determination regarding any relationships between this construct and recovery orientation. Moreover, there was no training provided to the peer workers regarding confronting stigma.

While the PSHP project did little to address stigma, it seemed to have more of an impact on self-esteem of clients, largely through instrumental support in the areas of hygiene, access to income, and social support. Client A serves as a good example of a client who appeared to change dramatically over the course of the client’s involvement with the PSHP project; Client A’s recollection of the experience was one of empowerment and opening doors to new possibilities. The peer workers supported Client A in improving communication skills, reflecting on interactions with family members and others, and fostered a sense that the client could pursue bigger goals like education and gainful employment. Similarly, the peer workers supported Client C when the client was demoralized by what they characterized as an abusive relationship with the client’s brother and feelings of loneliness. The client’s interest (albeit without follow-through) in volunteering appeared to be a sign of personal growth for Client C. Client D’s sudden change in appearance and household cleanliness could have been prompted by interactions with the peer workers, although this is more likely based in resurgent pride resulting from people telling the client what to do. Nonetheless, the peer workers managed to offer avenues for clients to gain self-esteem simply through providing social and functional support, or, in Client D’s case, a reminder that the clients were capable of improving their own lives despite living with mental illness.

5.2 Client Impressions of Participating in the PSHP Project

While all client participants recalled receiving services through the PSHP project, only one (Client A) noted in a positive way that how it was delivered, namely using peer workers, was something special and valuable to the client. The other client participants viewed it as no different from other services provided by professionals, albeit with a hint of stigma applied in scrutinizing the credentials of the peers to serve them. This is contrary to a study by Flanagan and colleagues (2015) that suggests that stigma does not play a role in client perceptions of or willingness to work with peer providers. Nonetheless, other studies have suggested that there is a lack of awareness generally among clients and clinicians alike on the application of peer support (Adame & Leitner, 2008) and that many clients are skeptical of peer support due to lack of familiarity with it (Gidugu et al., 2015). Colson and Francis (2009) suggest that "individuals certainly have not been empowered to appreciate the value of their own contribution…[and] demonstrate a degree of shame about their mental health problems" (p. 398). As a result, clients may have difficulty viewing others living with mental illness as capable of empowerment beyond the hierarchical positioning of patients below clinical service providers. Nonetheless, clients acknowledged that at the very least the peer workers offered someone to talk to who could relate in a non-judgmental manner, which Dalgin and colleagues (2011) found was a commonly desired service among participants in their study on a peer-run phone line.

A review of the literature found no previous research directly examining awareness of peer support and recovery among mental health clients, but this issue may be central to the reasons why peer support appears to have such mixed results in terms of uptake and outcomes (Lloyd-Evans et al., 2014). In essence, there are undertones of the deeply rooted impact of oppression on the identities of people with mental illness and relationships to the world around them, similar in many ways to the effects of colonization and consequent intergenerational trauma underlying recent efforts towards truth and reconciliation for indigenous peoples.

> Conversations about the extent to which trauma and past abuse impacts self-concept, relationships, and community is a way to break down people's sense of victimhood – feeling responsible for making the abuse happen, incapable of mutually supportive relationships, or discomfort with their bodies. When we begin to speak the truth of our lives, express our pain, and find out the depth of the embedded messages common to abuse survivors, the language of symptoms is replaced by the deepening of personal relationships and our ability to advocate for a more politically astute mental health system. (Mead, Hilton, & Curtis, 2009, p. 18-19).

While there appeared to be efforts on the part of AHS to educate therapists on the value of peer support, there was little evidence of similar efforts to engage clients themselves, and certainly not within a narrative of traumatic history. It is true that the clients participating in the study do not represent the broader population of mental health clients, and there is a possibility that people in a younger age group may have been more exposed to recovery and peer support messaging. Consequently, there is substantial further exploration required on the extent to which clients recognize value in themselves and how this is projected towards peer providers, the impact of histories of direct and indirect oppression on these perceptions, and, ultimately, how these relate to their knowledge and acceptance of peer providers. Once this is better understood, it will be possible to develop, test, and assess effective approaches to help raise awareness of peer-based interventions among clinicians and clients alike.

5.3 Role of Peer Workers in Delivery of the PSHP Project

It is evident from the discussion on comparing the Recovery Wheel to the PSHP project that, while the original program model focused on more instrumental or functional targets, the application of peer support intrinsically added focus on several other unexpected areas, including symptom management, issues with medications, facilitating service access, providing social support, responding to victimization, and generally supporting clinicians in their work. Moreover, delivery to each client was largely determined by the clients themselves. This is in line with what Rebeiro Gruhl and colleagues (2016) describe as "authentic peer support…[which is] flexible and idiosyncratic…driven by the recipient of peer support rather than drawing upon a particular list of duties or activities" (p. 82). Further, outside of the modules on money management and cleaning, the services provided relied primarily on the peer workers' own knowledge and reflexivity, applying what they learned as clients themselves in what Austin and colleagues (2014) call "re-appropriating experience" (p. 881). In many ways, due to their positioning outside of traditional clinical hierarchies, peer workers offer another avenue for supporting clients in decision-making that fosters well-being not through coercion, but what Adame and Leitner (2008) call “interpersonal influence…[which is] a more stable and productive form of power” (p. 884). In this way, they seem to fill the role that natural support networks like family members might play (Gidugu et al., 2015), and this is part of the difficulty associated with negotiation of boundaries, particularly those between patient and provider, and provider and friend (Wrobleski et al., 2015). As Watson (2016) writes about her own experiences as a peer worker, this role, which occupies the space in between natural and professional supports (Faulkner & Basset, 2012), creates a constant struggle as the relationship becomes more personal, and especially so when disengagement becomes a necessity.

This unorthodox positioning of peer support within the context of a professionally driven mental health system creates problems of its own, mostly with regard to the valuing of lived experience and the trust of professionals in peer workers. Even the term peer support has a derogatory tone to it, as it relegates practical expertise to a level beneath professional expertise (Clossey et al., 2015). Oddly enough, there was naturalness to the ways in which the peer workers in the PSHP project entered into domains like medications, symptoms, and poor service delivery, yet these were considered more or less off-limits to the peer workers; these issues could only be trusted in the well-educated hands of clinicians. There is great irony in this assumption that people with mental illness, who experience these challenges first-hand and overcome them despite adversity and a sometimes oppressive relationship with the mental health system (Adame & Leitner, 2008; Mead & McNeil, 2004; & Mead, Hilton, & Curtis, 2001), are considered incapable or otherwise inappropriate providers of advice on issues that professionals may never have experienced beyond their training. In the words of a peer worker, one “can’t learn what we've learned in a textbook…it's priceless" (Rebeiro Gruhl et al., 2016, p. 82). Nonetheless, several studies have shown that clinicians may view lived experience as a lesser form of knowledge than what is gained through professional training and experience (Clossey et al., 2015; Rebeiro Gruhl et al., 2016; Adame & Leitner, 2008; Mead & McNeil, 2004; & Colson & Francis, 2009). Further, there is often a strong focus among clinicians on perceived risk in the peer relationship (Holley et al., 2015), with concerns about adequate supervision, exacerbation of symptoms for the worker and client alike, and liability of clinicians versus accountability of the peer workers (Clossey et al., 2015). In this sense, the way the PSHP project was delivered – i.e., with minimal involvement (or intrusion) of the OT beyond training, and regular support and reporting (not supervision) via the OTA – offered therapists some sense of confidence in the peer workers and at least the veneer of professional oversight for what turned out to be mostly a peer-driven service.

