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Homelessness and Mental Health: A Participatory Action Research Approach

John D. Rogers

A dissertation submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

In

Partial Fulfillment of the Requirements for the degree of

Doctor of Philosophy

Department of Graduate Psychology

May 2021

FACULTY COMMITTEE:

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Dedication

This project and dissertation are dedicated to Jeannie, with deep affection and admiration.

Acknowledgments

This dissertation is the culmination of a non-traditional academic journey, one which would not have been possible without the inspiration and encouragement of my family, teachers, and mentors. I give thanks to my family: Jeannie, Serena, Ursula, Hannah, and Shelby, for sustaining me during this process. My deepest admiration and thanks to my James Madison University dissertation committee chair: Amanda, and members, Debbie and Eric, who have also inspired and taught me throughout my graduate school journey. I am constantly inspired by the core JMU faculty who shaped my pathway to counseling and scholarship: Lennie, Michele, Renee. My gratitude goes to the wonderful staff at the Haven, especially Stephen, who has steadfastly supported my work with its clients. Finally, to the five extraordinary people who took a risk and became members of this project's working group: Thank you for sharing your experiences and for offering a vision of resilience and hope to others struggling with homelessness and mental illness.

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Abstract

The co-occurring problems of homelessness and mental illness is addressed through Participatory Action Research. A group of five people who have experienced homelessness and mental illness collaborated with the principal researcher through interviews and a working group in order to generate responses to the challenges they encounter. The study sought to examine several research questions which included exploring the lived experiences of individuals who are homeless and are diagnosed with a mental illness, the barriers that they experience, their practical recommendations to support individuals dealing with these challenges. Four key themes emerged: The trauma of homelessness, addiction, and mental illness, the power of personal connection, personal agency and achievement, and meaning through action.

Keywords: homelessness, mental illness, Participatory Action Research

Chapter 1: Introduction

On any given night, over 568,000 people are homeless in the United States (United States Department of Housing and Human Development [HUD], 2020). On the average night, approximately 200,000 people spent the night without shelter, meaning that they were on a sidewalk, in an abandoned building, on vacant land, or in other dangerous and unsuitable places (HUD, 2020). Amid a decade-long economic expansion, the U.S. homeless rate increased by three percent between 2018 and 2019 (HUD, 2020), particularly in major urban areas. Suburban and rural areas each accounted for approximately 20% of the total number of homeless, with six percent of the total located in urban areas outside the 50 largest cities in the United States (HUD, 2020).

This data is based on a point-in-time estimate of the number of homeless people in America, as measured by HUD (2020). The point-in-time method utilizes 397 homeless shelters and other facilities across the United States to estimate, during a ten-day period each January, the number of people who are homeless in their area (HUD, 2020). This data is then aggregated and used to estimate a national number for the population of people who are homeless on any given night (HUD, 2020).

With this large and growing social problem as backdrop, the present study considered the combined challenges of homelessness and mental health issues. Studies estimate that the co-occurrence of homelessness and mental illness and/or substance use disorders ranges from 30-60% (Fazel, et al., 2008; Montgomery et al., 2013; Viron et al., 2014). While causality is not well-understood, recent studies suggest that

deinstitutionalization, poverty, lack of access to care, and the traumatic experience of homelessness itself are associated with frequency and acuity of symptoms of mental illness (Greenwood et al., 2005; Montgomery et al, 2013).

While considerable resources have been directed toward the combined presentation of homelessness, mental illness, and/or substance use disorders, the perspectives of those experiencing this are rarely heard. The purpose of this study is to collaborate with a group of people who have experienced homelessness and mental illness in order to generate responses to the challenges they encounter. This chapter outlines the scope of the problem, the purpose of the study and its significance, and briefly describes the study's framework.

Statement of the Problem

Homelessness is a complex phenomenon with social, economic, political, and institutional roots (Martin, 2015). Homelessness is associated with elevated rates of morbidity and mortality (Kasprow & Rosenheck, 2000, Martin, 2015). The homeless population is systematically stigmatized, marginalized, and experiences discrimination (Bullock et al., 2017).

This complexity is partly due to the nature of initiatives to address homelessness. The Continuum of Care is recommended by the United States Department of Housing and Urban Development (HUD) as the standard of service delivery to the homeless population, including individuals with mental health problems (Greenwood et al., 2005). While Continuum of Care was designed to provide people experiencing homelessness with a range of services, consumers of this approach express dissatisfaction with a model that provides resources based on what institutions think people need, rather than on what

they say they need (Greenwood et al, 2005). In response, a housing first approach has become widely adopted in cities nationwide. This approach seeks to resolve the need for shelter and offer a range of social services as consumers request them. While the housing first model has promise, the voices of those it seeks to serve are being filtered through an unresponsive system and are not being clearly heard (Padgett et al., 2006).

Purpose of the Study and Research Questions

The present study focused on homelessness and mental health through a collaboration with people who have lived experience with these issues. While there is extensive research on homelessness and mental illness from a variety of perspectives, relatively few studies address this problem from the perspective of those most affected by it (Padgett et al.; Gulcur, 2006; Zlotnick et al., 2013).

The present study sought to identify, using Participant Action Research (PAR), perspectives on the complex problems experienced by this population. Described more fully in Chapter 3, PAR is a flexible qualitative methodology that is based on a collaboration among co-participants (McLeod, 2011). Using a recursive and dialectical process, PAR is oriented to promote change at multiple levels, including for the co-participants, the principal researcher, and the systems examined by the research questions (McIntyre, 2008). In this study, the principal researcher used Interpretive Phenomenological Analysis (IPA) to organize and analyze the data generated. As a method of analyzing the experiential element of research, IPA is well-suited to studies using Participatory Action Research (McLeod, 2011; Merriam & Tisdell, 2016; Smith & Shinebourne, 2012). In addition, the principal researcher reviewed the data generated using the lens of critical theory. This integrated theoretical framework incorporates the

goals of empowerment, growth, and emancipation from systemic injustice (Merriam & Tisdell, 2016). This integrated theoretical approach may have the additional benefit of triangulation of themes and findings (Merriam & Tisdell, 2016).

The study launched a collective effort involving co-participants from a homeless shelter in Central Virginia who had a history of mental illness and had experienced episodes of housing instability and homelessness. As a working group, participants in the study addressed the intertwined phenomena of homelessness and mental illness. With respect to these problems, the present study may contribute to heightened understanding and awareness, generate practical initiatives, and may inspire additional action research as an epistemological framework for addressing these problems. As a constructive subsidiary result, the PAR process *per se* has been found to support empowerment and therapeutic growth for those involved in it (McLeod, 2011).

The study addresses one principal and several subsidiary research questions:

- What are the lived experiences of individuals who are homeless and are diagnosed with a mental illness?
 - What are the barriers that individuals who are homeless and are diagnosed with a mental illness experience?
 - Drawing on the lived experience of homelessness and mental illness, what practical recommendations can be generated to support individuals dealing with these challenges?
 - What themes from these lived experiences are salient in understanding the barriers these individuals face?

- For this group of participants, do forms of empowerment emerge through the PAR process?

These questions were addressed through interviews and working group sessions that sought to generate epistemological meaning through planning and action.

Significance of the Study

Despite decades of federal, state, and community focus, hundreds of thousands of people continue to experience the nexus of mental illness, substance use, and lack of shelter (United States Department of Health and Human Services, 2012). The persistence of this experience constitutes a problem that merits continued study (Zlotnick et al., 2013). One avenue toward understanding this problem is to conduct research that is centered on the experiences and recommendations of those experiencing it as consumers of services (Padgett et al., 2006).

This study may address a gap in research by applying a PAR methodology to a diverse group of people who have experienced homelessness, mental illness, and or substance use disorders. In this area, previous action research has contributed the voices and experiences of specific sub-groups (Moxley & Washington, 2012), but there remains an opportunity to bring the epistemological frameworks implicit in PAR and in critical theory to this problem. When policy solutions that have been developed and implemented from the top-down fail, despite decades of attempts, a research framework that examines frameworks of power and reductive epistemologies has the potential to offer new and useful answers (Delgado & Stefancic, 2017). When the suffering and chronicity of the homeless is reframed as structural violence (Bourgeois & Schonberg, 2009), it is possible to imagine the empowerment and creative value of a collaborative

research process that raises the role of those subjected to institutionalized power. The study sought to promote change from those most affected by the problem.

Organization of the Study

Chapter 1 introduces the topic of homelessness and mental illness and describes the persistent gaps in listening and responding to the individuals most affected by this phenomenon. The chapter sets out the research question and the significance of the study.

Chapter 2 is a thorough review of the extant literature on homelessness and mental health issues. It is organized around topics of homelessness and mental illness including substance use disorders, marginalization, models of care, and counseling work with this population. Attention is given to the literature from the experiential and action research traditions as well as critical perspectives.

Chapter 3 sets out the study's methodology. It incorporates an introduction, the research purpose and questions, the study design, step-by-step procedures, and information about the study's co-participants.

Chapter 4 incorporates the results from the study. These are expressed as four major themes: The trauma of homelessness, addiction and mental illness; the power of personal connection; personal agency and achievement; and meaning through action.

Chapter 5 summarizes the study's findings and offer conclusions, discussions, limitations, and opportunities for further research.

Chapter 2: A Review of the Literature

This literature review is a thematic summary of aspects of the research problem, specifically the combination of homelessness and mental health issues. It incorporates an exploration of housing instability, a review of the problem's magnitude, dimensions of comorbidity, the societal context of homelessness, models of care, and counseling with this population. Particular attention is given to the literature from the experiential and action research traditions as well as critical perspectives. The chapter concludes with a summary of themes and findings from the literature review.

Understanding Housing Instability

Defining homelessness and housing instability is an inexact undertaking (Frederick et al., 2014, Kushal et al., 2006). While it is convenient to consider housing as a binary condition of either housed or homeless, there is a spectrum of states of housing that can be described physically and psychologically. The state of being without a home of one's own does not, per se, equate to homelessness. Equally, the state of being housed but on the brink of eviction hardly seems to encompass a secure situation. From an objective standpoint, Frederick et al. (2014) broadly defines housing stability as the extent to which one's accustomed availability of quality housing is maintained. To assess this, they developed a measurement tool based on eight dimensions of material factors leading to housing instability (Frederick et al., 2014). This approach extends our understanding that for many people, homelessness is the bottom of an undulating cycle encompassing being securely housed, unstably housed, homeless, and in transitional states.

Studies of homelessness and mental health approach the definitional issues around housing status in a variety of ways. Some take a dichotomous approach based on real-time measures of housed or unhoused (in shelters or sleeping on the streets), while others amend this to establish a temporal definition, often six months or more without housing (Brush et al., 2016; Schiff, 2003). Other studies use an ordinal approach to housing status, with degrees of housing instability combined in some cases with temporal measures (Amore et al., 2011). One of the most extensive explorations of housing programs for people with mental illness used a dichotomous definition of homelessness in its focus on the history of housing assistance programs for this population (Sylvestre et al., 2017).

These attempts to define homelessness reflect the challenge of attaining a consensus on an objective measure. This leaves unanswered the experiential element of defining housing instability, which defies classification in an empirical framework. Among the few studies that have explored this aspect of homelessness, Jacubec et al. (2012) used a phenomenological approach to describe the lived experience of providers and users of housing in order to understand housing instability from the inside out. The elements of meaning that emerge from this approach go beyond physical housing to embrace an array of social spheres (Jacubec et al., 2012).

The Great Recession of 2007-2010 triggered a wave of unemployment and dislocation in the housing sector, with an estimated 3.8 million foreclosures taking place in the U.S. (Dharmasankar & Mazumder, 2016). The prospect and reality of foreclosure threw millions of Americans into various stages of residential crisis. This economic dislocation brought the issue of housing instability into what had historically been a focus

on homelessness (Bennett et al., 2009). While a direct causal relationship between the Great Recession and mortality is difficult to establish, the number of Americans who took their own lives doubled between 2005 and 2010 (Fowler et al., 2015).

A decade after the Great Recession spurred a newfound research on housing instability, the COVID 19 pandemic of 2020-21 triggered a global wave of job layoffs, furloughs, bankruptcies, and unemployment, which reached a high of 14.7% in the United States in April 2020 (U.S. Bureau of Labor Statistics, 2020). Emergency legislation provided temporary economic assistance and froze a likely surge in foreclosures, utility cutoffs, and evictions for millions of vulnerable Americans. Nonetheless, uncertain economic prospects and concerns over the potential health impact of contracting or transmitting COVID 19 contributed to a jump in indicators of mental health distress (Liu et al., 2020).

In light of recent social dislocations such as the Great Recession and the COVID 19 pandemic, researchers have added depth and breadth to our understanding of the nature and experience of housing instability. In seeking to define its features, Pavao et al. (2007) focus on difficulty or inability to pay rent, housing costs representing more than 50% of income, needing to move frequently, and needing to live in others' homes due to inability to pay for housing. The definition of severely burdened status when housing costs exceed 50% of household income is widely used in the United States (Joint Center, 2016). Adding social dimensions, Burgard et al. (2012) found that housing instability is positively correlated with measures of marginalization, including social, economic, racial, and health status. In the face of COVID 19, researchers report a convergence of

factors including low wage-earners' likelihood of becoming unemployed, contracting the coronavirus, and experiencing housing instability (O'Hanlon et al., 2020).

Housing instability has psychological and physical health implications that studies indicate lie somewhere between the state of stable housing and homelessness (Kushal et al., 2006). Through a meta regression approach, Reid et al. (2008) identified a relationship between housing instability and higher hospitalization rates. Taylor et al. (2006) found that men experience potential housing instability as equivalent to the psychological stress associated with divorce or unemployment, while for women, it is prolonged unsustainability of current housing arrangements that are most psychologically damaging. Kushar et al. (2006) found housing instability was associated with poor access to health care, defined as not having a usual source of care, postponing needed services, and postponing purchase of needed medications. Foreclosure and housing instability have been associated with elevated levels of stress, depression, and cardiovascular problems (Bennett et al., 2009, Gilman et al., 2003). Pavao et al. (2007) found a positive correlation between intimate partner violence and housing instability. Eviction can trigger a cascading series of problems, including sustained housing instability, downward migration in terms of residential setting, and physical and mental health issues (Montgomery et al., 2017).

The magnitude of housing instability is challenging to estimate. One survey of women in California reported 8.2% of respondents had experienced housing instability in the previous 12 months (Pavao et al., 2007), with separation, divorce, and poverty level positively correlated with housing instability, and age negatively correlated with housing instability. Another study conducted during the Great Recession found one third of

respondents recently reporting some form of housing instability (Burgard et al., 2012). Harvard University researchers reported a record number of 11.4 million severely burdened renters, defined as using more than 50% of household income for housing expenses, in 2014 (Joint Center, 2016).

Homelessness and Mental Illness

This section of the literature review focuses on the forms, frequency, and possible roots of homelessness and mental illness as a co-occurring phenomenon. Not only do these conditions frequently occur together (Fazel et al., 2008), their morbidity is often entwined in a downward spiral (Kaspro & Rosenheck, 2000). Causality is a complex web of historical legacies of deinstitutionalization, socioeconomic factors, societal norms, institutional bias, competing models of care, and the traumatic experiences of homelessness and mental illness (United States Interagency Council on Homelessness, 2010).

Manifestation and Frequency

Not only has homelessness increased in recent years (HUD, 2020), it is a problem with serious personal and social consequences. People who are unhoused experience higher rates of serious illness and mortality (Hodge et al., 2017), higher rates of incarceration (Greenburg & Rosenheck, 2010), and higher incidences of mental illness and substance use disorder than in the general population (Hwang, 2001; Viron et al., 2014). While the social consequences of homelessness are important, the focus of this study, and therefore the following review of the literature, is on the lived experiences of people experiencing both homelessness and mental illness.

In order to address a human problem of this magnitude, a clear idea of its prevalence and persistence is needed. In this respect, considerable research on homelessness and mental health has sought to quantify the extent and severity of psychiatric conditions within the homeless population. Through meta-analysis and epidemiological data, we can draw some general observations about prevalence and factors associated with homelessness. The most-cited statistical picture of homelessness in the United States was noted earlier and is a cross-sectional, point in time estimate of this population as of a single night in January (HUD, 2020). The more than half million people identified as homeless are further segmented by the U.S. government into subgroups (HUD, 2020). Ranked by number from highest to lowest, these groups include individuals, people in families, chronically homeless individuals (defined as an individual or head of household with a diagnosable mental or physical disability who has been unhoused for at least one year or on four separate occasions in the last 3 years), veterans, and unaccompanied youth (HUD, 2020). Many individuals fall into multiple categories, and additional levels of intersectionality exist and are reported separately, including gender, age, and race.

Methodological Issues in Defining Homelessness

There are significant limitations with the AHAR methodology. The mechanics of estimating homeless numbers based on a canvassing approach, which is one of the alternatives open to communities participating in data-gathering, are challenging. One study used volunteers as decoys and reported that such plants were missed in 29% of the canvas areas covered (Hopper et al., 2008). In addition, through detailed interviews of homeless individuals, the same study estimated that 31% of the truly homeless population

was uncounted due to lack of visibility, for example by sleeping in cars or in hidden locations (Hopper et al. 2008). For people without stable housing, invisibility in temporary shelters, be they porches, shanties, abandoned buildings, or encampments, promotes security and the possibility of some rest (Hopper et al., 2008). Volunteer census-takers are often forbidden from venturing into these areas out of concern for their personal safety, therefore excluding this sub-population from the annual homeless count. For those counting sites that choose to use a homeless shelter as their basis for collecting data, an obvious shortcoming is that individuals who do not seek services will not be counted (Hopper, 1992). Another significant limitation for researchers seeking to associate homelessness with other factors is that the AHAR survey does not collect demographic information that could be used to extend our understanding of mediating or contributing factors (Fusaro et al., 2018).

A point in time (PIT) estimate understates the problem of homelessness, as it identifies only a fraction of people who may experience it during their lifetime. As even a single instance of homelessness is associated with elevated risk factors for mental and physical illness, among other outcomes, it is important to consider period prevalence measures as an alternative to PIT surveys. In recent years, a number of cities have begun to implement this approach, and aggregated data suggest that approximately 1.6 million Americans may avail themselves of homelessness-related services each year (Lee et al., 2010). A more ambitious approach to seeks to measure the lifetime prevalence of homelessness (Oppenheimer et al, 2016). Analysis of nationwide epidemiological survey data points to a lifetime prevalence of homelessness for approximately five percent of the United States population (Greenburg & Rosenheck, 2010). Using the 2019 U.S.

population estimate, this would imply that 16.5 million Americans will experience homelessness at some point in their lifetime (United States Census Bureau, 2020).