It is not clear what, if any, training or support the peer workers would have received in terms of applying their own lived experience as a service provider, but at the time of PSHP project delivery there was little in the way of resources such as peer specialist training (PSACC, 2016) or guidelines for providing peer support (MHCC, 2013). Even the Mental Health Commission of Canada's seminal report on peer support (MHCC, 2010) was more than a year away from publication, and included a paragraph referencing the PSHP project.

> A few years ago the provincial government allocated some time limited funding for a peer program in Edmonton. When provincial funding ceased the host agency paid for the peer support out of its operational budget. Currently there is no provincial government funding directly allocated for peer support. (MHCC, 2010, p. 51)

In Rebeiro Gruhl and colleagues' (2016) study, most peer providers did not receive specific peer support training; it is probable that this would have been the case for the peer workers in the PSHP project as well. Training and support is required to help peer workers "develop a specific skillset in negotiating the ‘grey area’ between the provider-recipient relationship and friendship” (Holley et al., 2015, p. 487), in which purposeful disclosure is performed not for solidarity as a peer, but for credibility as a service provider (Austin et al., 2014). Although functional support was the dominant focus of peer worker training and PSHP project delivery as-intended, the fact that it was largely overshadowed by numerous other factors not intended in the program model may have been an inevitable consequence of peer-based delivery. Gidugu and colleagues (2015) noted that tangible support serves primarily as a vehicle for relationship building, teaching, and mentoring towards recovery. Thus, for the purpose of helping clients move towards a recovery orientation, peer worker training needs to go beyond assistance with instrumental tasks to helping them apply their own lived experience to foster a strong sense of trust in the recovery process through a combination of practical support and emotional support (Gidugu et al., 2015). As Rabenschlag and colleagues (2012) found, this relationship needs to be longstanding and continuous to have longer term impact on the extent to which clients benefit from a change in their perception of recovery for themselves. Generalizing these findings to the context of the PSHP project would suggest that if it had been evaluated for achievement of outcomes, there may not have been any notable effect of a short-term peer-based intervention on recovery orientation nor the ability to differentiate between the effects of the PSHP project and other external factors (Rabenschlag et al., 2012).

When the Recovery Wheel is applied in analysis of PSHP project delivery, it is apparent that clients received a variety of services across most levels that, in many cases, they likely would not have received were it not for the intervention of peer workers and the PSHP project team as a whole. The analysis of the PSHP project suggests that peer workers provide an avenue for filling holes in a fragmented system (Lawn et al., 2008; & Gidugu et al., 2015). As evidenced by PSHP project delivery, there was a notable impact in terms of moving clinicians and service providers to act on clients' behalf, an advocacy role referenced by Gidugu and colleagues (2015) in their study. As Perez and Kidd (2015) note, peer workers may be invaluable as an adjunct to primary care in order to bridge the gap in services between physical health and mental health care. With all these paraclinical opportunities for peer-based intervention, it seems obvious that training should be provided to peer workers so they can build on their own lived experience with professional knowledge and practical skills. However, there is "risk that 'professional' knowledge could supplant experiential knowledge – especially when current practice relegates such knowledge to a less credible status" (Colson & Francis, 2009, p. 397). This is a concern shared by others, especially those applying a critical survivor lens on the perceived medicalization of peer support (Mead & McNeil, 2004; Mead, Hilton, & Curtis, 2001).

In many ways, peer workers should be expected to help clients recover not only from their illnesses, but also the system itself, guiding them in "coming to terms with the mental health system…[and] maturing to the point…[that they] can take part without being engulfed by it" (Austin et al., 2014, 882). This requires peer workers to be able to be critical of the system (Rebeiro Gruhl et al., 2016) because they constitute a direct affront to the medical model itself (Clossey et al., 2015). "People have gotten stuck in a medical interpretation of their experiences…constantly trying to deal with their perception of what is wrong with them instead of what's wrong with the situation" (Mead & McNeil, 2004, p. 7). This "situation" comprises the interpersonal, institutional, and societal parts of the Recovery Wheel and, if peer support is a core requirement of recovery orientation, it needs to actively fight against established structures, policies, and practices that hold people with mental illness back on their journey towards it (Davidson et al., 2007). The location of the PSHP project within the SSA afforded it the benefit of being able to operate outside of the system, but in partnership with it. As Perez and Kidd (2015) state, “peer workers are ideally located in an NGO setting where funding and clinical accountability can be managed from a non-partisan perspective” (p. 86). While differing views exist that suggest that peer workers are best situated within the system (Rebeiro Gruhl et al., 2016), Mead and McNeil (2004) make a strong case for separation: “one can’t both work for the medical system and refute its very foundation” (p. 20). Further, until the culture of the formal system, as well as other agency service providers, fully embodies recovery orientation, there will continue to be barriers to achieving true, mutually supportive partnerships among clients, peer workers, and clinicians (Clossey et al., 2015). This is an issue that must be resolved in order to ensure that peer workers can operate in the spaces left by the mental health system to reach beyond the medical model and support people with mental illness to transcend existences of dependency and achieve recovery on their own terms.

5.4 Limitations and Suggestions for Future Research

There are several limitations of this study that should be considered before drawing conclusions or generalizing the findings beyond the context of the study setting. These include recruitment strategy, sample size and makeup, study design, and investigator bias. Each is presented in the sections below and is followed by ideas for addressing them in future research.

5.4.1 Limitations in Recruitment Strategy

The strategy used to recruit client participants for the study was onerous and convoluted, requiring two- or three-party communication in order to reach them. The lack of documented consent from the PSHP project’s clients to use their information for research or evaluation purposes was interpreted in the original ethics review as a barrier to contacting them for recruitment in the study. Moreover, the time between delivery of the PSHP project and recruitment of participants (over five years) may have presented an insurmountable barrier in reaching former clients, particularly those with poorer outcomes including service disengagement or experiences of homelessness. For future research to evaluate similar service delivery projects, it is critical that clients provide informed consent that allows for them to be contacted for recruitment purposes without complicated communication strategies.

5.4.2 Limitations in Sample Size and Makeup

While enough participants were recruited to achieve theoretical saturation for the purposes of qualitative analysis, the small sample size limits the generalizability of the findings. Particularly, the very small number of client participants recruited for the study, when compared to therapist participant recruitment, may have served to drown out their perspectives in analysis and strengthen therapist viewpoints. This is an important consideration in light of the differing standpoints and the power dynamics between these two groups. In terms of the client participants, there are also reservations regarding the diversity of experiences represented in the group. For example, the concept of recovery may be viewed very differently by someone who continues to struggle greatly or endures other sorts of marginalization, be it because of sexual identity, ethnicity, or other characteristics not shared by client participants. For future research, it is recommended that recruitment strategies should be enhanced to allow for larger numbers of therapists and clients to participate. Among the latter group, special attention needs to be given to reaching clients with a variety of profiles and lived experiences; those who have had more struggles or are more familiar with the recovery discourse could introduce further depth to the data. Having larger numbers of participants would also allow for perspectives to be contrasted between the two groups to find areas of convergence or divergence.

5.4.3 Limitations in Research Design

As discussed, the research design was originally for a quasi-experimental study to determine differences in outcomes between a treatment group and a control group. However, with poor client participant recruitment and the complete lack of a control group, the research design had to be modified retroactively. A significant amount of data had to be discarded to keep the study aligned with its new focus. Further, the findings could be interpreted as the result of secondary analysis of qualitative data collected with a different focus, confined to the scope and intent of questions that were not exactly applicable anymore. Further, there are limitations in the way data were collected to assess delivery of the PSHP pilot project. Despite the presence of rich client contact logs, there may be other information, for example in PSHP project staff emails or administrative records, that could provide more context. Recommended improvements to the study include additional data collection based on the modified design instead of relying solely on pre-existing data collected for slightly different purposes. Further, while retrospective evaluation was the only option for studying the PSHP project, future studies could apply a prospective approach to evaluate similar projects in the future as they are being delivered.

5.4.1 Limitations in Investigator Bias

There are limitations related to the student investigator's own biases and experiences that should be considered when interpreting the findings of the study. His experiential background, while on one hand serves as an asset in the study, infuses inherent biases with respect to particular service delivery modalities, views of the mental health system and its gaps, feelings about client empowerment, interpretation of social and policy influencers, the benefits of lived experience of mental illness, and the perceived value of peer-based models. Future research, especially with respect to continued learning from the PSHP project, should consider the value of an impartial and unconnected researcher to conduct data collection, analysis, and interpretation of findings to allay any perceptions of investigator bias. Further exploration of recovery or peer support would ideally engage peer researchers in a meaningful way to align with the underlying spirit of this study.

5.5 Conclusion

The PSHP project was developed and implemented to address gaps in the mental health system for people with mental illness that left them at greater risk of housing instability and poorer clinical and social outcomes. Its design was intended to provide services that could address their need for skills development and connection to resources, utilizing peer workers to achieve outcomes of housing stability, independent living, social engagement, and recovery orientation. As emerged from analysis in this study, these outcomes all center around the concept of recovery, feeding it at the same time as they are reciprocally fed by it.

Through examination of these outcomes from the perspectives of therapists and former PSHP project clients, a variety of factors emerged that that had not been considered in the original program model. These factors can be grouped into an ecological framework, called the Recovery Wheel, that includes personal, intrapersonal, interpersonal, institutional, and societal domains. The factors in the Recovery Wheel interact with each other, and each must be considered when determining what facilitators and constraints exist for a person with mental illness moving from a disability orientation to a recovery orientation.

In the personal domain, cognitive capacity, upbringing, personal history, and personality were identified. Notably, none of these factors are mentioned in other recovery frameworks in the literature. Cognitive capacity, by virtue of its connection to risk of victimization, and upbringing, especially the impacts of adverse life experiences and independent living skills training in the home, figure prominently among the factors in this domain in terms of their role in constraining recovery possibilities. In the intrapersonal domain, functioning, symptomology, substance use, physical wellness, and outlook emerged as factors. Notably, psychotic symptoms appear to have less of a negative impact on recovery orientation than expected. On the other hand, substance use requires more attention, particularly with respect to the adoption of harm reduction approaches to adapt to shifting of ideological paradigms and public opinion. In the interpersonal domain, housing, family, social network, and community were identified as factors influencing recovery. The findings expose the dire state of housing for people with mental illness exposed to a predatory environment due to the lack of non-market affordable and supportive options. While family and social networks are recognized as both positive and negative influencers in a person’s life, there is a strong emphasis on feeling that one is part of a community with others who share values and life experiences. Faith communities are specifically highlighted as an underutilized avenue to provide natural support and a sense of belonging for otherwise marginalized people with mental illness.

In the institutional domain, functional supports, clinical supports, medications, and system orientation were identified as key factors. The findings highlight deep deficiencies in the underlying structure of the mental health system, including disconnects among health professionals, a lack of services or very complicated ways to access them, overreliance on medications with reluctance to pursue other treatment modalities, and power dynamics that stress the primacy and dominance of clinical viewpoints over client choice.

In the societal domain, perception of mental illness, security and vulnerability, income and poverty, and self-esteem were identified as factors influencing recovery. The ever-present stigma of mental illness and its persistence in social spheres contributes to internalized stigma and consequent lower self-esteem. Dependence on inadequate income support programs and few employment opportunities keep people with mental illness in poverty, further marginalizing and excluding them from a sense of normalcy and social participation. Perhaps most importantly, the study places a spotlight on seemingly ubiquitous victimization and exploitation of people with mental illness by practically everyone around them, including family members, ‘friends’, landlords, service providers, and others.

With respect to the PSHP project, many of the factors identified in the Recovery Wheel were addressed through service delivery by peer workers, albeit much of it was unintended within the original design. Peer workers, although likely not trained to do so, appeared to infuse their own lived experience into their service delivery, broaching topics and addressing issues that had been left out (intentionally and unintentionally) of the PSHP project design. While trained to provide instrumental support and help with development of independent living skills (related to the functioning and functional supports factors in the Recovery Wheel), they tended to focus on issues that were most affecting their clients, like side effects of medications, poverty and loneliness, deficient support from the mental health system, victimization, relationships with family, among many others.

The findings from analysis of PSHP project delivery through the lens of the Recovery Wheel suggests value over and above the mere provision of services that comes from having peer workers serving clients. Certainly, from a service delivery standpoint, the peer workers appeared to operate as one would expect support workers to serve clients, achieving fairly intensive levels of client engagement and demonstrating rigour through the sophistication of their work and meticulous recording of their efforts. However, the peer workers did more than supplement inadequate availability of services from the mental health system: they provided a layer of support that is non-existent in the clinical sphere that transcends professional boundaries and knowledge. It is evident that they are not mere adjuncts added to clinical and functional supports offered by the system, but constitute a capstone that bridges between professional expertise and the lived experience of mental illness. The role of peer workers incorporates practical expertise in a therapeutic alliance built on a non-hierarchical relationship and deeper empathy borne out of shared experience. In many ways, the application of peer workers in this context serves as a countervailing force against the continuing struggle of the mental health system to pull away from its history of oppressive practice and imbalanced power dynamics with the people who depend on it.