Connections Between Housing Instability and Mental Health Concerns

When we add dimensions of mental health to the phenomenon of homelessness, research leaves little doubt as to association. Greenburg & Rosenheck (2010) was one of numerous studies identifying a link between mental health issue and homelessness, particularly in the area of substance use disorders (Greenburg & Rosenheck, 2010). This association was extended in research that found a statistical connection between adverse mental and physical health outcomes in even a single instance of homelessness, with mental health issues occurring at twice the rate of those with any history of homelessness compared to those surveyed with no such event (Oppenheimer et al. 2016). Meta-analysis corroborates these findings and indicates a substantially higher incidence of substance use disorder among the homeless than was the case in the age-matched general population, and also found a higher prevalence of serious mental illness among homeless samples than in the general population (Fazel et al., 2008).

In an effort to ask the obverse question and correct earlier methodological shortcomings, several nomothetic studies examined the incidence of homelessness among those with mental illness (Montgomery et al., 2013). After controlling for various factors such as race, gender, socioeconomic status, and setting (Montgomery et al., 2013), these studies indicate that there is an increased risk of homelessness when psychiatric conditions exist, that this is exacerbated by the presence of substance use disorders (Folsom et al., 2005; Montgomery et al., 2013), and that individuals experiencing homelessness are higher users of hospital and other emergency services (North et al.,

1993), particularly when homelessness and mental health issues co-present (Chun et al., 2016). Aubry et al. (2012) used a longitudinal approach to housing status among a group of Canadians and found that degrees of housing instability were positively associated with complexity of mental health conditions. Reaching back further in the developmental curve, Larkin and Park (2012) found that 52% of the homeless individuals in their study had four or more adverse childhood experiences, compared with six percent in the original ACES study conducted by Felitti et al. (1998).

While homelessness and mental health conditions often co-occur, it is less clear why this is the case. One theory aligns with the concept of cumulative trauma and points to indications that episodes of homelessness contribute to higher frequency and severity of psychiatric symptoms and substance use (Castellow et al., 2013; Lippert & Lee, 2015). High ACES scores, along with low income, measures of personal trouble, and availability of social support are all correlated to the combined presentation of homelessness and mental illness (Booth et al., 2002; Greenburg & Rosenheck, 2010).

Homelessness and Substance Use Disorders

While substance use disorders are nosologically defined as a category of mental illness, the literature on homelessness typically distinguishes between substance abuse and other mental health issues by dealing with them discretely or as comorbid disorders (American Psychiatric Association, 2013; Gonzalez & Rosenheck, 2002; Kemp et al., 2006; Lyons Reardon et al., 2003). This differentiation is understandable when we understand the degree to which substance use disorders and homelessness are interconnected (Kemp et al., 2006; Shelton et al., 2005). Multiple studies have identified significantly higher rates of diagnosable substance use disorders not only among the

homeless population as a whole, but also among subgroups (Johnson & Fendich, 2007). Recent intravenous use has a particularly high association with homelessness (Kemp et al., 2006), as does comorbidity of substance use disorders with other mental health problems (Lyons Reardon et al., 2003). In addition, substance abuse appears to continue at elevated levels even after stable housing has been attained, which points to the need for supportive services to complement access to a place to call home (Lyons Reardon et al., 2003).

As is the case with other characteristics of homelessness, the direction of causality regarding substance use disorders and lack of housing has not been conclusively established. One study explored the social selection model, in which substance use precedes a slide into housing instability, versus the social adaptation model, in which homelessness precedes an acceleration of substance use, in part as a coping mechanism (Johnson & Fendich, 2007). This study did not support a unidirectional model of causality, and more research is needed in this area.

Within-Group Differences and Intersectionality

Research on discrete populations offers deeper perspectives on the etiology of homelessness and mental illness. The full list of groups studied is extensive, and the current study focuses on the major categories within this inventory. In addition, intersectionality of characteristics, for example Black females who are experiencing homelessness, is common.

Homelessness and Women

The mortality rate among women who are homelessness is higher than for the population as a whole. Particularly for younger women, this approaches the mortality

rate of similar-aged homeless males (Cheung & Hwang, 2004). Homeless women without families have risk factors that in some respects resemble those of the male homeless population, including substance abuse and mental illness (Averitt, 2003). In addition to mental health and addiction issues, risk factors that are elevated for women include childhood abuse, intimate partner violence, physical and sexual assault, prostitution, and other forms of economic exploitation (Phipps et al., 2019). Rates of trauma among homeless women are also higher than among unhoused men (Phipps et al., 2019). Women's reproductive health needs expose them more acutely to lack of access to care, and sexual victimization and resulting injuries and sexually transmitted diseases exacerbate this reality (Arangua et al., 2005).

Women report heading 90% of homeless families in America, and families have been one of the fastest-growing groups of people experiencing homelessness (Anderson & Rayons, 2004). Qualitative research in this area illustrates the institutional barriers to bringing children into shelters and other systems of care, along with the stigmatization that accompanies women struggling to head a family and coping with homelessness (Bonguli et al., 2013).

Homelessness and Race

Studies have identified race as a major risk factor in predicting homelessness (Folsom et al., 2005). Racial minorities are overrepresented in the homeless population, with Blacks comprising 40% and 22% of the total identified as Hispanic/Latin American (HUD, 2020). Estimates of lifetime prevalence of homelessness have found that, within the Baby Boom generation of Americans born between 1944 and 1964, minorities experienced between four times (Blacks) and 1.6 times (Hispanics) higher rates than

whites (Fusaro et al., 2018). One analysis found statistically significant differences in homelessness between whites and Blacks, even using a multivariate model, but found that such differences did not reach the level of statistical significance when a multivariate model was used to compare Hispanics and whites (Fusaro et al., 2018). This leaves open the possibility that factors such as education, income, age, and urbanicity can mediate homelessness and ethnicity.

Incarceration and Homelessness

As is the case with many risk factors, incarceration and homelessness are interconnected. A study of the homeless population in Baltimore found high association between homelessness as both prelude and consequence of incarceration (Center for Poverty Solutions, 2002). These findings were echoed when populations outside the United States were studied. In Norway, one third of the prison population sampled was homeless or experiencing housing instability prior to incarceration, and two thirds of this population experienced homelessness following release from custody (Dyb, 2009). Using a longitudinal study of urban households, Geller and Curtis (2011) found that men who had been incarcerated faced double the probability of experiencing housing instability, compared to those never imprisoned, and that this gap was larger than that accounted for by racial differences. When narrowing the definition to episodes of homelessness, the probability rose to four times the rate for those ever imprisoned versus those never experiencing incarceration (Geller & Curtis, 2011).

It is important to focus on people experiencing incarceration, in part to address trenchant perceptions of vagrancy as a status associated with criminality (Moschion & Johnson, 2019). It is true that rates of homelessness and mental illness in those with

criminal records are significantly above the general population (Greenberg & Rosenheck, 2008). While causality is difficult to establish, studies suggest that incarceration is a predictor of homelessness (Moschion & Johnson, 2019). This defies the discriminatory narrative that becoming homeless leads to criminal behavior and therefore people who are homeless merit a higher degree of public safety scrutiny (Malone & Malone, 2009).

Homelessness and Military Service

Persistent high rates of homelessness among veterans and over multiple decades has attracted sustained public policy and research focus. As a group, veterans have a demographic profile with several protective factors against homelessness, including educational status, higher rates of marriage, and better access to care (Rosenheck, 1994). Despite this, rates of homelessness have remained above levels found in the general population. A systematic review of the literature conducted by Tsai and Rosenheck (2015) identified substance abuse and mental illness as the strongest and most consistent risk factors across methodologies. As these are also strongly correlated with homelessness in the general population, we can conclude that studies have failed to establish a clear connection between risk factors unique to veterans and homelessness, and the field remains open for further research, particularly given the significant military mobilization and multiple and sustained tours of combat duty experienced by American soldiers in the war against terrorism begun in 2001.

Although homelessness in the general population is often stigmatized and criminalized (Narendorf, 2017), in the case of veterans the policy response has a valence toward a moral, national duty to help end homelessness (Donovan & Shinseki, 2013). This focus may be bearing fruit, as the AHAR data from 2019 showed a nearly 50% drop

in the number of homeless veterans at a single point in time (HUD, 2020). This corresponds to eight percent of homeless adults, which compares to the U.S. adult population, which contains approximately seven percent veterans (United States Census Bureau, 2020).

Homelessness and the LGBTQ+ Youth Community

As many as 400,000 young Americans who identify as member of the LGBTQ+ community may experience homelessness in a single year (National Alliance to End Homelessness, 2008). Studies have found that it is a misconception that being expelled from the family home is a primary cause of homelessness in this community (Ream & Forge, 2014). Still, non-traditional sexual or gender expression can push an already unstable home situation beyond the stage where young people feel able to stay at home. The common factor here seems to be instability in the home situation, rendering the question of being forced out vs. leaving home one of a distinction, rather than a difference (Ray, 2006). In this sense, the same protective social factors that mediate against homelessness in the general population may work to help LGBTQ+ youths stay housed or exit homelessness quickly (Ray, 2006).

Once homeless, LGBTQ+ youth are exposed to the same cycle of victimization and marginalization that is connected with mental illness and substance use disorders (Cochran et al., 2002). Sexual exploitation, forced criminalization, manipulation, and physical assaults are common forms of victimization faced by LGBTQ+ youths experiencing housing instability or outright homelessness (Keuroghlian et al., 2014).

Perspectives on Causality

While contributing breadth and statistical significance to our understanding of conditions, research on prevalence and association do not address causality, leaving open the question of how to address root causes behind chronic homelessness and mental illness. While homelessness and mental health conditions often co-occur, it is less clear why this is the case. One theory aligns with the concept of cumulative trauma and points to indications that episodes of homelessness contribute to higher frequency and severity of psychiatric symptoms and substance use (Castellow et al., 2013; Lippert & Lee, 2015). What are now commonly referred to as high ACES scores, representing adverse childhood incidences (Center for Disease Control and Prevention, 2020), along with low income, measures of personal trouble, and availability of social support are all correlated to the combined presentation of homelessness and mental illness (Booth et al., 2002; Greenburg & Rosenheck, 2010). In addition, being of color, male, single, and middle-aged are all associated with higher incidences of homelessness (Burt et al., 2001; Greenberg & Rosenheck, 2010; Martens, 2001).

Studies suggest that at least two-thirds of youths and young adults experiencing homelessness meet criteria for a mental illness (Hodgson et al., 2013; Hodgson et al., 2014). Young adults who received crisis psychiatric services describe a Gordian knot that binds homelessness, substance use, and mental illness into a trauma-laden nexus (Narendorf, 2017). Interviews and data from homeless young adults paint a picture of the intersection of broken family relationships, unavailable support systems, substance use, and trauma (Narendorf, 2017).

This theme of antecedents to homelessness was further developed in research that indicated that recently unhoused youths presented with a wider and more serious psychiatric symptomology than in the population as a whole, and that these symptoms increased as the duration of homelessness lengthened (Martijn & Sharpe, 2006). The significance of trauma along the pathway to homelessness for young people was also made clear, with over half of one group surveyed identifying a history of physical abuse (Martijn & Sharpe, 2006).

In seeking to understand antecedents to co-occurring homelessness and mental illness, it is important to consider groups who are particularly marginalized. The temporal relationship between mental illness, including substance use disorders, and homelessness has been studied using longitudinal methods, but results are not conclusive in establishing which phenomena precedes the other (Lyons Reardon et al., 2003).

Another method of understanding homelessness and mental health issues is to explore elements that help people find pathways out. Deductive methods suggest that factors including being female, relatively unencumbered by debt and with minimal judicial history are associated with escape velocity (Christensen and Vinther, 2005). This is substantiated by qualitative studies indicating that the availability of a support system, opportunities for self-expression, access to services, high measured levels of self-efficacy, and spirituality are also supportive of pathways out of chronic homelessness and mental illness (Epel et al., 1999; Patterson & Tweed, 2009).

Experiential Dimensions of Homelessness

Beyond the data available on frequency and factors associated with homelessness, the experience of housing instability and homelessness, combined with some form of

mental illness, takes many dimensions. This section of the literature review discusses several major facets of this experiential matrix. Most studies in this area rely on surveys, interviews, and ethnographic methods to capture and seek to understand the lived experience of aspects of homelessness.

Homelessness and Marginalization

The nexus of homelessness and mental illness results in marginalization, discrimination, and vilification (Donley & Jackson, 2014; Narendorf, 2017). People who are unhoused evoke stereotyped expectations of coldness, incompetence and lack of status and evoke emotions of disgust and contempt (Fiske, 2012). Mental illness is highly stigmatized, with those diagnosed with serious mental illness are widely perceived as unstable and dangerous (Alexander & Link, 2003). A host of ironically named quality of life laws passed in many municipalities make it illegal to perform acts including begging or laying down in public spaces, thus spatially discriminating against people experiencing homelessness (National Healthcare for the Homeless Council, 2013).

One way of assessing the degree of marginalization here is to apply a capabilities framework of basic human freedoms (Kerman & Sylvestre, 2020). Measured against such standards, people are marginalized not only during episodes of homelessness and mental illness, but also once housed (Kerman & Sylvestre, 2020). Powerlessness is a dominant theme in this population (Smith, 2013), particularly in the face of scapegoating, othering, and exclusion from public spaces (Bullock et al. 2017). These burdens contribute to a negative valence in the composition of self-worth and agency. Discrimination in housing is widely reported as a barrier to exit from homelessness (Benbow et al., 2011), as many landlords require evidence of employment to secure a

lease, and many employers exhibit prejudice against individuals without a fixed residence (Shaheen & Rio, 2007).

As noted above, subgroups of this population have increased levels of intersectionality and as a result may experience additional forms of discrimination and oppression. Women who are unhoused are particularly vulnerable to sexual exploitation (Narendorf, 2017), experience higher rates of sexual assault and other forms of physical violence than women who are housed (Stermac & Paradis, 2001). Youths recently aging out of foster care can experience abandonment and loss of financial and social support (Narendorf, 2017). Among individuals experiencing incarceration, Fox et al. (2016) found that victimization was the principal mitigating factor between mental illness and homelessness. They suggest initiatives to address substance use and community support services to address these significant mediating factors (Fox et al., 2016).

Invisibility, particularly for homeless women, is another aspect of marginalization that perpetuates the conditions of homelessness and mental illness (May et al., 2007). While women comprise a large percentage of homeless individuals (HUD, 2020), females are rarely seen sleeping on the streets or panhandling (May et al., 2007). This invisibility, borne of fear of exploitation, often places women outside the services provided by, for example, mobile outreach programs.

When viewed through the lens of critical theory, a review of research methodologies makes clear the institutional and normative forces behind continued marginalization for this population. For example, one commercialized product in wide use among recovery groups for people experiencing homelessness was described as based on principles of Participatory Action Research (Joy, 2011). Despite containing

epistemological elements of PAR, the product developers used a predetermined set of parameters as the basis for focus group meetings (Joy, 2011; Petersen et al., 2014). This is illustrative of the way that a qualitative framework such as PAR can become subsumed in an expert-driven approach that marginalizes the voices of those experiencing the phenomenon under study.

Homelessness and Substance Use

Research to date on the lived experiences of people dealing with homelessness and substance use disorders highlights several themes. Women in this situation frequently describe abuse as children, early marriage, intimate partner violence, escape, and coping (Burlingham et al., 2010). Men report growing up in families experiencing mental illness, substance abuse, and violence (Lowe & Gibson, 2011). As adults, males report a cycle of temporary employment or criminality to support their habits, polysubstance abuse, and pervasive low self-esteem, anger, and hopelessness (Lowe & Gibson, 2011). Once on the streets, a lack of privacy, logistical challenges, and confronting bureaucracy are often cited as near-daily events in a social milieu of normalized violence (Burlingham et al., 2010).

The role substances play in the everyday lives of homeless people is often ignored when considering their needs. Collins et al. (2012) found that alcohol is used as a source of well-being, of self-medicating, of forestalling withdrawal, and of maintaining relationships and community. The dichotomous nature of continued use or complete abstinence makes the rules governing many housing alternatives a Hobson's choice for the large population who are homeless and addicted to drugs and/or alcohol.

For people experiencing addiction and homelessness, treatment for substance use is one pathway to housing, often in the form of conditional residency in a recovery program. This is both an opportunity and a burden for those considering an offer to be housed in exchange for often extensive house rules. As we will discuss later, abstinence-based housing creates an often-untenable choice, and many participants regard it with ambivalence (Collins et al., 2016). Most transitional housing for people experiencing substance use disorders is based on a moral model, which incorporates punishment and exclusion for those who are judged to have failed at the requirement of abstinence (Collins et al., 2012). This judgment contributes to the stigmatization experienced by clients in such facilities, who are often immediately expelled in cases of relapse (Allen, 2003).

Inpatient substance treatment is another alternative to homelessness, and some studies note their participants' strategic use of inpatient stays to cope with seasonal weather extremes (Collins et al., 2016). The institutional environment that typifies inpatient programs has been reported as contributing to feelings of marginalization and powerlessness (Collins et al., 2016). Harm reduction, an alternative to abstinence and inpatient recovery, is cited as a valued approach in surveys of people experiencing homelessness and alcohol use disorders (Collins et al., 2016). Here, the sense of agency, flexibility, and pragmatism is widely cited as attractive.

Homelessness and Mental Illness

Phenomenological and ethnographic research on the lived experiences of groups of people experiencing homelessness and mental illness point to several shared themes. Among these, rejection, uncertainty, social isolation are most commonly cited (Lafuente

& Lane, 1995). The feeling of detachment while simultaneously being depending on others was experienced as a confusing experience (Lafuente & Lane, 1995). Perhaps surprisingly, obtaining daily necessities was not widely cited as a problem, as shelters and other agencies are widely available for food, showers, and clothing.

The shift in recent years toward housing first and away from treatment first, to be discussed in detail below, in part reflects the growing body of qualitative research on living with mental illness and without housing. Studies that found that having a place to call home, per se, contributes to stabilization of mental health (Padgett, 2007). Members of this population who were enrolled in housing first programs reported themes of freedom from the oppression, violence, and marginalization of living on the streets, as well as liberty to explore the resources made available to them as consumers, rather than patients, and to create community on their own terms (Padgett, 2007). Freedom from supervision and the strict rules of shelters and institutional care was another common theme, as was the relief at finding privacy from constant intrusions from police, dealers, and others commonly encountered on the streets (Padgett, 2007). Space to create an identity beyond mental illness and homelessness, which are defining characteristics of life on the streets, was a major theme in the lived experiences of those obtaining housing (Padgett, 2007).

One focus group-based study summarized the experience of mental illness and housing instability as a cyclone, developing quickly and uncontrollably and leaving a wake of devastation (Forchuck et al., 2006). Within this metaphor of a tornado, participants described an initial phase of loss of control, of home, of mental capacity, followed by a battle to simply survive and meet physiological needs, and finally a phase

of finding a place to live and regaining some sense of identity and stability (Forchuck et al., 2006). These phases were intertwined and recursive, and they are described in one study as a cycle of being on the move constantly, based on weather, shelter openings and limits on stays, and of this transience spilling over into a lack of consistency in relationships (Kirkpatrick, 2009).