In sum, this study provides additional fuel for the ongoing exploration of the concept of recovery and how it figures within approaches to address the needs of people with mental illness, especially application of peer support to this end. Further research is required to validate the factors that emerged through the development of the Recovery Wheel, and to explore perspectives of a wider range of clinician and client viewpoints to ensure that the framework is truly comprehensive. Also, with respect to the role of peer workers in helping clients, more research is required to clarify the mechanism through which application of lived experience can augment and complement services available through the system, and what is the best positioning – i.e., within or outside of the system – for them to provide the most value in supporting people with mental illness towards recovery.

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Appendix A – Recruitment Materials

CENTRE FOR HEALTH PROMOTION STUDIES
SCHOOL OF PUBLIC HEALTH

Information Letter (Former PSHP Clients)

Title: Evaluating Long-Term Outcomes for Participants in a Peer Housing Support Project

Researcher:	Giri Puligandla, MSc candidate School of Public Health University of Alberta Phone: [removed]	**Supervisor**:	Dr. Candace Nykiforuk, PhD School of Public Health University of Alberta Phone [removed]

Purpose of this Study: The purpose of this study is to find out what can help a person living with mental illness with their living skills, housing, social life, and recovery.

Background: Between 2007 and 2009, the Schizophrenia Society of Alberta offered a service called the Peers Supporting Housing Pilot (PSHP) Project. People who received this service were taught skills for living on their own. We want to see if people who got this service still have those skills. We also want to see if the service helped people in their housing, social life, and recovery. We are going to look at a group that received the service and one that did not.

Procedure: Giri (the researcher) wants to talk to you because you were in the PSHP project. He will meet with you three times. Each interview will last about an hour. It can take place in your home or any other quiet place. At the first meeting, Giri will ask some questions about you, where you have lived, your illness, and services you have used. Next, he will look at your notes from the PSHP project. At the second meeting, Giri will ask you about what independent living and recovery mean to you. He will also ask you about what you remember about the PSHP project. At the last meeting, he will ask you questions about your living skills, recovery, and social life. The second interview will be recorded. A written copy of the recording will be made. You can choose not to be recorded. You can also tell Giri to stop recording at any time.

Risks: Talking about any hard times you have had can make you feel bad. If it bothers you, you can stop, delay, or quit the study at any time. If Giri notices you are feeling bad, he will stop the meeting. He will then call you again in a day to see if you want to meet again. In an emergency, Giri will call your therapist or the Crisis Team.

Benefits: This study may not help you. The study might help people like you get better services. You will get $10 for the first interview, $15 for the second interview, and $25 for the third interview, for a total of $50 for all three interviews.

Confidentiality: Giri will make sure that everything you say is private. All his notes will be locked in a filing cabinet. You will get to choose a fake name that will be put on all of your notes. Giri will never use your real name when he writes about the study. He will keep everything for five years and then destroy it. He might use the notes for a future study. Giri would need approval by a research ethics board before he could use your notes.

Freedom to withdraw: You do not have to take part in this study. You can choose to leave the study anytime. You do not have to give a reason.

Additional Contacts: If you have any questions about this research study, you can call:

Dr. Candace Nykiforuk,
School of Public Health
University of Alberta
Phone [removed]

Or

Research Ethics Office
University of Alberta
Phone (780) 492-2615.

UNIVERSITY OF ALBERTA

CENTRE FOR HEALTH PROMOTION STUDIES
SCHOOL OF PUBLIC HEALTH

Information Letter (Referred Non-Clients)

Title: Evaluating Long-Term Outcomes for Participants in a Peer Housing Support Project

Researcher:	Giri Puligandla, MSc candidate School of Public Health University of Alberta Phone: [removed]	**Supervisor**:	Dr. Candace Nykiforuk, PhD School of Public Health University of Alberta Phone [removed]

Purpose of this Study: The purpose of this study is to find out what can help a person living with mental illness with their living skills, housing, social life, and recovery.

Background: Between 2007 and 2009, the Schizophrenia Society of Alberta offered a service called the Peers Supporting Housing Pilot (PSHP) Project. People who received this service were taught skills to help them live on their own. We want to see if people who got this service still have those skills. We also want to see if the service helped people in their housing, social life, and recovery. We are going to look at a group that received the service and one that did not.

Procedure: Giri (the researcher) wants to talk to you because you were referred to the PSHP project but did not receive the service. He will meet with you three times. Each interview will last about an hour. It can take place in your home or any other quiet place. At the first meeting, Giri will ask some questions about you, where you have lived, your illness, and services you have used. Next, he will look at your notes from the PSHP project. At the second meeting, Giri will ask you about what independent living and recovery mean to you. He will also ask you about your experiences or thoughts on peer support. At the last meeting, he will ask you questions about your living skills, recovery, and social life. The second interview will be recorded. A written copy of the recording will be made. You can choose not to be recorded. You can also tell Giri to stop recording at any time.

Risks: Talking about any hard times you have had can make you feel bad. If it bothers you, you can stop, delay, or quit the study at any time. If Giri notices you are feeling bad, he will stop the meeting. He will then call you again in a day to see if you want to meet again. In an emergency, Giri will call your therapist or the Crisis Team.

Benefits: This study may not help you. The study might help people like you get better services. You will get $10 for the first interview, $15 for the second interview, and $25 for the third interview, for a total of $50 for all three interviews.

Confidentiality: Giri will make sure that everything you say is private. All his notes will be locked in a filing cabinet. You will get to choose a fake name that will be put on all of your notes. Giri will never use your real name when he writes about the study. He will keep everything for five years and then destroy it. He might use the notes for a future study. Giri would need approval by a research ethics board before he could use your notes.

Freedom to withdraw: You do not have to take part in this study. You can choose to leave the study anytime. You do not have to give a reason.

Additional Contacts: If you have any questions about this research study, you can call:

Dr. Candace Nykiforuk,
School of Public Health
University of Alberta
Phone [removed]

Or

Research Ethics Office
University of Alberta
Phone (780) 492-2615.

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CENTRE FOR HEALTH PROMOTION STUDIES
SCHOOL OF PUBLIC HEALTH

Information Letter for Therapists

Title: Evaluating Long-Term Outcomes in a Peer Housing Support Project

Researcher:	Giri Puligandla, MSc candidate School of Public Health University of Alberta Phone: [removed]	**Supervisor**:	Dr. Candace Nykiforuk, PhD School of Public Health University of Alberta Phone: [removed]

Purpose of this Study: The purpose of this study is to find out what programs and services can help a person living with mental illness live independently, have a good social life, keep stable housing, and manage their illness.