While the experience of homelessness and mental illness is almost universally described in negative terms, people who have survived and moved forward with their lives point to a number of sources of strength. Recent metasynthesis of experiential studies points to an increasing focus on coping skills and resilience as a heretofore under-researched aspect of the experience of homelessness and mental illness (Karedzhof et al., 2020). The ability to use coping skills, insight into their health issues, and spirituality help generate hope, optimism, and self-esteem, despite the overwhelming circumstances they are experiencing (Paul et al., 2018). Studies of ethnic minority members facing homelessness and mental illness also point to using family networks as instrumental support systems (Paul et al., 2018). Women who have experienced homelessness, mental illness, and victimization frequently exhibit characteristics of resilience, post-traumatic growth, and positive coping strategies (Huey et al., 2013).

Homelessness and Criminality

Ethnographic studies of people caught up in a cycle of homelessness and interaction with the judicial system describe the experience as a self-reinforcing downward spiral. This phenomenon seems particularly acute for Black males, and is experienced as a matrix of discrimination, marginalization, punishment, and survival (Gowan, 2002). For homeless drug users, petty crime and incarceration can become a

way of life (Bourgeois & Schonberg, 2009). Critical approaches to this phenomenon identify neoliberal policy regimes that have withdrawn social services and replaced them with campaigns to criminalize, remove, and punish people with homelessness as contributing to the nexus of housing instability and incarceration (Metreaux & Culhane, 2004; Bourgeois & Schonberg, 2009; Gowan, 2002).

Models of Care

The corpus of research helps us understand the degree to which homelessness, mental illness, and substance abuse are intertwined. It has not resolved questions of causality or persistence, and taken as a whole, concludes in analytical circularity. This absence of root causes lends to a wide range of models of care available to people who are homeless and experiencing mental illness (Martin, 2015). These models form a continuum. Treatment first models, which classically dictate sobriety and medication compliance, bookend one end of the spectrum. Housing first models, which are often no- or low-barrier to entry, constitute the other (Rogers, 2018).

There is an active debate over treatment first versus housing first models, with some federally sponsored and faith-based programs aligned with the former, and many community-based programs evolving toward the latter (Rogers, 2018). In recent years, the weight of research in this area has supported a housing first model of care, particularly when housing services are surrounded by social and health-care services (U.S. Interagency Council on Homelessness, 2010). A major research focus on housing first models has been on usage rates of social and medical care systems, and indications are that housing first models contribute to higher levels of outpatient visits and correspondingly lower usage of emergency services as well as more stable housing (Burt,

2012; Gilmer et al., 2010). In addition, experiential research has added ontological perspectives on the importance of being housed, with markers such as identity formation, privacy, and security dominating the experiences of those given housing first (Padgett, 2007).

Evidence-Based Perspectives

In the United States, decades-long deinstitutionalization transitioned people with mental illness to community-based care. By design, service models oriented toward this population replaced inpatient psychiatric facilities (Zlotnick et al., 2013). One assumption underpinning this migration was that clients would be more satisfied with deinstitutionalized care models (Watson, 2012). Where such models are oriented toward consumer choice, research supports this proposition. For example, when people experiencing homelessness were randomly assigned to a choice-based treatment program or to conditional treatment models, the choice-oriented program resulted in higher compliance with treatment plans, lower use of services, and higher reported satisfaction (Shern et al., 2010). A similar result was obtained in comparing participants enrolled in a program oriented that focused on sustained employment and housing, versus people not participating in the program (Burt, 2012).

For agencies seeking government funding, U.S. federal funding for research, pilot programs, and sustained operations is often conditional on the use of evidence-based models (U. S. Interagency Council on Homelessness, 2010). Under federal law, all grants offered by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) must incorporate specified measurement tools (U.S. Department of Health and Human Services, 2020). Given this mandate and the economic

incentives associated with it, there has been a sustained focus on seeking to quantify outcomes by using, for example, side-by-side comparisons of treatment modalities. Research along these lines offers mixed results, with rates of substance use showing no significant difference (Kertesz et al., 2009), but measures of agency suggesting stronger outcomes from housing first programs (Henwood et al., 2015; Watson, 2012). In terms of stable housing, the conditional nature of treatment first programs, which predicates housing on sustained abstinence, makes side-by-side comparisons inherently difficult (Watson, 2012). Nonetheless, a number of studies, including controlled models, indicate that housing first programs result in significantly higher rates and duration of rehousing compared with both treatment first models and other continuity of care models, which are variants of treatment first (Kersez & Weiner, 2009; Tsemberis, 1999).

Experiential Perspectives

To deepen our understanding of the nexus of homelessness and mental illness, mixed-method and ideographic studies address the lived experiences of this population. While much of the research on models of care focuses on outcome metrics such as use of outpatient services, relapse, and residential stability, another increasingly popular avenue is to focus on experiential measures of client satisfaction with services. Research findings in this area are less conclusive than is the case with objective measures such as housing status and mental health (Helfrich & Chan, 2013; Rayburn, 2013). Life skills training is one example of a programmatic feature that did not produce conclusive evidence of improved outcomes (Helfrich & Chan, 2013). Methodological challenges may explain these findings, and there remain opportunities for further research in this area.

In the search for understanding the experiential elements of successful care systems, a pragmatic lens has proven useful. One mixed-methods study utilized a realist review method through a team whose members were drawn from the academy and the community (O'Campo et al., 2009). The team identified six strategies that they expected to improve mental health and, to a lesser extent, reduce substance abuse (O'Campo et al., 2009). Watson (2012) used symbolic interactionism as a framework and measured, with interviews and focus groups, the experiences of homeless people and service providers in four different care models. To measure the impact of models of care, Rowe et al. (2016) used thematic analysis to organize information from focus groups, interviews, and field observation of workers in multiple versions of assertive outreach programs in New England. This approach identified four main themes, three of which related to care provider capabilities, and one related to availability and breadth of services (Rowe et al., 2016).

Long-term qualitative research in this subject area is scarce, but two studies are worth noting. Rayburn's (2013) work with homeless drug users in New Orleans who participated in a rehousing and substance use treatment program yielded mixed results. From the perspective of nearly two decades after its completion, the Rayburn (2013) hypothesis that social bonding theory would identify factors such as partnership, employment, and faith as explanatory for lasting success was supported by interviews with participants, but this was not supported by the accompanying quantitative analysis (Rayburn, 2013). Perhaps the longest retrospective approach available came from a study that combined a timeline narrative and action learning framework to review 25 years of integrated services to homeless and mentally ill people in India (Narasimhan et al., 2019).

Their findings, based on interviews and reviews of documents, recommend that program design focus on exemplars including dynamism, responsiveness, innovation and resonance with users (Narasimhan et al., 2019).

Other studies have sought to document the subjective interactions between users and systems of care based on objective criteria. This dimensional approach provides indications that programs may succeed in helping those enrolled to survive their circumstances but are less successful in helping them to thrive. This was the primary finding of a study that utilized, possibly for the first time with this population, a capabilities approach (Kerman & Sylvestre, 2020). An example of one representative parameter used was “having the opportunity to live a normal human life and not die prematurely” (Kerman & Sylvestre, 2020, p. 416). The research, focused on the lived experiences of people dealing with homelessness and mental illness, illustrates the limitations of systems of care. It is a reminder that assessing care systems defies reduction to a simple set of outcomes.

Another way to consider models of care is from the perspective of critical theory. Viewed through the lens of intersectionality, systems of care that emphasize peer support, gender-oriented services, culturally competent agency leadership, and flexibility are valued by their clients (David et al., 2015). For mothers in homeless shelters, socially constructed roles resulted in marginalization and loss of agency (Glumbikova, 2019). In this sense, the rules and norms imposed by institutions combine with invisible bias in perpetuating oppression and silencing the voices of those the agencies were intended to serve (Swick & Williams, 2010).

Another method of bringing user experiences into service models is to combine participatory research with expert implementation. Here, people with experiences of homelessness and mental health issues help generate recommendations which are then reviewed and operationalized by agency professionals. In one such study, a team of African American people who had experienced homelessness and mental illness collaborated with service providers and investigators through a series of focus groups (Corrigan, 2017). The resulting recommendation to introduce peer navigators was implemented and its results were evaluated (Corrigan, 2017). A variation of this approach that used the framework of a gap analysis resulted in the identification of a need to integrate a level of care model into the provision of services for this population (Stergiopoulos et al., 2010).

Participatory research has also been a helpful lens in identifying best practices and delivery gaps in service models. Spatial experiences of lostness--temporal dislocations that were described as nonexistence--and other states described by study participants offer a counterbalance to the often highly structured nature of programs for people who are homeless (Petrusak et al., 2017). The institutional and societal biases noted above are echoed in PAR research involving people experiencing homelessness, but not co-occurring mental illness, that sought to push back against this framework through an editorial campaign (De Oliveira, 2018).

Several themes emerge when we summarize the research on models of care. Systems that provide low barriers to housing resolve the problem of homelessness, but do not necessarily alleviate symptoms of mental illness unless they are integrated with additional services (Burt, 2012; Gilmer et al., 2010). Regardless of the delivery model,

institutionalized forms of oppression persist, and the voices of those being served need to be heard in order to address this population's needs beyond simple survival (David et al., 2015; Kerman & Sylvestre, 2020).

Counseling Those Who are Experiencing Homelessness and Mental Illness

The literature on counseling people experiencing co-occurring homelessness and mental illness is scarce. To the extent that research exists, it emphasizes themes including intersectionality, marginalization, context, and the multiple roles likely to be played by counselors working with people facing these problems (Huey et al., 2013). Studies on the topic also emphasize the value of bringing counseling students into awareness of the needs and opportunities involved in working with this group.

Settings, Roles, and Training

Counselor training programs that are accredited by CACREP are required to incorporate a broad perspective on the multiple roles and diverse populations with which counselors may work (CACREP, 2016). Counselors may establish professional relationships with people who are homeless and dealing with mental illness in their roles working with marginalized populations (McBride, 2012). Homeless shelters, community mental health centers, free clinics, street outreach programs, and public psychiatric hospitals are among the wide variety of sites that provide services to this community. Part of multicultural competency, as it pertains to this population, includes understanding and supporting their complex needs (Baggerly & Zalaquett, 2006; Huey et al., 2013; McBride, 2012). This may include a working knowledge of local social services agencies, housing coordinators, medical providers, and similar connections. Counseling work with the homeless may also entail employment-oriented support, substance use,

family dynamics, and other wide-ranging subjects. This theme has been woven into a doctoral-level counselor educator program as part of social justice training, with positive results (Clements-Hickman et al., 2019).

Counseling Considerations

Considerable research suggests that mental health counseling for people experiencing homelessness can drive improved functioning, particularly for young adults (Morton et al., 2019; St. Arnault & Morali, 2019; Sun, 2012). Using the lived experiences of people from this population as a touchstone has generated helpful considerations for counselors (McBride, 2012). To be effective, counselors must incorporate these clients' likely needs on the foundational segments of Maslow's hierarchy, including housing, employment, safety, and social connection (McBride, 2012).

A counseling approach that responds to these needs can incorporate action as a form of empowerment (ACA, 2014; McIntyre, 2011). In this sense, a counselor-led working group can be viewed as a therapeutic experience (Corey et al., 2014). A community-based participatory project designed to support homeless youth in Los Angeles used this approach (Garcia et al., 2014). The project was reported to have helped empower, engage, and create change agency among the participating youths, and it serves as an illustration of the potential of PAR to create an impact (Garcia et al., 2014).

In reviewing the literature from the perspective of counseling, we see that counselor educators can help prepare students for work with this population, and that there are many clinical settings where counselors will have such opportunities. To explore the group context further, there are studies that take an explicit participatory

perspective (van Draanan et al., 2013) and others that add an action step such as photovoice as the means to empower residents to influence their health and wellness (Cheezum, 2019; Corrigan, 2017). Nonetheless, there is virtually no research that contains both the participant and action planning elements in PAR by engaging people who experience homelessness and mental illness. This leaves unmet the research opportunity to generate therapeutic growth and empowerment through the action element of PAR.

Summary and Implications

As a result of decades of quantitative research, we know that homelessness, poverty, mental illness, and substance use disorders co-occur with greater frequency and chronicity than in the general population (Martin, 2015). What is less clear is the nature of causality, cyclicity, and recovery. Research on models of care, both qualitative and quantitative, points to housing first with integrated services as the gold standard in terms of outcomes (Rogers, 2018). There is limited research based on critical theory or utilizing Participatory Action Research methodology in order to generate empowerment and change models through an inductive process. The opportunity to test such a framework with a group of people who are homeless and experiencing psychiatric issues remains open.

Chapter 3: Methodology

Introduction

Stergiopoulos et al. (2013) point to a gap in published research on empowerment strategies for people experiencing homelessness and mental illness. To address this gap, the purpose of this study was to collaborate with a group of people who had experienced homelessness and mental illness in order to generate responses to the challenges they encounter. The study, which is based on the action research tradition, responds to several research questions. These included exploring the lived experiences of individuals who are homeless and are diagnosed with a mental illness, the barriers that they experienced, their practical recommendations to support individuals dealing with these challenges, the themes from these lived experiences that are salient in understanding the barriers these individuals face, and forms of empowerment that can be developed through the PAR process for this group of co-inquirers. The study uses Participatory Action Research to shift the locus of control toward people living with these conditions. To support this reconceptualization of power, the principal researcher analyzed the collected data through a critical theoretical lens. This chapter describes the method and operational steps in the study, its setting, major participants, techniques and artifacts, as well as considerations of researcher positionality and aspects of trustworthiness.

Research Design and Rationale

The study used a Participatory Action Research design to engage people in a homeless shelter in a collaborative approach to research questions. This group generated themes, considered strategies, developed action plans, and assessed progress. PAR embodies the epistemological perspectives of action as a method of knowing, of

knowledge through co-construction, and of the importance of a critical stance with respect to social and institutional power dynamics (Kramer-Roy, 2015; McIntyre, 2008). As applied to the population, breadth of research questions, and resources available, PAR's democratic, evolutionary, and flexible nature make it a suitable fit as a research design.

The PAR methodology involves a recursive, adaptive process of discussing, planning, action, observation, and reflection (Herr & Anderson, 2015; McIntyre, 2008). Inherently, PAR dictates that aspects of the research itself will evolve over the course of the project (Merriam & Tisdell, 2016). While the broad framework of methodology, design, and research questions are established at the outset, the democratic nature of PAR means that participants have a hand in evolving these elements as the process unfolds (McIntyre, 2008). Through a braided evolutionary process, using the experiential knowledge of the participants, this project sought to help answer the research questions across several dimensions. These included insights into participants' lived experiences, recommendations regarding systems of care, action steps, participant empowerment, and a critical attunement to power and privilege. As an additional benefit, this research design can offer an empowering experience for participants who have experienced marginalization and powerlessness (Herr & Anderson, 2015; Kramer-Roy, 2015).

Researcher Positionality

Both PAR and critical theory incorporate an explicit discussion of researcher positionality and reflexivity (McIntyre, 2008; McLeod, 2011). One of the characteristics of PAR is that the principal researcher engages in multiple roles (Herr & Anderson, 2015). In conducting the study, the principal researcher embodied elements of both

insider and outsider with respect to the shelter and the working group (Merriam & Tisdell, 2016). These dual roles resulted in a third, liminal state, which itself offered an opportunity for reflexivity and insight as the principal researcher considered their place in this relational borderland (Reid & Frisby, 2008).

As an insider, the principal researcher had worked as a volunteer at the shelter for several years and was familiar with its operations, staff, and population. Initially serving for four years staffing the welcome desk several mornings each week, the principal researcher developed knowledge and familiarity with the functions of the shelter. Subsequently, the principal researcher established a pro bono counseling program at the shelter. For two years prior to the initiation of the research, the principal researcher spent one day per week in residence at the shelter providing counseling and social support to its clients.

Another aspect of positionality involves consideration of potential conflicts of interest or power relationships. With respect to the latter, during the study the researcher was not in any formal relationship of power over participants in the research. As the principal researcher provided pro bono counseling services at the site under the supervision of an outside agency, direct conflicts of interest were expected to be minimal. In cases where individual counseling clients wished to participate in the study, the principal researcher took steps to clearly separate their role as researcher and co-participant from that of counselor and discussed the potential for dual roles with the client in advance of participation.

On the other side of the relational divide, in the process developing, proposing, and documenting the study, the principal researcher's role was as outsider (Herr &

Anderson, 2015). This is unavoidable and heightens the need for reflexivity regarding issues of power, position and privilege (Herr & Anderson, 2015). To incorporate and utilize this constructively, the principal researcher utilized three processes, each of which is described below.

First, during the interview and working group stages of the research, the principal researcher sought to be transparently reflexive regarding their power and positionality. This process element of critical theory brings power relationships into the here and now, as opposed to waiting until the data analysis stage (Merriam & Tisdell, 2016). PAR research presupposes a collaborative relationship, and through an authentic presence the principal researcher can model norms and behaviors that support a productive working group (Reid & Frisby, 2008). In keeping with this, the principal researcher in PAR bears the responsibility of demystifying the process and leveling power relationships (Grant et al., 2008).

The second element of reflexivity from the outsider perspective was a personal praxis of engaging in and documenting the principal researcher's interludes of critical reflection over the course of the research process in a fieldwork journal (Reid & Frisby, 2008). PAR engages the principal researcher as both practitioner and participant, and self-reflection on the meaning-making aspect of this research is part of the PAR process (Herr & Anderson, 2015).

The third reflexive process encompassed data analysis following the completion of the group activities. Here, the principal researcher utilized critical theory, itself a reflexive framework based on an examination of power (Merriam & Tisdell, 2016). This involved an explicit awareness of sources of inequality surrounding and affecting the

research group and process (McLeod, 2011). With respect to the study's trustworthiness, the critical theoretical framework may provide a source of triangulation with respect to the project themes and findings (Merriam and Tisdell, 2016).

Research Procedures

The next section provides a detailed description of the procedural aspects of this study's research design. It includes the project setting, population, recruitment, interviews and working group meetings, and data collection and analysis.

Setting

The research project was based at a day shelter for homeless people in the mid-Atlantic region of the United States. The shelter serves a combined population from a small city and the surrounding county of over 100,000, as well as guests who are in transit through the community. The shelter has been operating since 2010 and provides meals, personal hygiene services such as showers and laundry, computers, and rest areas. In addition, the shelter administers grants and uses its own financial resources to provide housing assistance. The shelter describes itself as a low-barrier shelter, meaning that all are welcome, regardless of physical or mental state. The shelter rules forbid weapons, drugs, alcohol, and abusive language or violence on site (The Haven, 2019). Prior to the COVID 19 pandemic, the shelter provided services to approximately 80 guests each day. State-mandated restrictions due to COVID 19 reduced the shelter's capacity, resulting in a reduction of daily visits to approximately 40 per day.

Population and Sample Selection

The shelter provided written consent to be used as the research site (Appendix A) Co-participants in this project were sourced from the shelter's client base. This resulted in

a target population of 100-120 people. This clientele arrived at the day shelter from a range of overnight situations, including spaces on sidewalks, doorways, or other ad hoc arrangements, encampments in wooded areas around the outskirts of town, night shelters including the Salvation Army and a floating night shelter operating out of church basements in colder months, temporary housing in hotels with friends, and in some cases from permanent housing. This diverse set of arrangements provided the study with a population representing a breadth of experiences with homelessness, including current, recent, recurring, and past episodes.

The shelter's clientele was multi-dimensionally diverse. Discussions with members of the Haven's staff and the author in 2020 suggested that approximately 50 percent of the typical daily population was African American by race, with an equal representation of males and females. There was representation by Asian-Americans, Latinx-American, Arab-American, and Native American clients. These discussions and the author's personal observations as a volunteer indicated that guests came from all age categories, including mothers with infants and young children, young adults, and the elderly. There was also diversity with respect to the LGBTQ+ community. From the standpoint of mental health, research indicates that there is a high probability that between one-third and one-half of the shelter's clients had a history of mental health issues, including substance use disorders (Fazel et al., 2008; Montgomery et al., 2013).

Sample Selection

Recruitment and Initial Interviews. The primary data for this study was collected from clients of the shelter. Minors below the age of 18 and pregnant women were not included in the research in order to focus on adult participants and to minimize

methodological complications arising from including subjects in protected categories. Potential participants were identified through three avenues: open recruitment by means of flyers posted inside the shelter (Appendix B), the principal researcher's familiarity with the shelter's clientele, and through a combined criterion and snowball sampling approach to referrals from clients known to the principal researcher and recommendations from the shelter's staff. The realms of experience most salient to the study and sought in the initial screening, based on self-report, included a history of multiple episodes of homelessness, a history of mental illness and/or substance use disorder, and a history of interactions with social services agencies and health care systems as a result of these factors. Interviewees with this experience set who were willing to join the working group were eligible for participation in the study. One goal of the recruitment process was to achieve diversity in the working group. This, among other things, supports generalizability of findings (Merriam & Tisdell, 2016). The shelter's clients represented a diverse population with respect to age, race, gender, sexuality, and ethnicity, and the final working group reflected this diversity.

Potential participants were informed about the study through a pre-interview meeting with the principal researcher. In this setting, the principal researcher provided a verbal description of the study, its purpose, logistical aspects, confidentiality considerations, and other details. In addition, a written summary of the project was provided to potential participants (Appendix C). Potential participants who consented to an interview and agreed to participate in the working group were given a verbal description of consent to participate, as well as a written consent form to review and sign (Appendix D).

Working Group Selection. Once potential participants had been identified, an initial, semi-structured interview, described in detail below, was conducted to ascertain suitability and interest in joining the working group. The criteria for suitability included experiences of homelessness, mental health issues and/or substance use problems, and a willingness to participate in the working group. The semi-structured interview is widely-viewed as an appropriate instrument in qualitative research design (Creswell & Clark, 2011). With respect to working group size, in order to optimize the group's cohesion while retaining a level of diversity of experiences, as well as to accommodate health and safety measures related to COVID 19, the group size was limited to 6 participants, including the principal researcher (Corey et al., 2014).

Instrumentation

The initial meeting with potential participants took the form of an interview. The semi-structured interview instrument (Appendix E) was created by the principal researcher using an interview guide approach to organize themes and questions in order to address the relevant research questions (Zohrabi, 2013). This instrument was developed for this study, given that the principal researcher was not aware of any previous PAR research study with the same parameters. The instrument was categorized as a semi-structured oral interview with both open- and closed-ended questions (Creswell & Clark, 2011; Merriam & Tisdell, 2016). This interview had three primary objectives: Creating knowledge that could be used to further the research process; understanding the interviewee's past history in order to ascertain its relevance to the topic under study; and seeking the interviewee's participation in the working group. The principal researcher reviewed and tested two drafts of the interview format as part of its development. It was

refined and reviewed for format and content validity considerations by sponsoring faculty advisors.

Working Group

The instrument of working group meetings was employed as a form of co-inquiry and is considered appropriate as an element of Participatory Action Research (Herr & Anderson, 2015; McLeod, 2011; Reason & Bradbury, 2008). As the working group met, key observations, findings, initiatives, and outstanding questions were documented through audiotaping and field journaling (Appendix F). The principal researcher wrote summaries of each meeting, and these were reviewed by the working group in the subsequent meeting (Appendix G). Areas of consensus and areas of non-consensus or dissent were noted (Heron & Reason, 2008). The focus group instrumentality is considered to be an appropriate data collection instrument in order to address research questions which have defied resolution through deductive methodologies and may be helpfully addressed through the epistemological framework of experiential understanding (Gaya Wicks et al., 2008).

Audiotaping

Interviews and working group sessions were recorded using a password-protected Apple iPhone, backed up with a password-protected Apple iPad. Recordings were transcribed onto Microsoft Word, using the Microsoft Word transcription software. All transcriptions were checked for accuracy and hand corrected by the principal researcher. This data was kept in a password-protected file on a secure data storage system. Each interviewee was given a coded, numeric identifier, and the identification key was safekept by the principal researcher in a password-protected Excel file with a paper copy

kept in a locked file cabinet in the possession of the principal researcher. Interviewee names were replaced with these codes on all written materials. This instrumentation is suggested as appropriate for interview and focus group data management (Merriam & Tisdell, 2016).

Artifacts

The study design stipulated that any artifacts produced during the course of the study would be physically preserved in a locked cabinet in the principal researcher's possession and images would be digitally recorded and were stored in a secure data storage medium.

Field and Fieldwork Journals

The principal researcher kept two journals, a field journal (Appendix F) and a fieldwork journal (Appendix H), both designed by the principal researcher. The former was used to record details from working group sessions, notes on logistics, schedules, and a methods log. The fieldwork journal was primarily a reflexive journal of thoughts, questions, and impressions of the principal researcher (Krefting, 1991; McLeod, 2011; Merriam & Tisdell, 2016; Phillippi & Lauderdale, 2018). These journals served multiple functions; they were part of the principal researcher's epistemological journey through the PAR process, were elements in the trustworthiness of the research, and they were used as tools to enable forward progress with the focus groups (Herr & Anderson, 2015). Both journals types are suggested as appropriate instruments for action research methodologies (Herr & Anderson, 2015; McLeod, 2011; Reason & Bradbury, 2008). To preserve confidentiality, the principal researcher utilized numeric codes in place of participant names on field and fieldwork journal entries.

Meeting Summaries

After an initial review of audiotapes, transcripts, and field journal notes, the principal researcher prepared summaries of working group meetings using the meeting summary instrument produced by the principal researcher (Appendix G). This instrument was developed as an integration of formats recommended by multiple sources (Krefting, 1991; McLeod, 2011; Merriam & Tisdell, 2016). These summaries were reviewed and discussed by the working group at their subsequent meeting, and the principal researcher would append any amendments. Meeting summaries were stored electronically in a password-protected, secure data storage medium. Meeting summaries are a recommended form of instrumentation for participant action research (Herr & Anderson, 2015; McIntyre, 2008).

Data Collection

Screening interviews with potential participants were held in a private meeting room at the shelter. These meetings included the principal researcher and the interviewee, with data collected by the principal researcher using the field journal and audiotaping as described above. The interview materials were a written set of preselected demographic questions as well as of thematic areas that could be used as the basis for discussion. There was one screening interview per prospective participant and the interview was scheduled to last approximately one hour.

The principal researcher recorded elements of each interview in the field journal. These included location, date and time, interviewee number, duration of interview, individuals in the room, and any unusual interview elements. Each interviewee was given a numeric identifier, and the key was kept by the principal researcher in a password-

protected electronic file with a paper copy kept in a locked file cabinet in the possession of the principal researcher. Audiotapes and digital transcripts of interviews were kept in a password-protected digital file, accessible solely to the principal researcher. In transcripts and all written materials, the interviewee's name was replaced with their coded identifier. Following conclusion of the study, all interview records and the participant code key were stored as described above by the principal researcher for a period of five years. At the end of this period, all records will be permanently deleted or destroyed.

Working Group

From a process perspective, the study design took the following framework: The initial research questions were discussed by the working group. As themes emerged, they were organized with a bias toward action steps that the group could consider in order to embody these perspectives (McIntyre, 2008). Working groups in PAR processes often develop along the lines referred to by Tuckman as forming, storming, norming, performing, and adjourning (Bonebright, 2010; Mead, 2008). The first and second meetings typically involve role induction, review of the study's purpose and research questions and goals, familiarization, and logistical considerations. From there, the group moves to a deeper exploration of the research questions, with a bias toward agency and action. Epistemology in working groups can emerge from a variety of traditions, including community norms, values, rituals, and other ethnographic sources (McIntyre, 2008). As action steps emerge, the group moves toward a natural conclusion as it reviews these actions and lessons learned (McIntyre, 2008).

In the present study, weekly working group meetings were held in the conference room at the shelter, with tables and chairs arranged in a square so that all participants

could see and hear one another. Participants included working group members, one of whom was the principal researcher. The meetings were held at mid-day and participants were provided with lunch and a \$5 gift card. Meeting data was collected by the principal researcher using the field journal and meetings were audiotaped by the principal researcher via digital recording technology. The working group met a total of six times.

Audiotapes of working group meetings, made using Apple iPhone and iPad, and digital transcripts, made using Microsoft Word, were kept in a password-protected digital file accessible solely by the principal researcher. Following conclusion of the study, all interview records and the code will be stored in this manner by the principal researcher for a period of five years. The field journal and fieldwork journal were created using pen and paper and were kept in a locked file cabinet in the principal researcher's possession. After conclusion of the study, these journals will be stored in this manner by the principal researcher for a period of five years.

Artifacts

The PAR process generally leads to the production of artifacts through the action element of the process (Ludema & Fry, 2008). The study was designed such that any artifacts would be collected by the principal researcher for safekeeping and the principal researcher would record digital images of these artifacts while they were being produced and as they were completed. Notes on the production of such artifacts would also be made by the principal researcher in the field journal. Following conclusion of the study, physical artifacts could be distributed to working group participants, community organizations, or other entities wishing to preserve or, with unanimous agreement of working group members, display them. Digital images of the artifacts would be kept by

the principal researcher in a password-protected digital file, and after conclusion of the study, would be stored in this manner by the principal researcher for a period of five years, after which time they would be deleted.

Principal Researcher Data

Personal impressions, thoughts, feelings, and other subjective experiences of the principal researcher were self-reported in the fieldwork journal (Appendix H). This data could emerge from any part of the research process, including interviews, working group meetings, side conversations, as well as the integration of these experiences in the principal researcher's epistemological development (Heron & Reason, 2008). Entries could be made at any time and such entries were time-dated. The journal was produced by pen on paper. Codes were used in place of participant names. The fieldwork journal was kept in a locked file cabinet in the principal researcher's possession, and after conclusion of the study, will be stored in this manner by the principal researcher for a period of five years, after which time it will be destroyed.

Participant Withdrawal

Participants were free to exit the study at any time. Participants were informed that, in the event they missed two working group meetings, the principal researcher would meet with the participant to ascertain their intentions regarding further participation. The study designed included the opportunity for participants who wished to exit the program to have a debriefing meeting with the principal researcher. In the course of implementing the study, no such requests were made, and no debriefing meetings were held.

Preparation of Data for Analysis

The principal researcher prepared interview and working group session recordings for analysis by cross-checking and correcting all mechanical transcriptions against digital recordings for accuracy and completeness. The principal researcher then downloaded all transcriptions into Dedoose, a commercially available data analysis software system. The field and fieldwork journals were reviewed by the principal researcher for accuracy and completeness on a weekly basis. Demographic data from interviews was cross-checked and cleaned prior to data entry in a Microsoft Excel spreadsheet.

Data Analysis

By design, the data collected through the instruments described above can be grouped into blocks, one of which is descriptive and can be represented quantitatively, the others of which are qualitative data. A visual representation of these blocks and the data coding and analysis process can be found in Appendix I.

Initial Data Review

Blocks of data were reviewed by the principal researcher for completeness, accuracy, and chronological ordering. Any needed corrections to the data blocks were made by the principal researcher. The principle used Interpretive Phenomenological Analysis in a recursive, inductive process of transcript readings, extraction of quotes, development of themes, and coding (Creswell & Clark, 2011).

Demographic Data

Demographic information from initial interviews of working group members was manually entered by the principal researcher into Microsoft Excel. Descriptive statistical

data including age, gender, and ethnicity were produced to generate a demographic profile of the working group.

Transcription and Data Analysis Software

Voice recordings were transcribed using the transcription software embedded in Microsoft Word. Interview transcripts formed one block of data to be coded and analyzed, and transcriptions of working group meetings formed a second such block. Transcriptions were loaded into Dedoose, a data analysis software package. Field journal and fieldbook entries formed a third and fourth block of qualitative data to analyze and compare with other blocks.

Data Coding Procedure

Data from the qualitative blocks were classified, coded, and analyzed by the principal researcher using Dedoose. The coding occurred sequentially by block (Appendix I). Qualitative data was coded by the principal investigator utilizing interpretative phenomenological analysis (IPA). As a theoretical and practical approach, IPA is in concordance with the principles underpinning participant action research by focusing on the lived experience of the process and people conducting it (Merriam & Tisdell, 2016). Applied to PAR, this phenomenological coding and analysis incorporates the *how* of the experience, including the processes, stages, actions, and outcomes (Merriam & Tisdell, 2016). In addition, IPA emphasizes the experiential element of cases, be they individual or group, which lends itself to research with relatively small samples (McLeod, 2011; Smith & Shinebourne, 2012).

The coding process occurred as follows: For each of the qualitative blocks, the principal researcher conducted multiple readings of transcripts. The principal researcher

identified excerpts that embodied members' lived experiences both inside and outside the study, as well as quotes related to the study's research questions. These excerpts were accompanied by the principal researcher's marginal notes. The principal researcher then identified emerging themes, incorporating additional readings of the transcript (McLeod, 2011). The principal researcher cross-referenced these themes against the field journals, fieldwork journals, and the meeting summaries in order to confirm or amend them. This step was performed manually. Next, the principal researcher conducted a third reading of transcripts, summaries, and journals, with the themes in hand. The objective here was to identify commonalities and further organize the data. This step, performed using Dedoose to view and organize data, resulted in ten primary codes. For the next step, the principal researcher reflected these codes against the study's research questions, which led to consolidating the ten codes into four primary themes, each with sub-themes (McLeod, 2011). Member-checking with working group participants was used to corroborate this set of results.

The principal researcher collected multiple facets of working group members' biographies. While primarily descriptive, this data generated insights into patterns, similarities, and themes that emerged in other blocks of data.

Group Analysis of Themes

In PAR, one element of data analysis takes place in working group sessions through a recursive, braided process that in itself is a form of meaning-making (Herr & Anderson, 2015; McIntyre, 2008). The epistemological core of PAR is that knowledge comes through action, including the analysis of data (Pedler & Burgoyne, 2008). The study generated proposals for action to analyze and engaged in a recursive process of

analytic inquiry. The group inquired about knowledge and meaning that emerged from their processes and actions (McIntyre, 2008). Analyzing this information was conducted collectively, in working group sessions, through group reviews of summary meeting notes and themes, their implications, and pathways to forward movement (Herr & Anderson, 2015).

This feedback loop is a primary form of data analysis within PAR (Cahill, 2007). As transparency and genuine collaboration are determinants of the quality of data analysis in this stage (McIntyre, 2008), the lead researcher emphasized sharing of information and resources with co-participants throughout the process as part of the collective data analysis. To enable this collective data analysis, written summaries of previous sessions were presented and discussed at each working group meeting. This information generated additional lines of inquiry (Merriam & Tisdell, 2016).

Summary Analysis

In PAR, data analysis incorporates not only the action step of *what* happened, but also a review of *how* it happened (Merriam & Tisdell, 2016). The research questions posed at the outset were directed toward positive changes in conditions that could be important to the co-participants. Accordingly, a summary analysis conducted at the last working group session addressed the pragmatic value of the project itself (McCleod, 2011). In addition, the final themes and subthemes emerging from the IPA process were member-checked by working group participants (Merriam & Tisdell, 2016; Swantz, 2008).

Another aspect of summary data analysis was conducted by the principal researcher. Using a critical theoretical lens, the principal researcher interpreted the data

from the contextual perspective of structural systems and normative dynamics of power (Merriam & Tisdell, 2016). Particular attention was paid to the themes emerging from the fieldwork journal in order to illustrate elements of positionality and power dynamics as observed and experienced by the principal researcher.

Trustworthiness

As PAR is a qualitative research method, the framework for judging its quality and relevance of is built on trustworthiness (Herr & Anderson, 2015; McLeod, 2011; Merriam & Tisdell, 2016). The current study was designed to support aspects of trustworthiness shared by most qualitative designs, as well as elements somewhat unique to the PAR methodology. This section describes elements of the study design aimed toward trustworthiness along four dimensions: Credibility, transferability, dependability, and confirmability (Krefting, 1991).

The PAR data collection method incorporated several elements that support credibility, including mechanical data recording, multiple co-inquirers, peer scrutiny, and use of low inference descriptors (Zohrabi, 2013). For example, the working group performed collective data analysis by reviewing and confirming summaries of previous sessions against the research questions. This peer-review element addressed the question of consistency of results compared with data generated (Merriam & Tisdell, 2016).

In addition, extensive field experience and the reflective fieldwork journal were also study elements that support credibility (Krefting, 1991). The study also incorporated triangulation of data collection and coding through member checking (Merriam & Tisdell, 2016). Triangulation occurred through multiple data collection methods at various stages of the research, including the interview, working group, and analytical

stages. This approach was adopted to strengthen the credibility and reliability of findings (Creswell & Clark, 2011). The PAR method emphasizes that data is collectively “owned” by the co-researchers (McIntyre, 2008), necessitating the sharing of findings, learning, and experiences in a transparent manner across the working group. This collective element should contribute to credibility.

With regard to transferability, as participant action research is expressly designed to identify practical solutions, its external validity and utility are central objectives. Toward these goals, the study design incorporates sample diversity. The degree to which the working group is diverse across multiple dimensions was expected to have a relationship to transferability and generalizability of findings (Merriam & Tisdell, 2016). The working group process was densely presented through data analysis, and the multidimensional descriptions of its members also supports transferability of the study results (Merriam & Tisdell, 2016). The result of collecting and analyzing the initial interview data is a demographic and experiential profile of the working group members. This can contribute to interpretations and insights and adds to transferability by helping quantify the degree of variation in the sample (Merriam & Tisdell, 2016).