Background: Between 2007 and 2009, the Schizophrenia Society of Alberta offered a service called the Peers Supporting Housing Pilot (PSHP) Project. People were referred to the project by their therapist and they worked with a team of people living with mental illness who were hired, trained, and supervised by an occupational therapist. The peer workers taught them skills to live independently in the hopes that it would help them maintain their housing over the long term, be more social, and be more confident in their recovery from mental illness. This study will evaluate the project to see if it was successful in meeting these goals over the long-term by comparing a group of people who participated in the project to a group of people who were referred to the project but did not complete intake. It will also explore the interrelationships among the concepts of peer support, independent living, and recovery. Alberta Health Services – Addiction & Mental Health is supporting this research project.

Procedure: You are the therapist for one or more clients referred to the PSHP project when it was in operation. It is hoped that you will be able to assist the researcher (Giri Puligandla) in recruiting clients who either participated in the PSHP project, or were referred but did not participate, for his study. If the researcher is unable to recruit a sufficient number of clients for his study, he will ask you to participate in an interview that will last about 1 hour. He will ask open-ended questions about what independent living and recovery mean to you, and your thoughts and experiences regarding peer support. The interview will take place in your office or another quiet, private area you choose. The interview will be recorded and a written copy of the recording will be made. You can choose not to be recorded. You can also tell the researcher to stop recording at any time.

Risks: You are unlikely to experience any distress by participating in an interview. You may however experience cultural or social risk if your expressed opinions become known to others. To reduce this risk, any potentially identifying information in your interview will be removed. Any quotes intended for publication will be provided to you in advance for your approval before they are included.

Benefits: This study may not be of any direct help to you or your clients. However, by taking part in this study we can learn about what programs and services can help people maintain housing, live independently, have a good social life, and recover from mental illness.

Confidentiality: The researcher Giri Puligandla and his supervisory committee will maintain the privacy of the interviews. All information will be kept for five years after the study is done and then destroyed (as mandated by the University of Alberta Research Policies and Services Manual, sections 5.2 and 7.5). The information will be kept in a locked filing cabinet. Your name or any other information that might identify you will not be attached to the information you give. Names will never be used in any presentation or publication of the study results. All information will be held confidential and private, except when required by law. The information gathered for this study may be looked at again in the future to help answer other study questions. If so, the ethics board will first review the study to ensure the information is used ethically.

Freedom to withdraw: You can choose not to participate in this study. You are free to withdraw your consent or stop participation in this study at any time. You do not have to give a reason.

Additional Contacts: Any questions or concerns about this research study, should be reported to:

Dr. Candace Nykiforuk,
School of Public Health, University of Alberta, Edmonton, Alberta, Phone [removed]

Or the Research Ethics Office at the University of Alberta, Edmonton, Alberta. Phone (780) 492-2615.

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CENTRE FOR HEALTH PROMOTION STUDIES
SCHOOL OF PUBLIC HEALTH

Consent Form

Title of Project: Evaluating Long-Term Outcomes for Participants in a Peer Housing Support Project

Student Investigator:	Mr. Giri Puligandla, School of Public Health University of Alberta [removed]	Supervisor:	Dr. Candace Nykiforuk, School of Public Health University of Alberta [removed]

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate, or to withdraw from the study at any time, without consequence, and that your information will be withdrawn at your request?	Yes	No
Has the issue of confidentiality been explained to you? Do you understand who will have access to your information?	Yes	No

Who explained this study to you? ____

I agree to take part in this study:

___________________________ ____________________

Signature of Research Participant Date

____

Printed Name

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

__________________________________ ___________________________

Signature of Investigator or Designee Date

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CENTRE FOR HEALTH PROMOTION STUDIES
SCHOOL OF PUBLIC HEALTH

CONSENT TO THE DISCLOSURE OF INDIVIDUALLY IDENTIFYING HEALTH INFORMATION AUTHORIZED BY THE HEALTH INFORMATION ACT (HIA), SECTION 55

CLIENT INFORMATION:

Name: ____
(surname) (given name/names)

Date of Birth: ______________________
(day/month/year)

Address: ____

I authorize my individually identifying health information related to:

My first and last name, my phone number, and my email address

to be disclosed by ____
(name of custodian)

in accordance with section 55 of the Health Information Act to:

Mr. Giri Puligandla (School of Public Health, University of Alberta)

for the following purpose(s):

The researcher, Giri Puligandla, can call or email me to arrange for a meeting to explain the research study and ask me if I want to participate in it.

I understand why I have been asked to disclose my individually identifying information, and am aware of the risks or benefits of consenting, or refusing to consent, to the disclosure of my individually identifying information. I understand that I may revoke this consent in writing at any time.

Dated this _____ of ____________, ________. Expiry date (30 days): _____ of ___________, ________
(day) (month) (year) (day) (month) (year)

____
Signature of client/authorized representative*
* if you are signing on behalf of the client, the following information must be provided:

__________________________________	_____ _________________________________
Print Name of Authorized Representative	Print Source of Representative's Authority [refer to HIA section 104(1)]
__________________________________	_____ _________________________________
Witness Signature	Witness Name

Script for SSA Staff Assisting with Recruitment of Former PSHP Clients

A researcher wants to interview you because you participated in the Peers Supporting Housing project a few years ago. He is doing a study on what can help a person living with mental illness live independently, have a good social life, keep stable housing, manage their illness, and recover from it.

If you want to participate, he will interview you three times for about an hour each time. In the first interview, he will ask you about who you are, your illness, what programs and services you've used, and where you've lived. In the second interview, he will ask you about what independent living, recovery, and peer support mean to you. In the third interview, he will ask questions about your living skills, social life, and recovery from mental illness.

Whether or not you call him will not affect your services in any way. It is completely up to you if you want to participate or not.

Again, it is up to you if you want to participate. Again, your choice will not affect any services you get form me or anyone else.

Are you interested in talking to the researcher?

→[If YES]

The researcher's name is Giri (pronounced like "GARY"). His phone number is [removed]. You can call him anytime. After you talk to him on the phone, he will meet with you to go over the details of the research and make sure you understand it. If, after learning more about the research, you want to participate, he will make arrangements with you for the three interviews. He will give you $10 for the first interview, $15 for the second interview, and $25 for the third interview, as a token of appreciation for your time. You are free to stop participating in the research at anytime without any obligation.

→[If NO] OK, not a problem at all. Like I said, completely up to you. Thanks for your time.

Thank you for your help!

If you or your client has any questions, please call Giri (the researcher) at [removed].

Script for Therapists

A researcher wants to interview you for a study he is doing on what can help a person living with mental illness live independently, have a good social life, keep stable housing, manage their illness, and recover from it.

If you want to participate, he will interview you three times for about an hour each time. In the first interview, he will ask you about who you are, your illness, what programs and services you've used, and where you've lived. In the second interview, he will ask you about what independent living, recovery, and peer support mean to you. In the third interview, he will ask questions about your living skills, social life, and recovery from mental illness.

Whether or not you call him will not affect your services in any way. It is completely up to you if you want to participate or not. If you choose to participate, you will get a small cash gift as a token of appreciation for each interview you complete.

If you are interested in participating, you have two options:

1) You can take this information sheet and call him at the number on the sheet.

2) I can give him your phone number to call you.

It is up to you if you want to participate. Again, your choice will not affect any services you get form me or anyone else.

QUESTION: Are you interested in talking to the researcher?

→[If YES]

QUESTION: Do you want him to call you or do you want to call him?

- If your client says "I will call him", provide the information sheet.
- If your client says "I want him to call me", ask:
  - QUESTION: Can I give him your phone number?
    - If your client says YES: assist your client in filling out the HIA Section 55 Consent Form and call the researcher at [removed] to pass on your client's phone number. He will call him within one day.
    - If your client says NO: provide him with the information sheet and say "OK, then you can call him if you want to participate."

→[If NO] OK, not a problem at all. Like I said, completely up to you.

Thank you for your help!

If you or your client has any questions, please call Giri (the researcher) at [removed].

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CENTRE FOR HEALTH PROMOTION STUDIES
SCHOOL OF PUBLIC HEALTH

Brief Information Sheet (to be given by therapist to the client)

A researcher wants to interview you for a study he is doing on what can help a person living with mental illness live independently, have a good social life, keep stable housing, manage their illness, and recover from it.

If you want to participate, he will meet with you three times. At the first meeting, he will ask some questions about you, where you have lived, your illness, and services you have used. At the second meeting, he will ask you about what independent living and recovery mean to you. He will also ask you about what you remember about the PSHP project. At the last meeting, he will ask you questions about your living skills, recovery, and social life. Each interview will last about an hour. They can take place in your home or any other quiet place you choose.

Whether or not you call him will not affect your services in any way. It is completely up to you if you want to participate or not.

The researcher's name is Giri (pronounced like "GARY"). His phone number is [removed]. You can call him anytime.

After you talk to him on the phone, he will meet with you to go over the details of the research and make sure you understand it. If, after learning more about the research, you want to participate, he will make arrangements with you for the three interviews. He will give you $10 for the first interview, $15 for the second interview, and $25 for the third interview, as a token of appreciation for your time. You are free to stop participating in the research at anytime without any obligation.

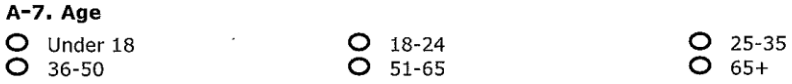
Appendix B – Data Collection Tools

Demographic Questionnaire **Alias: ___________________________**

Please answer the following questions. You may choose not to answer any or all of the questions. I will use a fake name (an "alias") so you and I know that the information on this form is about you but no one else will know. I will keep your completed questionnaire separate from other questionnaires and forms I use to write down what you tell me. I will use your answers to these questions to see if the people I am interviewing are similar to each other and to see if the people I am interviewing are typical of people receiving mental health services in Edmonton.

Age

How old are you? Client Response: _____________

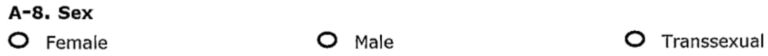


A-7. Age

○ Under 18 ○ 18-24 ○ 25-35
○ 36-50 ○ 51-65 ○ 65+

Gender

What is your gender/sex? Client Response: _____________

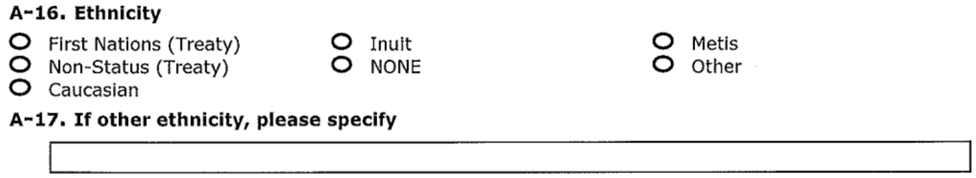


A-8. Sex

○ Female ○ Male ○ Transsexual

Ethnicity

What is your cultural background or ethnicity? Client Response: _____________



A-16. Ethnicity

○ First Nations (Treaty) ○ Inuit ○ Metis
○ Non-Status (Treaty) ○ NONE ○ Other
○ Caucasian

A-17. If other ethnicity, please specify

Family or Relationship Status

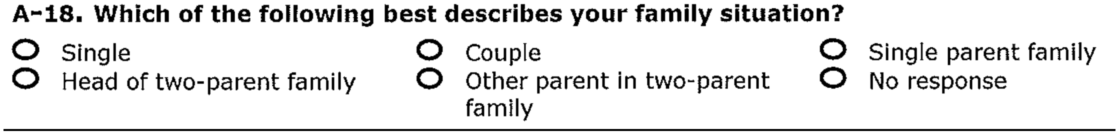
What is your relationship status?

Single ☐ In a significant relationship: Married ☐ Common Law ☐ Other Relationship ☐

Any Children? No ☐ Yes ☐: How many? _________

If children, describe family situation:

Two parent family ☐ Single parent family ☐

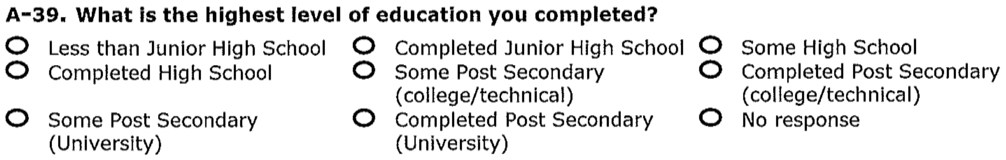


A-18. Which of the following best describes your family situation?

○ Single ○ Couple ○ Single parent family
○ Head of two-parent family ○ Other parent in two-parent family ○ No response

Highest Level of Education Attained

What is the highest level of education you completed? Client Response: ________________
(Record degree, certificate, diploma, or grade)

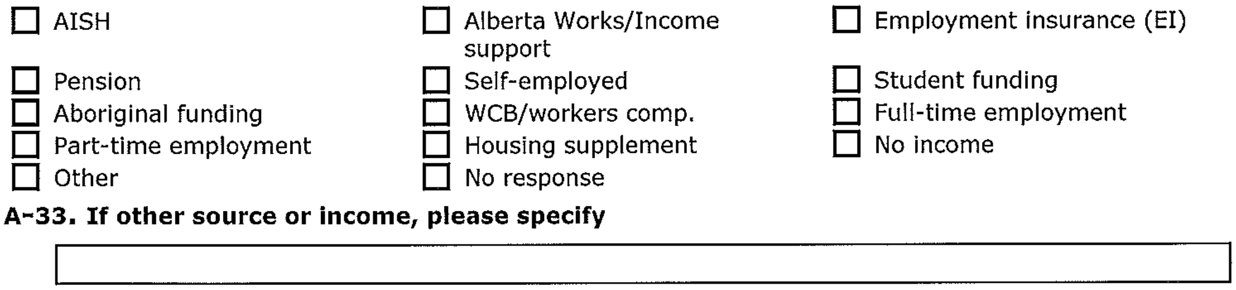


A-39. What is the highest level of education you completed?