The principal researcher’s analytical framework may also support dependability. Utilizing critical theory to analyze the data brings what Morrow (2005) describes as “consequential validity” (p. 250) to the study. Here, an explicit focus on power relationships and institutional structures invited a disruptive approach to validity by questioning the degree to which the research study generated challenge, discourse, and change (Morrow, 2005). Using working group members as co-inquirers was expected to

support the congruence, objectivity, and grounding of the method's research findings.

PAR also incorporates a thorough audit trail, which supports reliability (Krefting, 1991).

In considering the confirmability of the procedures, the PAR approach incorporated a deep reflection by the principal researcher on their own positionality and on power relationships. This inquiry into the researcher's position was aimed toward a deepening of the inductive, observational power of the research. Clarification of the researcher's social position and status should support external confirmability and transferability (Zohrabi, 2013). The triangulation procedures noted above should also support confirmability of the study's methods and results.

Ethical Procedures and Protection of Co-Researchers

The spirit and praxis of participant action research is humanistic and democratic (McLeod, 2011). The quality of the research project and of its meaning-making depends, therefore on upholding these principles. The principal researcher was responsible for conducting all aspects of the research project in an ethical and caring manner, primarily for the safety of co-researchers and the community, but also for the protection of the sponsors and community that supported the research effort. Approval of the project by the sponsoring institution's institutional review board (IRB) was a condition of its implementation (Appendix J). The principal researcher was bound by the ACA Code of Ethics (ACA, 2014) in all aspects of the project, as well as all legal requirements and related ethical guidelines for human subject protections. All interviewees and co-researchers were provided with written and oral descriptions of the project (Appendix C) and informed consent forms containing written expectations and disclosures of the limits of confidentiality to be signed (Appendix D). Use of names, identifying features, videos,

photos, or other likenesses were contingent on the co-participant's express written consent.

Data was anonymized by coding participants' names and utilizing these codes in all transcripts, journals, and other written data sources. Digital data was stored in password-protected files and physical data was stored in a locked file cabinet in the principal researcher's possession. All data will be destroyed five years after conclusion of the study.

As noted above, the principal researcher was both insider and outsider at the research site, having worked as a volunteer and counselor in residence at the shelter. This created the potential for dual relationships in situations where the principal researcher may at present or in the past have provided counseling to a member of the working group. As the principal researcher's counseling services at the site were supervised by an outside agency, conflicts of interest did not arise during the course of the study. In cases where individual counseling clients wished to participate in the research, the principal researcher clearly separated their role as researcher and co-participant from that of counselor through discussions with the client prior to the study's initiation.

Summary

The PAR methodology is an inclusive, recursive qualitative design that utilizes a working group as primary research instrument. It generates activities which become epistemological representations of participants' lived experiences. These unique attributes were embedded in the present study's methodology. PAR's imperatives for democratic process and principal researcher reflexivity were incorporated in study

design, and they also supported the study's trustworthiness and protection of co-participants. This study's design and methodology were intended to provide a welcoming environment for an authentic participatory project designed to create meaning, insight, growth, and agency.

Chapter 4: Results

The purpose of this study was to co-collaborate through individual interviews and focus groups with participants who had self-reported experiences with homelessness and mental illness. Through this collaborative process, participants identified the challenges they encountered. This study utilized Participatory Action Research to obtain insights on one primary, and several subsidiary research questions (Kramer-Roy, 2015; McIntyre, 2008). Its primary research question was focused on the lived experiences of individuals who are homeless and are diagnosed with a mental illness. Subsidiary research questions addressed the barriers these individuals face, practical recommendations can be generated to support individuals dealing with these challenges, themes from these lived experiences that are salient in understanding the barriers these individuals face, and whether forms of empowerment emerge through the PAR process. The principal researcher used interpretive phenomenological analysis to analyze the data produced and applied the lens of critical theory to support reflexivity and to consider social and institutional power structures in the context of themes emerging from the data. The chapter begins with a report on data collection, followed by a description of the data analysis. The study's results are detailed through the presentation of four major themes. The chapter concludes with a discussion of reliability and validity.

Participatory Action Research

This study used a Participatory Action Research design to engage people recruited at a homeless shelter in a collaborative, epistemological project. PAR's epistemological framework holds that action and co-construction are pathways to understanding (McIntyre, 2008). PAR's theoretical underpinnings incorporate flexibility and equality,

making it appropriate for working with marginalized groups (Kramer-Roy, 2015).

Methodologically, PAR incorporates adaptive, recursive rounds of conversation, planning, action, observation, and reflection ion (Herr & Anderson, 2015; McIntyre, 2008; Merriam & Tisdell, 2016). Inherent to the PAR methodology is the possibility that participants, through the democratic experience of action research, will experience aspects of empowerment (Herr & Anderson, 2015; Kramer-Roy, 2015).

Interpretive Phenomenological Analysis

While this study's data collection was conducted using the PAR theory and methodology, the principal researcher analyzed the data using interpretative phenomenological analysis (IPA). IPA is frequently selected for data coding and analysis in PAR studies, given its inductive, phenomenological framework (Merriam & Tisdell, 2016). The IPA approach to data analysis encompasses the phenomenology of how the PAR process (McLeod, 2011; Merriam & Tisdell, 2016; Smith & Shinebourne, 2012).

Data Collection Procedure

Following IRB approval, the principal researcher recruited subjects, conducted interviewed, and convened working group meetings. In keeping with the PAR framework, contributions from working group members formed the backbone of this study's data. These contributions took the form of the initial one-on-one interviews and of the working group sessions. The process of collecting this data is described below.

The Interview

Potential participants were provided detailed information regarding the study (Appendix C), and if interested, met with the principal researcher for an interview. Written informed consent (Appendix D) was provided by each interviewee prior to

interviews. The initial interview had multiple purposes. It was an opportunity for both the principal researcher and the participant to share information and consider the possibility of joining the working group. It also served as a source of data for interpretive phenomenological analysis. The interview was designed in a semi-structured format (Appendix E) and was also used to collect demographic and biographical information, which is presented below. Interviews lasted approximately one hour each. Five individuals, whose backgrounds are detailed below, participated in interviews. All five agreed to become working group members.

The Working Group

Through its meetings, the working group, served as the primary source of this study's data. A total of 6 people, including the principal researcher, formed the working group of co-inquirers. The group met a total of six times over the course of two months (Table 1). Through a consensual approach to scheduling, meetings were held at 1pm and were scheduled to last between 60 and 90 minutes. In practice, each meeting lasted between 60 and 75 minutes. Key observations, findings, initiatives, and outstanding questions were documented through audiotaping and field journaling and were summarized by the principal researcher. These summary notes (Appendix G) were reviewed and confirmed as a group. In addition to a review of previous meeting themes, each meeting focused on addressing the research questions with an orientation toward action steps that would reflect the emerging themes and insights (McIntyre, 2008). An action plan emerged, and implementation plans were developed and agreed as the study's data collection phase concluded.

Positionality and Reflexivity

Another facet of the PAR design incorporated principal researcher positionality and reflexivity (McIntyre, 2008; McLeod, 2011). The principal researcher held multiple roles with respect to the working group, including insider and outsider (Herr & Anderson, 2015). The fieldwork journal (Appendix H) is a PAR element designed to encourage principal researcher reflexivity throughout the study. Use of a fieldwork journal in Participatory Action Research provides the principal researcher with a tool to record impressions, observations, questions, and reflections on their roles in the research process (Merriam & Tisdell, 2016; Reid & Frisby, 2008).

To address the possibility of conflicts of interest, the principal researcher sought to avoid power-based relationships with working group members. Examples of such relationships includes those between employer and employee, instructor and student, or client and service provider (McIntyre, 2008). In addition, the principal researcher made every effort to be transparently reflexive to working group members regarding their own power and position. Examples of this included self-introduction at the interview stage, process comments and appropriate self-disclosure in working group meetings, fieldwork journal entries, and data analysis. These elements of PAR research were adopted to support collaboration and positive group norms through modeling of openness and self-disclosure (Reid & Frisby, 2008). As an additional contribution to reflexivity, rigor, and to support triangulation of results, the principal researcher incorporated elements of critical theory, a framework based on an examination of social and institutional power structures, (Merriam & Tisdell, 2016).

Credibility and Reliability in PAR

The PAR design included several methods to address this study's credibility and reliability. All interviews and working group meetings were recorded using a primary and backup digital device (Apple iPhone and iPad). They were then transcribed using Microsoft Word software, then checked for accuracy and corrected by the primary researcher. This process creating an audit trail for these two primary blocks of data. Written summaries of each working group meeting, prepared by the principal researcher, were distributed at the subsequent meeting in order to facilitate member-checking. These transcriptions and member-checked written summaries facilitated the principal researcher's use of specific, high-inference descriptors in data analysis (Zohrabi, 2013).

As to triangulation, the current study included all four forms noted by Denzin (2017). Methodological triangulation was achieved by collecting data through interviews, working group meetings, and the two journals. Data triangulation was generated through the use of multiple sources, including interviews, group meetings, and journals. Investigator triangulation was promoted through the use of co-inquirers in the participatory research design. Theory triangulation was addressed through the epistemological theory embedded in PAR, along with the principal researcher's use of interpretive phenomenological analysis and critical theory in the data analysis phase.

To support reliability, this study's PAR design generated an audit trail of all blocks of data, with interviews and working group sessions captured in the Dedoose software application, and journals and meeting summaries retained in the principal researcher's possession (Krefting, 1991).

Data Analysis: IPA

As a framework for evaluating this study's data, the PAR approach is epistemologically aligned with interpretive phenomenological analysis (IPA). This is a function of IPA's methodological embrace of the experience of participation and on the lived experiences of those engaged in it (McLeod, 2011; Merriam & Tisdell, 2016; Smith & Shinebourne, 2012). IPA includes a recursive method for the principal researcher to identify these experiences and interpret them through a hermeneutic lens (Larkin et al., 2006).

The principal researcher applied IPA to the study's data in several steps. The first was an initial reading of the interview and working group meeting transcripts. The principal researcher identified excerpts that reflected lived experiences, participation in the project, and/or related to the research questions. These excerpts were catalogued, by interview or working group session, within the Dedoose software. The principal researcher then read the excerpts as a whole and blocked these excerpts into a group of themes, using the memo function within Dedoose. With these themes in hand, the principal researcher performed a second reading of transcripts. The objective in this step was for the principal researcher to arrive at a set of broad themes. These themes were then cross-referenced against the field and fieldwork journals and the meeting summaries in order to confirm or amend them. This step was performed manually. Next, the principal researcher conducted a third reading of transcripts, summaries, and journals, with the themes in hand. The objective here was to identify commonalities and further consolidate the themes. This step, performed by the principal researcher using Dedoose,

resulted in ten primary codes. To generate conclusions for the study, the principal researcher then considered these codes in terms of the study's research questions, which led to organizing the ten codes into four primary themes, each with sub-themes. Member-checking with working group participants was used to corroborate this set of results.

Data Collection

Recruitment

Following institutional review board approval, participants were recruited through several means. The principal researcher posted a flyer (Appendix B) at the shelter announcing the study and seeking volunteers. This resulted in three guests contacting the principal researcher by leaving the shelter's front desk manager with their name and phone number. Of these three individuals, two consented in writing to an interview, following which both provided written consent to become working group members. The third guest did not respond to several telephone calls placed by the principal researcher.

One of above two working group members provided a snowball sampling referral to a person who, after telephone contact by the principal researcher, consented in writing to an interview. Following the interview, this person gave written consent to participate in the study as a working group member. Two additional individuals were known to the principal researcher as shelter volunteers. While at the shelter, in an informal conversation with the principal researcher both individuals expressed interest in participating in the study. They consented in writing to interviews, following which both gave written consent to become working group members.

Participant Interviews and Working Group Formation

Over September 2020, the principal researcher conducted five initial interviews, one with each person providing written consent. The principal researcher designed and implemented a semi-structured format (Appendix E). Interviews lasted approximately one hour each. Following each interview, all five interviewees gave written consent to join the working group. At six members (five volunteers and the principal researcher), the working group size was the maximum allowed by the institutional review board. The group's size was also within the 5–12-member range of participants cited in various studies as appropriate for Participatory Action Research (Boddy, 2016; Crouch & McKenzie, 2006; Mason, 2010).

Working Group Member Profiles

The working group was diverse across multiple dimensions, as illustrated by the following descriptions of its members. Participant 1 was a 29-year-old transgender African American female. They had been raised in the town where the research was conducted but moved to New York for several years. While in New York, they became homeless and were diagnosed with a substance use disorder and co-occurring mental illness. They returned to the town where the current study was conducted approximately two years prior. During the current study, Participant 1 was unhoused and using substances.

Participant 2 was a white, homosexual male, 46 years old. He had a diagnosis of post-traumatic stress disorder, had been hospitalized for psychiatric treatment, and had a history of substance abuse. He had experienced housing instability and homelessness for

most of his adult life. He had recently moved within the state to the research study's host town and had secured temporary housing through a local agency. At the time of the study, Participant 2 was in recovery and not using substances.

Participant 3 was a 64-year-old African American male who had lived his entire life in the town where the study was conducted. He became addicted to alcohol when his marriage was ending and spent over ten years homeless or in unstable housing before entering addiction recovery. Alcohol-free for over 15 years, Participant 3 was stably housed in an Oxford residence at the time of the study. He had previously volunteered at the shelter's welcome desk for several years.

Participant 4 was a 53-year-old African American female. She was diagnosed with bipolar disorder and experienced inpatient psychiatric hospitalization as a young adult. She became addicted to alcohol and street drugs during a time of relational conflict with her then-husband. She experienced homelessness and unstable for approximately two years before committing herself to a drug and alcohol rehabilitation program. She has been stably housed through a community grant program for the past several years.

Participant 5 was a 37-year-old white female. She grew up in Texas and was a victim of incest and other forms of domestic abuse as a child and adolescent. She fled her family of origin and subsequently became a sex worker while single and during her first marriage. She had been diagnosed with post-traumatic stress disorder and developed a substance use disorder as an adult. She had been unstably housed or homeless for the past several years and made a decision to live an itinerant life. At the time of the study, Participant 5's stated intention was to stay in the study's host town for some months before continuing her travels with her male partner.

Working Group Demographic Profile

The working group's demographic profile compares with the data on the overall homeless population in the U.S as follows. 40% of the working group was male, 40% female, and 20% transgender. This compares with HUD (2020) estimates of 40% female, 59% male, and 1% transgender/other gender identification. 60% of the working group identified as Black, which compares with the overall homeless population at 50% white, 40% Black, and 10% other (HUD, 2020). Estimates are that 30% of the homeless population is in a household with children, compared with 20% of the working group reporting minor children, although not currently sharing custody (HUD, 2020). There were no veterans of the U.S. armed services in the working group, compared with approximately 8% veterans in the homeless population (HUD, 2020). Finally, HUD (2020) estimates that 20% of the homeless population has a diagnosed serious mental illness (SMI), and that 16% has an active substance use disorder. One (20%) of the working group members was in active substance use at the time of the study, and 2 members (40%) reported a diagnosis of serious mental illness, while two other members reported a mental health diagnosis that would not be classified as a SMI.

Working Group Meetings

The working group met six times. The group met at 1 pm in a large conference room at the shelter. Meetings lasted between one hour and 75 minutes. The principal researcher recorded all interviews and working group sessions with an Apple iPhone. A backup recording was made with an Apple iPad. The principal researcher transcribed all recordings onto Microsoft Word, using Microsoft Word software. This program's feature converts speech to digital text in a Microsoft Word document. The principal researcher

then listened to each interview and each working group meeting to compare the voice recordings to the transcriptions. The principal researcher checked and hand-corrected any errors in the transcriptions.

The only deviation from the data collection plan presented in Chapter 3 was that the working group did not generate artifacts. This resulted in four, rather than five blocks of qualitative data to be coded and analyzed. This outcome is a common aspect of the working group element of PAR studies, which are open-ended and designed to generate epistemological value through the process of meeting, exploring research questions, and planning action steps (MacDonald, 2012; Sagor, 1992).

While the data collection process followed the plan presented in Chapter 3, it should be noted that the study was conducted during the COVID 19 novel coronavirus pandemic. The pandemic resulted in restrictions on mobility, increased social distancing, and other public health measures designed to protect against transmission of the disease. The current study's institutional review board included a number of specific guidelines, all of which were followed in the implementation of the research. These included the use of protective masks, participants' compliance with Centers for Disease Control and Prevention recommendations on physical distancing and hygiene practices, social distancing of a minimum of 6 feet, advance contact with participants to confirm asymptomatic status before each meeting as well as to inform all participants that protective masks were required, and verbal acknowledgment by each participant at the time of each meeting that they were asymptomatic.

Data Analysis

As outlined in Chapter 3, individual participant interviews and working group meetings were held in a conference room at the shelter in Central Virginia. The semi-structured interviews were designed to last between 60 and 90 minutes. Actual interviews lasted approximately one hour. By consensus of working group members, the working group sessions were scheduled to last between 60 and 90 minutes. In practice, the five working group sessions ran between 60 and 75 minutes. The five individual interviews and six working group sessions were recorded using an Apple iPhone, with a backup recording using an Apple iPad. The principal researcher transcribed all recordings onto Microsoft Word using its embedded transcription software. The principal researcher checked and hand-corrected all transcriptions against the original recordings. This data was kept in a password-protected file on a secure digital storage system. Summaries of working group meetings were prepared by the principal researcher and kept in a password-protected file on a secure data storage system.

As noted, the principal researcher maintained a fieldwork journal (Appendix H). The fieldwork journal included a section on critical reflections on each session, theoretical and methodological issues, analytical interpretations, and assumptions to bracket. This served as a reminder of positionality and a method of reflexivity throughout the study's implementation (Herr & Anderson, 2015; Reid & Frisby, 2008). The principal researcher's field journal and fieldwork journal were kept in a secure location at their office. Summaries of working group meetings were prepared by the principal researcher and kept in a password-protected file on a secure data storage system.

Analytical Steps

Moving forward from data collection, the principal researcher prepared data from the sets of interviews, working group meetings, field journal, and fieldwork journal. This section describes the preparation and analysis of these blocks of data, including the development of codes and themes.

Data Preparation

Data preparation for the two blocks of data, initial interviews and working group meetings, is described in detail below.

Initial Interviews. For each of the five initial interviews, the principal researcher prepared data for analysis by comparing each transcription against the original recording and correcting any transcription errors. These transcriptions were downloaded into Dedoose, a commercial data analysis software system. This system was password-protected, and data was stored on secure Dedoose servers. Demographic data from interviews was checked against the interview transcripts and entered onto a Microsoft Excel spreadsheet. This data was kept by the principal researcher in a password-protected file on a password-protected digital storage system.

Working Group Sessions. Transcripts from each of the six working group sessions were prepared in the same manner as was the case for initial interviews. The Dedoose platform was used to store this data and for analytical purposes.

Journals: The field and fieldwork journals were reviewed by the principal researcher for accuracy and completeness.