○ Less than Junior High School
○ Completed High School
○ Some Post Secondary (University)
○ Completed Junior High School
○ Some Post Secondary (college/technical)
○ Completed Post Secondary (University)
○ Some High School
○ Completed Post Secondary (college/technical)
○ No response

Income Sources

Which of the following are your current sources of income? (Check all that apply)



☐ AISH
☐ Pension
☐ Aboriginal funding
☐ Part-time employment
☐ Other
☐ Alberta Works/Income support
☐ Self-employed
☐ WCB/workers comp.
☐ Housing supplement
☐ No response
☐ Employment insurance (EI)
☐ Student funding
☐ Full-time employment
☐ No income

A-33. If other source or income, please specify

Clinical Information Questionnaire **Alias: ___________________________**

Please answer the following questions. You may choose not to answer any or all of the questions. I will use a fake name (an "alias") so you and I know that the information on this form is about you but no one else will know. I will keep your completed questionnaire separate from other questionnaires and forms I use to write down what you tell me. I will use your answers to these questions to see if the people I am interviewing are similar to each other and to see if the people I am interviewing are typical of people receiving mental health services in Edmonton.

Primary Diagnoses

Diagnoses: ___________________ ___________________ ___________________ ___________________

Age of Onset

Age : _______

Age of Diagnosis

Age: _______

Age when treatment was commenced

Age: _______

Service Usage

Please tell me if you have received any of the following services in the in the past three years, ever, or never?

AHS Clinical Services

AHS: Visit from the Crisis Team	No, never or don't know ☐ Yes: Past 3 years? Yes ☐ No ☐
AHS: Visit to a Community Mental Health Clinic	No, never or don't know ☐ Yes: Past 3 years? Yes ☐ No ☐
AHS: An Outpatient or Day Treatment Program in a Hospital	No, never or don't know ☐ Yes: Past 3 years? Yes ☐ No ☐
AHS: Home Visit from the Community Support Team	No, never or don't know ☐ Yes: Past 3 years? Yes ☐ No ☐
AHS: Appointment with a Psychologist	No, never or don't know ☐ Yes: Past 3 years? Yes ☐ No ☐
AHS: Appointment with a Psychiatrist	No, never or don't know ☐ Yes: Past 3 years? Yes ☐ No ☐
AHS: Appointment with an Occupational Therapist	No, never or don't know ☐ Yes: Past 3 years? Yes ☐ No ☐
AHS: Appointment with a Social Worker	No, never or don't know ☐ Yes: Past 3 years? Yes ☐ No ☐

AHS: Assertive Community Treatment	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐
AHS: Forensic Assessment and Community Services	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐
AHS: Stay in a city hospital psychiatric unit overnight or longer	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐
AHS: Stay in Alberta Hospital overnight or longer	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐

AHS Community Services

AHS: Cornerstone Apartments	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐
AHS: Anderson Hall	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐
AHS: Pathways Day Program	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐
AHS: Pathways Vocational Program	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐
AHS: BRIDGES/Footsteps Program	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐
AHS: Wellness Recovery Action Plan Training Program	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐
AHS: Employment Programs	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐
AHS: Housing Supports	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐
AHS: Home Visits from the Housing Outreach and Stabilization Team	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐

Any programs offered by CMHA? No, never or don’t know ☐ Yes: Past 3 years? Yes ☐ No ☐

CMHA: Community Rehabilitation Outreach Program (CROP)	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐
CMHA: Family Support Program	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐
CMHA: Housing Program	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐
CMHA: Moving Ahead Program (MAP)	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐
CMHA: Passages	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐
CMHA: Self Advocacy and Leadership Training (SALT)	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐
CMHA: Social Recreation for Adults	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐
CMHA: Support Groups	No, never or don’t know ☐	Yes: Past 3 years? Yes ☐	No ☐

Any programs offered by SSA? No, never or don't know ☐ Yes: Past 3 years? Yes ☐ No ☐

SSA/OBAD: Bipolar Support Group	No, never or don't know ☐ Yes: Past 3 years? Yes ☐ No ☐
SSA: ESCAPE Program	No, never or don't know ☐ Yes: Past 3 years? Yes ☐ No ☐
SSA: Family Support Groups	No, never or don't know ☐ Yes: Past 3 years? Yes ☐ No ☐
SSA: Partnership Program (Speaking Of Schizophrenia)	No, never or don't know ☐ Yes: Past 3 years? Yes ☐ No ☐
SSA: SOS Players Guild	No, never or don't know ☐ Yes: Past 3 years? Yes ☐ No ☐
SSA: Strengthening Families Together	No, never or don't know ☐ Yes: Past 3 years? Yes ☐ No ☐
SSA: Unsung Heroes	No, never or don't know ☐ Yes: Past 3 years? Yes ☐ No ☐
SSA: Your Recovery Journey	No, never or don't know ☐ Yes: Past 3 years? Yes ☐ No ☐

Are there any other programs or services you have used that are missing from this list?

	Past 3 years? Yes ☐ No ☐
	Past 3 years? Yes ☐ No ☐
	Past 3 years? Yes ☐ No ☐
	Past 3 years? Yes ☐ No ☐
	Past 3 years? Yes ☐ No ☐
	Past 3 years? Yes ☐ No ☐
	Past 3 years? Yes ☐ No ☐
	Past 3 years? Yes ☐ No ☐
	Past 3 years? Yes ☐ No ☐
	Past 3 years? Yes ☐ No ☐
	Past 3 years? Yes ☐ No ☐
	Past 3 years? Yes ☐ No ☐

Participant's Additional Comments:

Housing Stability Questionnaire Alias: _______________________________

1. Have you lived in your current residence for three years or more?

Yes No

If Yes, Q9. If No, Q2.

2. When did you move in to your current place? Response: _________

Number of Full Months: ____ (should be less than 36)

3. How many times have you moved in the past three years? Response: _________

None 2-3 times 4 or more times

4. Were you ever homeless during the last three years?

Yes No

If No, Q8. If Yes, Q5.