The data collection and preparation process established a platform from which the researcher proceeded to the next phase of data analysis. This involved recursive rounds of

readings, identification of key statements, thematic observations, coding, summarizing and critical reviews. As described in Chapter 3, the principal researcher coded data using interpretative phenomenological analysis (IPA). This method is consistent with the foundations of participant action research, given its focus on the lived experience of the research itself, as well as of its participants (Merriam & Tisdell, 2016; McLeod, 2011; Smith & Shinebourne, 2012).

First Readings

The study was designed to follow several stages of data coding. First, the five participant interviews and six working group meetings were read, respectively, as blocks in chronological order. Consistent with McLeod's (2011) approach to interpretive phenomenological analysis, the researcher considered descriptive, hermeneutic, and conceptual dimensions when reading the transcripts.

Initial Interviews. The five initial interviews were read as one block, in chronological order. For each interview, the principal researcher used the Dedoose excerpt function to identify specific examples of experiences, themes, and conceptual frameworks mentioned by the interviewee. This allowed relevant material to be highlighted and bookmarked for further analysis. A total of 131 such excerpts were created in the first readings of interviews.

Working Group Meetings. The principal researcher used the same approach with the first reading of the six working group meetings. Examples of themes, experiential reflections, concepts, areas of agreement and focus were highlighted using the excerpt function in Dedoose. A total of 387 excerpts were created in Dedoose from this block of data.

Initial List of Memos

The next step in data analysis was to read the excerpts as a block and generate an initial list of themes, using the memo function within Dedoose. The principal researcher used the theoretical frameworks of IPA and critical theory when analyzing this block of excerpts. The six working group meeting summaries, also maintained in Dedoose, were added as a measure of triangulation. From this recursive analytical process, the principal researcher created a total of 180 memos within Dedoose.

Emerging Themes

With these memos at hand, the principal researcher then performed a second transcript reading. This analytical step helped the principal researcher organize the memos into a set of broad themes. The working group meeting summaries and two journals were used to cross-reference the transcripts and support thematic development. This inductive process, performed manually, resulted in 26 broad themes (Table 2). These themes were then evaluated, blocked into broad groups, and reviewed for consistency against the written summaries of the meetings, which had been member-checked in subsequent working group sessions. The emerging themes were also cross-referenced against the respective blocks of data generated through the fieldwork journal entries and the field journal entries. This triangulation process established a basis for the next step, to develop primary codes.

Primary Codes

As described in Chapter 3, the principal researcher conducted a third reading of the transcripts, starting with the interviews and followed by the working group sessions, session summaries, and journals, all in chronological order. These readings included

constant reference to the themes, with the objective of consolidating them into a smaller group of codes. As a result, the 26 emerging categories were refined to result in a set of 10 primary codes (Table 3) encompassing the interviews and working group sessions (McLeod, 2011). The principal researcher performed this step of the analysis using Dedoose.

Themes

To develop analytical conclusions to the research, the principal researcher's next step was to apply the theoretical framework of IPA and critical theory to analyze these codes in terms of the study's research questions. This resulted in grouping the ten codes into four primary themes, each with its own sub-themes. With the exception of Participant 5, who left town shortly after the final working group meeting, working group participants met with the principal researcher to perform member-checking in order to corroborate this set of results.

Results

The data analysis described above generated four major themes: The trauma of homelessness, addiction, and mental illness; the power of personal connection; personal agency and achievement; and meaning through action. These themes and their sub-categories are listed in Table 4. The remainder of this chapter is organized around these themes, and this study's research questions are addressed within this framework.

The Trauma of Homelessness, Addiction, and Mental Illness

A primary finding from this study is that homelessness is a lived experience of trauma. This trauma is compounded by mental illness, including substance use disorders. Every working group member referred to the chaotic and traumatic experience of

homelessness, addiction, and/or mental illness during their initial interview and in group meetings.

The broad dimensions of trauma can be categorized into domestic relationships, where conditions at home may have contributed to housing instability, mental illness, and substance use; trauma experienced while homeless; and trauma experienced while experiencing addiction and/or mental illness. The boundaries between these dimensions are not always clear; they often intertwine and reinforce each other.

Domestic Chaos

All the participants referred to earlier versions of home as places they felt compelled to escape. In three cases this was primarily the family of origin, where physical and emotional abuse drove them away. In two cases the problems emerged as adults, while in committed relationships. Regardless of the timing, “home” became a place associated with danger, pain, and unpredictability. Recalling such chaos in her family of origin, Participant 5, a white female in her 30’s, described her mother as a schizophrenic alcoholic. In the initial interview, she offered this glimpse into her childhood:

I had a really violent upbringing, so school was challenging to pay attention to before I got pregnant and had to get out, so I ended up failing 9th grade like 3 times, just like my sister D--- did, and then I quit.

Participant 2, a white male in his 40’s, described leaving his family of origin shortly after coming out to his mother as gay:

Interviewer: You came out.

Participant 2: I did. I told my mom.

Interviewer: Wow.

Participant 2: But I moved out of my house before I finished--graduated high school. I took my sister with me 'cause it was bad.

Interviewer: Oh, OK, so there was abuse in the household?

Participant 2: For a long time, yeah. But I mean abuse comes in forms of different, different forms.

Participant 1, a transitional transgender female African American in their 20's, recalled an unending cycle of disruption and separation during childhood:

By the time I got to middle school, like me and my siblings we already went to 10 different elementary [schools]. That was the first time I experienced homelessness. My mom, like she was a single mother of three, and so, like, struggling, taking care of us kind of put us into a state of homelessness. We were homeless for like five years.... Once we got to high school my mom's like, you know, like, "I can't take this no more", like, so between middle school and high school there was a time period where me and my sisters had to go into foster care and my mom is in the shelter.

When referring to domestic chaos and trauma during adulthood, participants invariably noted the involvement of drugs and alcohol. Participant 4, a Black female, in her 50's, recalled needing to leave her husband and her home due to substance use issues:

So, after that, I said, "I got myself together, now you go!" He started smoking weed, drinking, and carrying on.... And then he started drinking, real heavy, I mean real heavy....That's when he started acting a fool and

drinking. Every time I come home, he be fussing with me, fighting with me, “don’t start something with me”. And I walked away, and most of the time I went over to my sister’s house.

The Trauma of Homelessness

Participants referred to episodes of housing instability in every interview and group session. These descriptions paint a picture of isolation and deprivation that can best be described as trauma. As Participant 3, a Black male in his 60’s, described his five years of homelessness, “I’m gonna be honest. In my case a major piece when I was in there, a major ordeal. I didn’t give a damn about nobody. I didn’t care about me.” Participant 1 echoed this picture of desperation, recalling his year of homelessness in New York City, “There was a point in my life where I was like literally walking around shoeless, like almost in a sense looking very deranged, same clothes on a week straight, kid you not.” Back in his hometown, the setting for the current research, Participant 1 sought shelter in his storage unit, on constant alert for security guards who would turn him out onto the streets:

So in the evening times, probably like around 9:00 p.m., I’ll go over there, I have an air mattress that I blow up in there, other than that if it, if it’s like being so much tension around my storage unit, ‘cause, like, sometimes the property manager will text me sayin’ “are you hanging out of my storage unit again?”

The Trauma of Addiction and Mental Illness

Participants in the current study shared their struggles with drugs, alcohol, and mental illness. Participant 1 recalled enduring a combination of depression, intravenous drug addiction, and derealization:

I didn't even have a desire. I would be hungry, I had lost so much weight.

I will be so hungry but I didn't have an appetite. I was just sitting there like in my head, just trapped in my own mind, looking back on things like “how did I get here”, you know what I mean?

Participant 2, who is HIV-positive, recalled spiraling into addiction and episodes of extreme risk-taking:

I did not care about anything. I started doing, I'd go down to D.C., you know, people going down to the clubs, do recreational drugs, you know, like socially. And, um, mine became, started becoming more and more. Yeah, when I kind of found, a week before that, out my roommate died and passed away from AIDS. School teacher.

Describing symptoms related to his diagnosis of Posttraumatic Stress Disorder, the same participant described being gang-raped and the flashbacks and avoidance symptoms that ensued: “And I'm glad I don't remember a lot, you know, but I do remember flashes. And so, I've always been like, I just, oh, I just don't, I don't trust like a lot of people and situations.” Participant 3, who struggled with alcohol use for over a decade, describes self-imposed exile from society: “Coz nine times out of 10 when you're homeless and you're in addiction, once you get enough change, you're gonna disappear. You don't want to be seen, you don't want to be seen no more than you have to.”

Power of Personal Connection

A second major theme speaks directly to this study's primary research question. In sharing their lived experiences of homelessness and mental illness, working group participants frequently referred to specific episodes when another person reached out to them. At times this person was a friend or a family member, but most often it was a worker or volunteer at a social services agency. These memories were expressed with clarity and energy, and participants frequently paired them with suggestions regarding the importance of putting a human face on services being offered. These perspectives shape a response to two subsidiary research questions: Practical recommendations to support individuals dealing with these challenges, and themes to help understand the barriers these individuals face.

We All Need Help Sometimes

To the question of practical recommendations to support people dealing with homelessness and mental illness, working group participants offered perspectives on what they needed when coping with these conditions.

Help When Times are Dark. A shared thread within this theme was the recognition by all participants that they needed and were open to help at points in their lives. Participant 3 recalled the day, nearly 20 years before, when a social worker made her way to his woodland camp outside of town:

And all of a sudden, you know, I was sitting there, you know, drinking my suds and not paying attention, and looked up, and here come this kind of blonde, kind of chubby lady, bopping on down through the woods....I looked up and quite naturally as soon as I looked up and saw who it was, I

knew who it was. Here come Miss A--- from downtown. And A--- and R--- come boppin' on down through the woods. And, um, she give me the question, "Would you like to move into an apartment?"

Participant 2 was kicked out of their home as a teen when they came out to their mother as a member of the LGBTQ+ community. They recalled a helping professional taking them under her wing at a crucial time:

So, once that happened, S---, like I'm in debt to her, she was my mentor at Lighthouse. With her I found basically my passion for film and photography, but this woman took me into her home with her children, her family, and she's like "I see the potential in you".

Help from a Trusted Person. As the working group sessions evolved, the conversation about help expanded. It encompassed a broader definition of the importance of a trusted ally to support working group members as they struggled with homelessness, addiction, and mental illness. Such helpers could be personal friends, agency employees or volunteers who had become trusted advisors. In some cases, the key support person was a family member. The following exchange between Participants 2 and 3 reflects this point:

Participant 2: We want to trust our go-to person. We don't want to go over the edge.

Participant 3: In other words, you want to find the person that you can actually put some faith in. Because, like I said a few minutes ago, ain't nobody perfect. Cuz, um, need some faith in, that you can go to and, um, you know, have a conversation with.

Participant 4 recalled pitching a tent in her sister's back yard one summer while homeless, and how their personal relationship has become her lodestone of support: "The only person I depend on is my sister....She stick by me through thick and thin."

Help Me by Seeing Me. A third aspect of this sub-theme, we all need help sometimes, was the group's conviction that the power of human connection, without any agenda, is important to people struggling with housing instability and mental illness. A discussion between Participants 2 and 3 on the subject of panhandling illustrates the point:

Participant 3: And, um, people are handing you something just to get you to scurry out of their way. And the thing is, sometimes, I would say people need to just ask that person, just ask him...

Participant 2: "...how you doing?"

Participant 3: "How you doing?" And, um, "What you going to eat?"

My Support System Keeps Me From Falling Back

As the working group considered dimensions of help across meetings, they created more evidence of the value of reaching out to their support system. In the member-checking process from meeting to meeting, they made a point of noting that they felt safest when they could preemptively tap into their personal networks when they noticed themselves slipping backward. In the following statement about the nature of personal connection, Participant 1 provided an example of how the working group engaged in member-checking and fine-tuning the messages they wished to convey:

And not only before we fall, I think we should put some main points in there too, specifically, you know, how they, they pretty much, they know

you inside out to the point, it's like they, they see a trigger coming for you, and so they reach out to you and say “Hey”, you know, “I just wanna make sure you're gonna be good in case you might need me by your side”, you know.

Participants 3 and 4 engaged in a discussion about how such a support network operates:

Participant 4: You always should have somebody, when you alone, like that, and you trying to get out of it, trying to get yourself together, after you get off your addiction or whatever, is always to have somebody there for you. You see what I’m saying? Just in case you slip and fall—am I right, #3?—Because if you be there...

Participant 3: Well, the way I would say it is, um, my main reason to say you have somebody there is before you fall, you always got the notion of doing it before you fall.

Participant 4: There you go.

Participant 3: When you get that notion, if you got that buddy you can call, that buddy is supposed to say, “What in the hell you thinking about?”

Participant 4: Right, right, right, yeah.

Participant 3: Or try to help you with the problem that you’re going through at that moment.

Participant 3, who has not used alcohol in 15 years, illustrated the importance of an ongoing network of personal connection this way:

Participant 3: Right now, I have 2 cats that just out of the blue will call me, just, just say hello.

Researcher: Check in.

Participant 3: Check in just, saying, um, “this is going on.”

Researcher: So, they’re supporting your recovery. Even though it's been years for you that you’ve been sober.

Participant 3: Yes. Even though it’s been years for me, and some of them, a couple of them, it’s been years for them, but just want to make sure we are still connected.

I Have Become a Helper

A fourth iteration of this theme of the power of personal connection incorporates agency. This went beyond participants’ experiences of receiving support, to incorporate their personal choices to help others in need. In the final group meeting, Participant 4 summarized the theme of personal connection, and added to it elements of her meaning-making and personal agency. She recalled with pride a chance encounter on the streets just prior to the final meeting:

Participant 4: Well, I should be patting my own self on the back because some guy came to me a couple days ago and asked me to help him to get in recovery.

Researcher: Really?

Participant 4: Yes, he did.

Researcher: Somebody came up to you and said, “I need some advice”.

Participant 4: Mm hmm. That's why I took him there. Took him to M--- Center.

Participant 3, who volunteered for the homeless shelter many years after achieving sobriety, reflected on what helping others came to mean for him:

And now I look back at how many, ah, over the years, how many people I have reached out and touched. And if not one way, one place or the other, have helped them move on in life. Because I done see some that come into this damn [shelter], and I actually set them down and told them: “You're getting too old, it is time to put the damn toys away and get your big pants on.”

Organizations Can Help

One of this study's subsidiary research questions addresses practical recommendations to support people dealing with homelessness and mental health issues. To this end, working group participants made frequent references to agencies that had helped them during their struggle with these conditions. These references were generally constructive and offered with a sense of gratitude. Discussions of helping organizations included several based in the town where the study took place, as well as services accessed in other cities and cities. An example came from Participant 3, as he described his first attempt to end a long period of homelessness:

Participant 3: I was homeless for about six years.

Researcher: Six years. That's a long time.

Participant 3: And that's how I got in touch with the [shelter]. It was through a program that helped me to get off the street, and...

Researcher: And what was that program called?

S13: Um, [program name].

I14: [Program name]. OK.

S14 Yeah, it was one of the first programs that they started in [town] to get people off the streets.

I15: Ah. Wow.

S15: I was one of the first batch.

Participant 1 recalled receiving support from an agency in New York City that specialized in supporting the LGBTQ youth community:

That's, like, where everyone felt welcome. It's such a big city and there's so much opportunity there that everybody just runs to New York so....They helped me out a lot. They put me in a transitional housing and from transitional housing they help me get into my own place....

Multiple readings of the transcripts and subsequent discussions with participants highlighted the importance of people within organizations, rather than the organization itself. An example of this reflection came from Participant 2, recalling psychiatric outpatient treatment received as a young man:

Not hospitalized, but I was in need of some assistance. I never went to like, I would seek help through [name] juvenile program. It's also where I went for my medical care, and I would see a therapist--oh man, she's so awesome....

The same participant, having moved recently to the town hosting this study, noted the presence of a network of supportive organizations, but specifically called out his case manager:

I would say also like [name], my case manager at [hospital], she's my support network. Um, [agency] has not been open, it's a wonderful place where we can go for groups for, like drinking, or suicide, or PTSD, or LGBTQ community.

As these examples illustrate, the theme of help revolved around interpersonal connection, as opposed to institutional services or models of care. Reflecting on the principal researcher's positionality was helpful in analyzing this data, as the potential to view the topic of help through the lens of organizations and care models would have obscured the clear message from the working group.

Personal Agency and Achievement

The prevailing theme in group meetings and interviews was of personal agency and achievement. This was confirmed and refined through member-checking following each group meeting. The power of personal agency and achievement represents a major conclusion in the present research, not only to the primary research question of lived experiences, but also to subsidiary questions regarding practical recommendations, dealing with barriers, and forms of empowerment. The theme of personal agency and achievement was expressed in multiple dimensions.

I Need to Do This My Way

Whether the topic was personal growth or helping others, working group participants were adamant that change had to come from the inside. While acknowledging the importance of supportive people and institutions, they made it clear that such resources were of limited value unless the person was ready to change. Participant 3 described the process as he experienced it:

Well, the thing, when you know you're beat, but you can still, somewhere in there is saying, "If you have the will, there's a way." And all my life I've been an independent person....And, I always have felt if I put my mind to it I could accomplish anything I want. But, um, this alcohol is getting in my way to doing things better than I'm doing. So, "I got tired of you now, you were fun for a while, but I'm tired of you now."

Participant 4 described the stages of change she went through:

Oh yeah, I helped myself. I didn't need nobody to help me, I helped myself. You see what I'm saying, what you gotta do, you gotta crawl 'fore you walk. And then you gotta help yourself before you get somebody else to help, see what I'm saying?

The same participant explained the futility of seeking to change others before they were ready:

Don't never push nobody into doing something they don't want to do.... Let me make that decision. You know what I'm saying? You got to help yourself before you try to help me. Preach yourself before you preach somebody else....Cuz there's one darn thing, you can't make somebody do something they don't want to do. You can't make nobody go.

I Can Survive This

Another facet of agency and achievement was the knowledge that, having survived deprivation and marginalization, participants carry the lived experience and confidence that they can handle virtually any hardship. Participant 5, a woman who was

homeless and on the road with her partner when she joined the working group, described how she developed coping skills:

I always needed to have something, too. And so, what helped me was replacing [drugs] with healthy habits. I got, like, really into dumpster diving and canning, and I got really into crocheting, and, you know, just anything to keep myself very busy.

Participants expressed pride in preserving aspects of dignity while on the streets.

Participant 1, who at times slept in their storage unit, described one such ritual:

I have a storage unit, and in the storage unit I will go back and forth to my storage unit to clean my bag. I will go to my storage unit and pull out different items of clothes I have in there, you know, and switch it up, and this is why I would want to switch my clothing to make it look like I wasn't homeless. Yeah, I'm trying to, you know, dress the part you wanna be, I guess.