5. How many times did you become homeless over the last three years? Response: __________

None 1 2 3 4 or more

6. How long have you been homeless, total, over the last three years? Response: __________

Never 1-3 months 4-6 months 7-9 months 10-12 months 1 year or more

7. In the last three years, have you ever been homeless continuously for over a year?

Yes No

8. What is the longest time you have been in your own place in the last three years? Response:________

Number of Full Months: ____ (should be less than 36)

9. In the last three years, has your housing been lost or threatened for any of the following reasons?

Had a relapse: Lost Threatened No
Victimization (abuse): Lost Threatened No
Problem with roommate: Lost Threatened No
Went into hospital: Lost Threatened No
Went to jail: Lost Threatened No
Went into drug treatment: Lost Threatened No
Eviction Notice: Lost Threatened No

Less support services: Lost Threatened No
Rent increase: Lost Threatened No
Utility increase: Lost Threatened No
Loss of subsidy: Lost Threatened No
Loss of family support: Lost Threatened No
Other:

Semi-Structured Interview (Clients)

I have a few questions I'd like to ask you about independent living and recovery. As I explained, I'm going to record our conversation and then write down everything later, taking out any information that can identify you. <u>Are you ok with me recording our conversation?</u>

Question 1: Tell me what it means to you to "live independently".

Prompts (not including prompts induced from analysis of previous interviews):

[If participant is unclear about what is meant to "live independently", say: "Living independently can mean not relying a lot on others to take care of you and your things, for example paying your own bills, going grocery shopping and making your own meals, or taking care of your own place and things."]
What do you think causes people to get evicted or lose their home?
What skills do you think are most important for living independently?
What do you think people need to live independently?
What do you think is the best way to learn how to live independently?
What would you say are the main reasons why some people can't live independently?

Notes:

Question 2. Tell me what you think about recovery from mental illness.

Prompts (not including prompts induced from analysis of previous interviews):

[If participant is unclear about what is meant by "recovery from mental illness", say: "Someone described recovery as 'a way of living a satisfying, hopeful and contributing life even with limitations caused by illness'" (Anthony, 1993; in Bellack, 2006, p. 436)]
In your mind, how would you know if you or someone else is "recovered"?
What do you think people need to recover?
How much do you think a social life is part of recovery?
What would you say are things that get in the way of recovery?
What is the relationship between independent living and recovery?
How helpful would it be to talk to someone who is "recovered"?

Notes:

[Former PSHP Clients Only] Question 3a: Tell me about what you remember about the PSHP project.

Prompts (not including prompts induced from analysis of previous interviews):

Were there any experiences that stand out for you?
What did you like the most/least about the PSHP project?
Did the PSHP project help you the way you wished it would?
Do you think having peers or non-peers in a service like this would make a difference?
How could peers help a person live independently?
How could peers help a person towards recovery?
How could peers help a person not lose their housing?
How could peers help a person with their social life?

Notes:

[Referred Non-Clients Only] Question 3b: Tell me what you think about “peer support”.

Prompts (not including prompts induced from analysis of previous interviews):

[If participant is unclear about what is meant by “peer support”, say: “Someone described peer support as ‘involving one or more persons…who have experienced significant [recovery from] their [mental illness] offering [support] to other people with…mental illness who are…not as far along in their own recovery process’” (Davidson et al., 2006)]
Have you ever participated in a peer support program?
Have you heard of anyone else’s experiences with peer support?
What do you think about people in recovery being hired to provide services to their peers?
Is there anything a peer can do better than a non-peer in terms of helping people with mental illness?
How could peers help a person live independently?
How could peers help a person towards recovery?
How could peers help a person not lose their housing?
How could peers help a person with their social life?

Notes:

Thank you for taking the time to talk to me today. If you think of anything else later on, you can always call me and let me know your thoughts on recovery, peer support, or independent living.

References:

Bellack, A.S. (2006). Scientific and consumer models of recovery in schizophrenia: concordance, contrasts, and implications. *Schizophrenia Bulletin, 32*(3)*, p. 432-442.*

Davidson, L.; Chinman, M.; Sells, D.; and Rowe, M. (2006). Peer support among adults with severe mental illness: A report from the field. *Schizophrenia Bulletin, 32*(3)*, p. 443-450.*

Semi-Structured Interview (Therapist)

I have a few questions I'd like to ask you about independent living, recovery, and peer support. As I explained, I'm going to record our conversation and then write down everything later, taking out any information that can identify you. Are you ok with me recording our conversation?

Question 1: Tell me what it means for a client to "live independently".

Prompts (not including prompts induced from analysis of previous interviews):

[If participant is unclear about what is meant to "live independently", say: "Living independently can mean not relying a lot on others to take care of you and your things, for example paying your own bills, going grocery shopping and making your own meals, or taking care of your own place and things."]
What do you think causes people to get evicted or lose their home?
What skills do you think are most important for living independently?
What do you think people need to live independently?
What do you think is the best way to learn how to live independently?
What would you say are the main reasons why some people can't live independently?

Notes:

Question 2. Tell me what you think about recovery from mental illness.

Prompts (not including prompts induced from analysis of previous interviews):

[If participant is unclear about what is meant by "recovery from mental illness", say: "Someone described recovery as 'a way of living a satisfying, hopeful and contributing life even with limitations caused by illness'" (Anthony, 1993; in Bellack, 2006, p. 436)]
In your mind, how would you know if one of your clients is "recovered"?
What do you think people need to recover?
How much do you think a social life is part of recovery?
What would you say are things that get in the way of recovery?
What is the relationship between independent living and recovery?
How helpful would it be for your clients to talk to someone who is "recovered"?

Notes:

Question 3: Tell me what you think about "peer support".

Prompts (not including prompts induced from analysis of previous interviews):

[If participant is unclear about what is meant by "peer support", say: "Someone described peer support as 'involving one or more persons…who have experienced significant [recovery from] their [mental illness] offering [support] to other people with…mental illness who are…not as far along in their own recovery process'" (Davidson et al., 2006)]
Have any of your clients ever participated in a peer support program?
Have you heard of any other therapists' experiences with peer support?
What do you think about people in recovery being hired to provide services to their peers?
Is there anything a peer can do better than a non-peer in terms of helping people with mental illness?
How could peers help a person live independently?
How could peers help a person towards recovery?
How could peers help a person not lose their housing?
How could peers help a person with their social life?

Notes:

Thank you for taking the time to talk to me today. If you think of anything else later on, you can always call me and let me know your thoughts on recovery, peer support, or independent living.

References:

Bellack, A.S. (2006). Scientific and consumer models of recovery in schizophrenia: concordance, contrasts, and implications. *Schizophrenia Bulletin, 32*(3)*, p. 432-442.*

Davidson, L.; Chinman, M.; Sells, D.; and Rowe, M. (2006). Peer support among adults with severe mental illness: A report from the field. *Schizophrenia Bulletin, 32*(3)*, p. 443-450.*