Participant 4 reflected on the dialectic of maintaining personal dignity while experiencing profound self-doubt:

I took pride in myself, you know what I'm saying? But then again, I wasn't proud of myself, you see what I'm saying? Didn't nobody put me in that predicament. I put my own self in that predicament, to be homeless.

Patience and Small Steps

Within the overall theme of agency and achievement, participants frequently mentioned patience. They reflected on their own journeys and commented on what they described as the unreasonable expectations of others they have witnessed working their

way through housing, addiction, and mental health issues. Participant 2 illustrated this theme:

Yeah. It doesn't all happen, you know, like that, you know, these, these, these small steps are vital, we don't trip over ourselves. And just get what we can done today, and like have patience, but also be involved in like growing, you know? So, that's what I've done.

Two women in the working group expressed similar thoughts in the following exchange:

Participant 2: I'm right there with that. You know, because I said that about baby steps. And I remembered some movie where, like they were talking about baby steps and some rather difficult, but it is, is a process, and it just takes time. And like you said, just take your time. You know, like, you've got to work through it yourself, not with anybody else.

Participant 4: There you go! You took the words out of my mouth.

Two of the group participants had volunteered in the homeless shelter that served as the base for the current study, and they voiced what they judged as unrealistic demands from others seeking help. The following conversation involved several of the working group members:

Participant 1: Most recovering addicts still got the feeling that somebody owes him something.

Participant 5: Right, right.

Researcher: Owes them something.

Participant 4: Took the words right out of my mouth

Participant 3: Ok, um, the first thing they got to learn that they didn't get sober and get addicted in one day. So, it is a process of getting things, they gotta take things slowly.

Participant 4: There you go, there you go.

This motif was explicitly tied to the struggle to find housing in this exchange:

Participant 3: Patience is a not one thing that the addict has at all.

Participant 4: There you go.

Researcher: Addicts don't have patience.

Participant 4: No they don't. No they don't.....

Participant 3: And see, that's why the thing of taking it slow. Say for instance you, you go to someone and they is helping you try to get you housed.

Researcher: OK.

Participant 3: Now, you didn't become homeless overnight. Now how do you think they going to be able to put you in a house in two days?

Staying in My Lane

Another facet of the theme of personal agency was the topic of staying grounded and within one's comfort zone. The following excerpt illustrates this point:

Participant 2: But you gotta keep focused and you gotta stay on your own, stay in your own motherfucking lane. That's it, yeah.

Participant 4: Yeah, thank you. Stay in your lane. And another thing, you need to stay in your lane, and you need to stay in your damn circle.

Researcher: The safe circle.

Participant 4: There you go.

Researcher: The circle that's safe for you.

Participant 4: Don't get in nobody else's circle. Stay in your own circle.

See what I'm saying, get in somebody else's circle, that's when you gonna get yourself in trouble.

Participant 2: I have something else to add. I'm not perfect.

Participant 4: There you go, thank you. I was just getting ready to say that.

Participant 2: I sometimes will fuck up.

Participant 4: There you go!

Participant 2: But it's still my motherfucking lane. And it's my decision.

Participant 4: There you go. Thank you.

I Have Power

Participants described building a sense of agency and a degree of self-confidence, even in the face of punishing circumstances and repeated setbacks. Participants 1 and 2 offered their perspectives on surviving as members of the LGBTQ community while homeless:

Participant 1: Even my own, you know, people within the community, you know, the LGBT community. But it's like the "T" is by itself, you know what I'm saying?

Researcher: OK. So that's, that's what that means for you. That makes sense.

Participant 2: But we will prevail. We just continue to go, just keep moving forward, you know, even with that rejection. It may knock us

down a little bit, but you gotta be strong, you know. I've had to be strong, you know. And, uh, I don't want to become jaded. I don't want to become like, you know, like people who get pulled down darkness.

Participant 4 recalled summoning the courage to make a speech at the end of her inpatient rehabilitation program:

Participant 4: And after I did my 31 days, I had to give a speech, to everybody, and I didn't like to do that (laughs). I didn't want to do that, but I went on ahead and did it anyway.

Researcher: Wow

Participant 4: So, my speech, it was "Thank you for letting me come down here in this program." Because I got, it helped me to get through what I had to do. As far as drugs is concerned. See what I'm saying?

Another example came from Participant 1, who described shouldering the load of making rent payments for self and family members:

Participant 1: After literally being homeless on the streets in New York City I came down here. I got three jobs. I worked so damn hard. I put me, my sister and her partner, her boyfriend, they were sleeping in her car when I came down here, I work so hard I put \$700. It was five people that moved into a three-bedroom house.

This expression of power encompasses relationships, as Participant 2 illustrated with this recollection of work he did for a family member:

Participant 2: Yeah, I just did a painting for my niece last night. She's my goddaughter, she calls me Uncle. I did a painting for her of, like, a turtle.

It's just, I'm working on continually improving myself, and it was just nice to do something like that, like, something I wanted to do, um, give feedback on it in a positive way, you know.

I Need to Protect and Nurture My Recovery

Working group members frequently raised the importance of guarding and consolidating progress. One of the tag lines that participants proposed for their multi-media art project was to learn to love yourself, don't be too hard on yourself.

As a form of self-preservation, Participant 2 shared his approach to protecting his progress:

I find that I'm a kind person and I really have to be careful on the streets, because people will take advantage of me. So, you have to have this exterior, you know, and create boundaries, which also people don't understand sometimes. So, I am a kind, kind, and have a very grateful thinking for that, you know. I am blessed.

Participant 1 likened their recovery to a phoenix, describing it as, "Rising, rising from the ashes. Because when you're homeless and you get a foothold on starting back up, it's like you're starting to be reborn all over again, then getting your, um, getting another foothold in life." At times, friendships are strained by the need to protect one's gains. Participant 3 recalled having to enforce the sobriety rules at his Oxford House residence when a longtime friend relapsed:

I have a real good buddy...that used to live in the house. And me and him was just like [puts palms together]. But when the time came that he decided he wanted to cross the road, I had to, as bad as it's hurting me, I

had to be the one to tell him, “Hey, we can no longer have you here, because you’re endangering my safety and the rest of the people’s safety.”

To summarize the theme of personal agency and achievement, there are multiple facets of the confidence that one can survive extremes of loneliness and isolation. These come with an awareness that everyone has their own timing and way of moving forward. By staying patient and within their own comfort zones, participants came to see that they had power, and described sharing this by helping others who reached out for support.

Meaning Through Action

The final major theme that emerged from this study speaks directly to the secondary research question: What forms of empowerment are developed through the PAR process for this group of co-inquirers? It also provides insights to the primary research question regarding the lived experiences of individuals who are homeless and dealing with mental illness. In this study, the working group’s journey to develop an action plan can be described as an empowering experience, one that participants described as meaningful in itself.

Consistent with the stages of group work described by Corey et al. (2014), the first and second working group sessions involved coming together and considering basic questions about the work. Participant 1 illustrated this early stage when they questioned how the findings would be disseminated:

This published, at that point where it is, um, where are these publishing items going? Are they going to be sold throughout the nation? Is it something that is being used, being given free out to people, to the homeless community? Also, is it going to be sent to those that are also

helping, helping the homeless community so we can find out like, what we can do at all to move to make this in it together, better?

Even at this early stage, themes of helping, contributing, and service are apparent, as is a hope that the project will be meaningful.

By the second working group session, participants expressed optimism and excitement about the project. As Participant 2 noted, “I think doing projects like this will really help. I’m a fan for projects like this, you know what I mean.” As the group entered what Corey et al. (2014) call the performing stage, in which the design of the project began to take shape, participants became excited and readily voiced their commitment. Participants 1 and 2, both active in the local arts community, made this offer in the third working group session:

Participant 2: I’d be willing to work extra time if you need, for anything, like, like, to work on anything also.

Researcher: Thank you.

Participant 2: Like, instead of just like, just today, whatever, if you need.

Participant 1: Yeah.

Researcher: That would be amazing, thank you.

Participant 2: I’m not really doing much right now.

Participant 1: I’m free most of the time.

The working group formed a consensus on the parameters of the action project by the fourth working session. It was agreed that a multi-media project involving video clips, written tags and commentary, and art works would be developed and shown at a local public arts space where one of the group members worked part-time. The project

would illustrate aspects of the themes described in this study, using participants' own words and choices of art.

In the course of developing this project and discussing the themes that would be displayed, working group members shared perspectives on how this Participatory Action Research project connected to their lives and meaning making. These perspectives can be organized in three sub-themes: Empowerment, opportunity, and community.

Empowerment

Working group members reflected on how participation in the research project represented a form of empowerment. Participant 1 described how it gave them the opportunity to present their authentic self in what came to feel like a safe space:

...like it's it's very helpful for me, 'cause like, just talking about it processing a lot of stuff you know 'cause I'm kind of person that I'll carry around a smile all day long, you know and I'll be going through some hell.... So, this is definitely a healing process for me.

Earlier in this chapter, Participant 4 described an encounter that occurred right before the final working group session, in which she assisted someone who was seeking help with substance use problems. Her description included an awareness of her empowerment through action:

He stopped me; he was over at McDonald's. He said, "Ma'am, excuse me, ma'am." I said, "Uh huh." He said, "I don't mean to frighten you." I said, "I ain't frightened." I said, "I been in [town] all my life. What's the problem?" And he said, "Well I need to go somewhere and get some

recovery.” I said, “And you done said the word, let me show you the way!

Let me show you the way!”

In direct response to this anecdote, Participant 3 offered his perspective on empowerment and on ways in which the Participatory Action Research project crystallized his thoughts:

Participant 3: I’m proud of my girl. Because see, that’s one of the main things we were talking about.

Researcher: Say more about that.

Participant 3: Setting an example by being yourself. And showing them that it can be done.

Researcher: Yeah, yeah. What was it that you guys were saying: I can give you a helping hand...

Participant 3: ...I can give you helping hand, but I ain’t gonna hold your hand.

The same participant reflected on how his experiences in recovery and volunteer work had empowered him to discover meaning in his life, “And now I look back at how many, ah, over the years, how many people I have reached out and touched. And if not one way, one place or the other, have helped them move on in life.”

At the conclusion of one of the final working group sessions, participants provided a glimpse of the empowering effect of Participatory Action Research:

Researcher: All right. Any last words for today?

Participant 4: Everybody did a good job today. I didn’t say anything.

Participant 3: May everybody in this room feel a little bit of love coz we just got involved!

Opportunity

Through their participation in this Participatory Action Research project, working group members expressed a sense of opportunity. As a form of empowerment, this expectation that they could make an impact is one of the present study's findings.

Participant 2 reflected on how the project had motivated him:

Of course, from my side, got me thinking about things, and thinking about groups like here, and you know that, to myself, you know. And I think it's, I think similarly, like, we all evolve into like, our attitudes. And so, I think that that's a positive, a positive and it creates positivity in itself and for the parties going forward.

Participant 4 saw one potential benefit of the action project as helping people who were on the path to recovery, saying:

So, and the reasons that I feel I want to do this is not so much as to keep them from going through some of this stuff, is to prepare them for when they get there, that they don't really hit a brick wall, saying: "I didn't see that coming."

The same working group member endorsed the potential for change created through action research this way, "The main idea is that what you get, you can't keep it. You gotta share it with somebody! You can't be worth havin' it if you can't share it!"

Community

Working group members echoed the results of multiple studies in describing the lived experiences of loneliness and isolation during their episodes of homelessness and mental illness. One of the current study's findings is that Participatory Action Research can contribute to a sense of community in working group members, itself a form of empowerment. In the final group meeting, Participant 4 reflected on her connection to the homeless shelter and its regular group of visitors and helpers. The COVID 19 pandemic had resulted in restrictions on guest numbers and activities within the shelter:

I guess that I'm so used to that, and see, by that gate not being open downstairs in the cafeteria, you know what I'm saying, that brings memories. You got to understand, that brings a whole lot of memories. But not just you, but a whole lot of people that have volunteered, you see what I'm saying (tears up), so I guess that gate won't ever open up to me, I guess, until everything is done.

Toward the end of the final session, Participant 3 offered this reflection on the new community created through the Participatory Action Research project:

Hey, you know the other good part about this: it actually made more kind of like a friendship of a little group. Although we knew each other and liked each other, but you know, we got, least I got, a little bit more understanding of where each and every one of you came from, you know.

To summarize results and research findings, four primary themes reflect the lived experiences of individuals who experience homelessness and mental illness. These include trauma, personal connection, personal agency, and meaning through action.

Subsidiary research questions including identifying and understanding barriers that these individuals face, practical recommendations to support such individuals, and forms of empowerment through the PAR process are addressed within these major themes and subthemes.

Reliability and Validity

This section of the results describes implementation of the trustworthiness strategies described in Chapter 3. Four dimensions of trustworthiness were addressed as part of the study's design: Credibility, transferability, dependability, and confirmability (Krefting, 1991).

Credibility strategies were implemented as outlined. These included mechanical data recording, participation of co-inquirers, peer and supervisory scrutiny, and use of low inference descriptors (Zohrabi, 2013). The use of a reflective fieldwork journal to supplement transcripts were implemented to bolster credibility (Krefting, 1991). As planned, member checking (Merriam & Tisdell, 2016) of emerging themes and codes was conducted, and triangulation took place at multiple stages of the research, including the interview, working group, and reflection stages. The sole adjustment to the implementation plan was that as the implementation of the action step was not included in the study, triangulation of this data element was not included.

With respect to transferability, sample diversity was an objective in the study design, and was achieved in several ways. The previous section outlining results includes demographic profiles and brief histories of each working group member. This information supports transferability by illustrating the degree of diversity in the sample (Merriam & Tisdell, 2016).

The data analysis and interpretation included, as designed, the use of critical theory in order to support validity (Morrow, 2005). Also, as planned, working group participants served as co-inquirers throughout the process. This was included in order to support the study's congruence, objectivity, and grounding. In addition, reliability was addressed with a detailed audit trail through implementation of the study design.

With respect to confirmability of the procedures, the study design was implemented as outlined. The principal researcher incorporated deep reflection on his positionality and power relationships in order to support the inductive element of the study (Zohrabi, 2013). The triangulation procedures, designed to support confirmability of the study's methods and results, were implemented as planned.

Summary

This chapter summarized the implementation of the Participatory Action Research and presented results of data analysis and major findings. Conclusions to the primary research question and subsidiary research questions findings were organized along four major themes: The trauma of homelessness, addiction and mental illness; the power of personal connection; personal agency and achievement; and meaning through action. The chapter concluded with a review of the study's implementation relative to design elements included to support trustworthiness.

Chapter 5: Discussion

This chapter includes a summary and discussion of key findings with reference to the research questions. It interprets these findings within the conceptual framework outlined earlier and compares them to the extant peer-reviewed literature on the subject. In addition, the study's limitations are outlined and recommendations for further research and policy initiatives are put forward.

The purpose of the study was to collaborate with a group of people who have self-reported experiences with homelessness and mental illness in order to generate perspectives on the challenges they encounter in these lived experiences. The combination of housing instability and mental illness is a significant and persistent problem in the United States (United States Department of Health and Human Services, 2012). The study used a Participatory Action Research design to capture and analyze data to create a collaborative approach to addressing the research questions.

This study's primary research question asked: What are the lived experiences of individuals who are homeless and are diagnosed with a mental illness? The key findings were presented in Chapter 4 in the form of four themes: The trauma of homelessness, addiction, and mental illness; the power of personal connection; personal agency and achievement; and meaning through action. This study posed additional sub-questions, and related findings are incorporated in the following section.

Findings, Interpretations, and Conclusions

This Participatory Action Research study was designed to share the evolution of this study with the co-participants. To reinforce this epistemological shift, the principal researcher interpreted the collected data through a combination of phenomenological and

critical theories. This co-construction approach generated the four primary themes discussed in detail in Chapter 4. In the following sections, these findings are compared to the current understanding of the research questions generated through the literature review.

The Trauma of Homelessness, Addiction and Mental Illness

The primary research question for this study was: *what are the lived experiences of individuals who are homeless and diagnosed with mental illness?* Individuals who self-identified as homeless and possessing a mental illness participated in focus group discussion. Through a semi-structured interview format, the participants shared their experiences with homelessness and mental illness. Participant responses were recorded. During the focus group meetings, the researcher summarized the discussions and shared these summaries with the participants as a method of member checking. Summaries were only included when group consensus was achieved.

A major finding of this study is that homelessness, mental illness, and their combined presentation may be traumatic. This is consistent with research that has identified dimensions of trauma arising from the domestic chaos and housing instability, substance abuse, and mental illness (Castellow et al., 2013; Kaspro & Rosenheck, 2000; Kemp et al., 2006; Lippert & Lee, 2015; Shelton et al., 2005). Participants in this study described losing the ontological sense of home as domestic relationships became dangerous, only to exchange this vulnerability for the traumatic experience of homelessness.

Within the mental health field, the definition of trauma appears in the context of classifications of trauma-related disorders as defined in the Diagnostic and Statistical

Manual of Mental Disorders (APA, 2013) and in the International Classification of Diseases (ICD-10), (World Health Organization, 2010). The former refers to traumatic events that include death or threatened death, serious injury, or sexual violence, while the ICD-10 refers to an exceptionally catastrophic or threatening situation or event that is stressful and of brief or long duration (World Health Organization, 2010). While the ICD-10 may offer latitude to define the conditions explored in this study as trauma, that may be less plausible within DSM guidelines. The DSM does include *V Codes* for housing problems in their “Other Conditions That May Be a Focus of Clinical Attention”, (APA, 2013, pp. 723-724). These designations are not considered to be mental illnesses but are still recognized as distressing.

Herman (1992) advocated for the inclusion of “complex post-traumatic stress disorder” (p. 119) in nosological classifications of mental illnesses. She described this condition in terms of a range of conditions that arise as a response to protracted exposure to multiple stressors (Herman, 1992). van der Kolk (2014) expands on this concept and notes the irony of treating adaptive responses to complex post-traumatic stress disorder, for example use of substances, as conditions to be eliminated. The present study’s findings regarding the constellation, duration, and intensity of traumatic experiences its working group members endured echo Herman’s experiences in working with traumatized clients.

In training counselors, the CACREP accreditation guidelines (CACREP, 2016) outline the requirement that programs include curriculum content under the topic of human growth and development that includes crisis, disasters, and traumas. It additionally directs counselor training programs to incorporate trauma-informed

programs as part of the counseling and helping relationships standards (CACREP, 2016). The CACREP standards do not identify specific populations in terms of counselor preparation, but this study's findings, echoing those of previous studies (e.g. Lippert & Lee, 2015; Shelton et al., 2005) indicate that counselor education programs should extend training modules and experiential training to cover the population of those experiencing homelessness and mental illness.

The working group discussions provided an opportunity to explore how intersectionality may have contributed to the experiences of trauma. Members of the working group all represented at least one dimension of marginalization based on race, gender, or sexual orientation. Two working group members had intersectionality in two dimensions of marginalization, and one working group member had three dimensions of intersectionality. Based on the interviews and working groups, it appears that these intersectional dimensions of identity may have contributed to the burden of cumulative trauma experienced. This was evidenced, for example, for the two self-reported LGBTQ participants, whose rejection by their families of origin was a factor in feeling unsafe at home. In addition, both experienced marginalization and violence on the street as a result of their sexuality. These findings were consistent with research describing aspects of marginalization experienced by different populations experiencing homelessness and mental illness (Cochran et al., 2002).

The current study confirms current knowledge of the experience of homelessness and mental illness as highly stressful, but it also explicitly defines this experience as trauma. The experiences of dissociation and derealization described by several working group members in this study may represent an extension of findings in previous research

that described the physical and psychic damages of living on the streets (Burlingham et al., 2010; Lowe & Gibson, 2011; Petrusak et al., 2017). By conceptualizing homelessness this way, particularly in the context of critical theory, we can extend recommendations for changes in policies and practices with this population. This is discussed in the final section of this chapter.

The Power of Personal Connection

A subsidiary research question addressed: *What themes from these lived experiences are salient in understanding the barriers these individuals face?* The semi-structured interviews and working group meetings generated thick descriptions of participants' experiences dealing with homelessness and mental illness. These themes were refined in working group meetings and were member checked for accuracy.

A second major finding from the current study is that the power of personal connection is a protective strategy. This both confirms and extends our current understanding of homelessness and mental illness (Jacubec et al., 2012). It also generates several responses to subsidiary research questions regarding recommendations to support and empower those experiencing such conditions, as well as counselors who work with them.

Working group members unanimously confirmed the importance of personal connection to help them survive and move forward. Relatively small gestures of recognition and support were frequently cited as moments of light amid the isolation and marginalization of homelessness and mental illness. Previous research described the power of personal connection in the context of ethno-racial minority groups experiencing housing instability (Lafuente & Lane, 1995; Paul et al., 2018). Bender (2007) described

the importance of peer networks for homeless youths. The current study extends these findings to a highly diverse group of research participants. This study also finds that helpers from social services agencies can make a lasting and positive impact on individuals in this population. Recommendations based on these findings are discussed below.

Research on qualitative measures to assess satisfaction of services to people experiencing housing instability and mental illness has been inconclusive (Helfrich & Chan, 2013; Rayburn, 2013). With respect to this dimension, participants in the current study voiced neutral to positive views on the organizations that supported them along their journey. It is important to note that the power of the personal connection consistently outshone reflections on the underlying agency or organization itself.

The current study may extend research on the theme of personal connection by partially illustrating participants' evolution from being the recipient of help, to that of becoming part of a helping network. Previous studies have identified the value of peer navigators as an element of systems of care for the homeless (David et al., 2015). The present study offers the finding that becoming such a helper is part of the empowerment journey that some individuals in this situation experience.

This study extends previous research on helpers by identifying the potential for counselors to fill a gap in growth and change-oriented, client-led services. Previous studies pointed to the potential benefits of mental health counseling for people experiencing homelessness (Morton et al., 2019; St. Arnault & Morali, 2019; Sun, 2012). The current study's findings regarding the importance of connection and the bridge to becoming empowered as a helper can serve as a framework for counseling services.

Counselors can consider theoretical and clinical frameworks that incorporate agency and growth to help clients experiencing homelessness and mental illness tap into the therapeutic power of becoming a helper.

The finding that help comes through personal connection offers an example of incorporating the principal researcher's positionality into PAR research. His instinctive stance of solutions-orientation, itself an implicit expression of power and privilege, has the potential to drown out the voices of those who have experienced homelessness and mental illness, and for whom interpersonal relationships were more prominent in their lived experiences than any institution or services delivery model. By reflecting on this position, underlying messages of agency and the power of experience voiced by all working group members, came into sharper focus.

Personal Agency and Achievement

This group of findings refers to this study's primary research question: *What are the lived experiences of individuals who are homeless and diagnosed with mental illness?* It also refers to a subsidiary research question: *What are the barriers that individuals who are homeless and are diagnosed with a mental illness experience?* Through the participatory action research process, a group of individuals who self-identified as homeless and possessing a mental illness participated in focus group discussions. Through analysis of these working group meeting transcripts and other data sources including semi-structured interviews and the fieldwork journal, themes in the area of agency and achievement emerged. During the focus group meetings, the researcher summarized the discussions and shared these emerging themes with the participants as a method of member checking.

This study's third major finding is that people with the lived experience of homelessness and mental illness can embody prominent dimensions of personal accomplishment. This responds not only to the primary research question, but also to subsidiary questions of suggested practices, overcoming barriers, and empowerment for those experiencing homelessness and mental illness.

Research on models of care has identified restrictive entry systems as sources of frustration and iatrogenic outcomes (Collins et al., 2016). The present study's finding that participants have an innate determination to find their own path serves to confirm this research. It extends this perspective by offering thick descriptions of members' resolve to actualize this approach. Every working group member endorsed the centrality of change as an inside-out process.

Survival and Beyond

The experiential research on homelessness and mental illness offers perspectives not only on deprivation and marginalization, but also of the sense of accomplishment held by those who have survived it (Forchuck et al., 2006). The current study confirms this dialectic, with working group members consistently voicing the sentiment that they can survive unimaginable circumstances. This study may extend the research in this area by providing several findings as to how individuals survive the experience of homelessness and mental illness. Specifically, the themes of patience and small steps, staying in one's lane, and needing to protect and nurture one's recovery are findings that may be useful.

This study confirms and extends previous findings that an existential state of retaining some power is a critical part of the lived experience of people experiencing

homelessness and mental illness (Epel et al., 1999; Paul et al., 2018). Even while acknowledging societal and institutional marginalization and exclusion, individuals seek to nurture and build their own sense of power and agency. Previous studies in this area have highlighted the importance of resilience, self-expression, opportunities to build self-efficacy, and spirituality as elements of achieving escape velocity from the cycle of chronic homelessness and mental illness (Karedzhof, Yuen, & Bond, 2020; Patterson & Tweed, 2009). Working group members in the current study emphasized that finding their own way was a manifestation of power and agency. This adds an additional facet to the understanding, developed in previous research, that restrictive and institutional systems of care may not address the existential needs of those they are established to help (Padgett, 2007).

Meaning Through Action

One of this study's subsidiary research question asked: *For this group of participants, do forms of empowerment emerge through the PAR process?* The study design of participatory action research is widely cited as an epistemological approach that can serve to generate meaning and agency to its participants (McLeod, 2011). Through working group meetings, analysis of transcripts, and member-checking, themes emerged that addressed this specific subsidiary question and are summarized here.

This study's fourth major finding is that Participatory Action Research generates empowerment, opportunity, and community for working group members. This study's identification of these three dimensions of meaning confirms and extends research on this area.

The current study is one of few published that implements the PAR process with a diverse group of people who have experienced both homelessness and mental illness. Prior studies incorporating a PAR design with groups of people experiencing homelessness have generally used a targeted population or have focused on homelessness or mental illness as discrete phenomena (Corrigan, 2017; De Oliveira, 2018; Garcia et al, 2014; Petrusak et al., 2017). As a result, the current study offers a perspective on the lived experiences of combined homelessness and mental illness from the perspective of a group containing members aged from their 20's to 60's, with male, female, cisgender and transgender, Black and white, heterosexual, and homosexual participants.

As previously noted, the scarcity of PAR research on this topic created an opportunity to engender therapeutic growth and empowerment through the implementation of the study design itself. The three dimensions of meaning making emerging from this study offer an extension of previous research in this regard. This was confirmed through thick descriptions from working group members of the meaning they derived by participating in the study.

The use of a critical theory lens to analyze data helped confirm previous research findings regarding the PAR design and dimensions of empowerment. Earlier studies using critical theory found socially constructed roles and institutional norms to be forms of oppression experienced by people experiencing homelessness (Glumbikova, 2019; Swick & Williams, 2010). A recent study found that the empowerment element of PAR contributed to insights regarding institutional and societal biases against people experiencing homelessness (De Oliveira, 2018). The present study adds the dimension of mental illness to the working group demographic. It confirmed that for this diverse

population, structural barriers and societal norms contribute to their marginalization. It also confirmed that a PAR approach can help build forms of empowerment that can offset the structural and societal biases noted above.

The open-ended nature of this study's action step is a variation on earlier studies that had either expert implementation of recommendations or used a gap analysis approach (Corrigan, 2017; Stergiopoulos et al., 2010). The present study left the choice of an action project to the working group, which ultimately chose a mixed-media art project to explore their lived experiences and learnings. This empowerment, itself a meaning-making opportunity, is an extension of previous research using the PAR design.

The third dimension of meaning-making generated by this study is of community. Previous research pointed to the lived experience of homelessness as having one's identity created and defined by others (Donley & Jackson, 2014). The present study suggests that using the PAR design to collaborate with people experiencing homelessness and mental illness can counterbalance this force and support the establishment of a sense of community. The working group offered rich evidence that participating in the project contributed to a valued sense of community, a major contrast from lived experiences of loneliness and isolation during periods of homelessness and mental illness.

Limitations

At six participants, including the principal researcher, the working group's size was at the lower end of the projected range. This was a function of the COVID 19 pandemic under way during the study. As noted above, the working group size fell within the range of participants cited as appropriate for Participatory Action Research studies (Boddy, 2016; Crouch & McKenzie, 2006; Mason, 2010).

In addition, although the sample size was offset by its high level of diversity measured by age, ethnicity, gender, and sexual identity, the sample did not perfectly match the overall demographic of the U.S. homeless population. It did not include a Latinex member or a veteran and was overrepresented by Black participants. Also, the evolution of themes and discussion topics during the working group meetings indicated that saturation was achieved on the topics covered.

The principal researcher's positionality merits consideration. An inherent element of the PAR process is the principal researcher's requirement to play multiple roles, including that of insider and outsider (Herr & Anderson, 2015). The principal researcher's status as a white male with relatively high socioeconomic status must be considered in identifying limitations of the present study. His participation in the working group may have influenced the group's behavior in ways that could differ from that of another principal researcher with different positionality. In addition, the principal researcher's phenomenological interpretation of the data may have been influenced by his positionality, although triangulation was used extensively to validate themes and findings. With respect to the limitations of positionality, a moderating factor inherent in PAR design is the importance of a collaborative relationship in which the principal researcher can model norms and behaviors that encourage a productive working group (Reid & Frisby, 2008). This puts the responsibility of leveling power differentials and demystifying the process squarely on the principal researcher (Grant et al., 2008). Another moderating factor is the role of the fieldwork journal as a reflexivity check. The fieldwork journal was specifically designed and used as a tool to provide reflections on the principal researcher's positionality throughout the study's implementation and

analytical phase. This step is viewed as enhancing PAR studies' external confirmability and transferability (Zohrabi, 2013).

Recommendations

This study's findings point to several policy recommendations and avenues for further research on the problem of homelessness and mental illness. Two of this study's research questions are oriented toward removing barriers and recommending practical supports for this population. Because the combined experience of homelessness and mental illness is a form of trauma, services to this population should be based on a trauma-informed model of care. Accordingly, this study's first major recommendation is that services to people who are homeless and dealing with mental illness should be based on the trauma-informed model of care. The denial of housing and other services as a form of punishment for slips or relapse into substance use is both a barrier to engagement and a retraumatizing experience that should not be imposed on clients. Current study participants described their struggles with the dual reality of housing instability and mental illness. This corroborates policy recommendations from previous studies that services to this population that focus on only one half of this combined presentation are handicapped from the outset (Burt, 2012; Gilmer et al., 2010).

This study's second major recommendation is that service providers apply a triaged approach that respects the dialectic between client needs and preservation of client autonomy. This recommendation derives from the finding that escape velocity from homelessness and mental illness is a personal process, of which empowerment and agency are essential elements. In this respect, rigid service models that punish relapse or focus solely on one of the many issues faced by this populations represent a form of

disempowerment and exclusionism. The theme of patience, frequently raised by group members, stands in contrast to what they described as the unreasonable expectations of others they have seen working their way through housing, addiction, and mental health issues. These observations suggest an approach to supportive practices. A triaged approach may allow individuals access to the services they most need in order to stay alive during what Prochaska and Norcross (2014) describe as their stages of contemplation. This may give individuals the resources they need in order to continue this process, rather than drive them away from supportive services by demanding, for example, compliance with treatment plans.

This study's third major recommendation is for systems of care to people who are homeless and experiencing mental illness to utilize counselors to personalize and sustain service delivery. This study found that the power of personal connection is highly valued and often adopted as a meaning-making activity by people with the lived experience of homelessness and mental illness. This leads to a third recommendation, that agencies working with this population emphasize the presence of counselors and peer navigators as essential team members. In the present study, the most-cited source of personal connection involved a worker or volunteer at a social services agency. Specifically, institutional best practice should recognize the importance of establishing and maintaining contact by managing caseloads, minimizing case handoffs, and emphasizing helping professionals' longevity within the agency. This study clarified that individuals who have struggled with homelessness and mental illness are potential resources as peer navigators. Their own meaning-making includes giving back by establishing and maintaining personal relationships with others facing similar challenges.

Further research regarding the form, function, and impact of counseling work with this population could generate insights as to how this helping profession can tap into the potential identified in this study. In addition, research on educational programs to prepare counselors to work with this population could help educators incorporate such learning into the counselor education curriculum. The curriculum guidelines for counselor education programs make no reference to homelessness or working with people who are homeless (CACREP, 2016). Given the scope and severity of this problem, a related recommendation is that accrediting agencies incorporate guidelines for counselor education programs that extend to working with this important population.

Appendix A: Consent Letter from Research Site**Site Coordinator Letter of Permission**

May 11, 2020

Institutional Review Board
James Madison University
MSC 5738
801 Carrier Drive
Harrisonburg, VA 22807

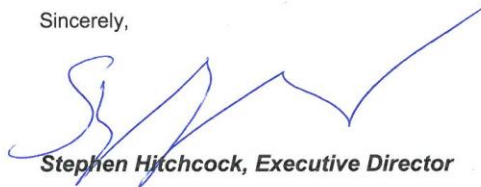
Dear Institutional Review Board,

I hereby agree to allow John Rogers, from James Madison University to conduct his research at The Haven, Charlottesville, Virginia. I understand that the purpose of the study is to identify, using Participant Action Research (PAR), possible solutions to the problems faced by people who are homeless and dealing with mental health and/or substance use issues.

By signing this letter of permission, I am agreeing to the following:

- ☒ JMU researcher(s) have permission to be on The Haven, Charlottesville, Virginia premise.
- ☒ JMU researcher(s) have access to the data collected to perform the data analysis both for presentation to James Madison University Graduate Psychology Department, Harrisonburg, Virginia and/or for publication purposes.

Sincerely,



Stephen Hitchcock, Executive Director

The Haven, Charlottesville Virginia

Appendix B: Recruitment Materials

To be posted in lobby of the shelter located at Charlottesville, Virginia:

ResearchParticipants Wanted

- Participants Wanted for Doctoral Research Study on Homelessness and Mental Health
- Study Title: Homelessness and Mental Health: A Participatory Action Research Approach
- Principal Investigator: John Rogers, MA/EdS, doctoral student at James Madison University Department of Graduate Psychology
- Volunteers are being sought for a research study. Participation involves an initial confidential interview and the opportunity to join a working group of 6-8 members to collaborate and take action steps to improve services to people experiencing homelessness and mental health and/or substance use issues.
- Participation is not compensated, although lunch will be provided for working group members.
- Potential benefits from participation in this study include increased awareness knowledge about services in the community, the opportunity to have your voice heard in improving the services available to people who are underhoused and struggling with mental illness or substance use. The study seeks to promote change through critical reflection and action by those most affected by the problem.

If interested, please contact John Rogers at counseling@thehaven.org, or speak to Owen Brennan or Stephen Hitchcock at the Haven.

Research Study
counseling@thehaven.org

Research Study
counseling@thehaven.org

Research Study
counseling@thehaven.org

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counseling@thehaven.org

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Research Study
counseling@thehaven.org

Research Study
counseling@thehaven.org

Appendix C: Written Summary of the Project for Potential Participants

On any given night, over 568,000 people are homeless in the United States (United States Department of Housing and Human Development [HUD], 2020). Approximately 200,000 people spent the night without shelter, meaning that they were on a sidewalk, in an abandoned building, on vacant land, or in other dangerous and unsuitable places (HUD, 2020).

Mental health problems may co-occur with the phenomenon of homelessness. Studies estimate that the co-occurrence of homelessness and mental illness and/or substance use disorders ranges from 30-60%

The purpose of this study is to collaborate with a group of people who have experienced homelessness and mental illness in order to generate responses to the challenges they encounter.

With a focus on the homelessness and mental health, study seeks to address the gap between consumers of services and providers of services through a collaboration with the people who need those services. While there is extensive research on homelessness and mental illness from a variety of perspectives, relatively few studies address this problem from the perspective of those most affected by it (Padgett, Gulcur, & Tsemberis, 2006, Zlotnick, Zerger, & Wolfe, 2013).

The present study will seek to identify, using Participant Action Research (PAR), practical solutions to the complex problems faced by this large and vulnerable population. PAR is a flexible methodology that is based on a collaboration among co-participants (McLeod, 2011). Using a recursive and dialectical process, PAR is oriented to promote change at multiple levels, including the for the co-participants, the principal

researcher, and the systems examined by the research questions (McIntyre, 2008). The principal researcher will utilize a critical theory framework to inform the PAR study (Merriam & Tisdell, 2016). This framework incorporates the goals of empowerment, growth, and emancipation from systemic injustice (Merriam & Tisdell, 2016).

Incorporating this theoretical framework may have the additional benefit of triangulation of themes and findings (Merriam & Tisdell, 2016). The study will engage in a collective effort involving co-participants from a homeless shelter in Central Virginia who self-report a history of mental illness and have experienced chronic homelessness.

Participants in the study will address the intertwined phenomena of homelessness and mental illness. The study may contribute to heightened understanding and awareness, generate practical initiatives, and may promote action as a form of knowing. As a subsidiary effect, the PAR process *per se* supports participant empowerment and therapeutic growth (McLeod, 2011).

The study addresses one primary and several subsidiary research questions:

- What are the lived experiences of individuals who are homeless and are diagnosed with a mental illness?
- What are the barriers that individuals who are homeless and are diagnosed with a mental illness experience?
- Drawing on the lived experience of homelessness and mental illness, what practical recommendations can be generated to support individuals dealing with these challenges?
- What themes from these lived experiences are salient in understanding the barriers these individuals face?

- What forms of empowerment are developed through the PAR process for this group of co-inquirers?

Once potential group participants have been identified, an initial interview will be conducted to ascertain suitability and interest in joining the working group. The anticipated size of the focus group is between 6-8 participants, including the principal researcher (Corey et al., 2014). The group's composition, with respect to additional members, will be determined by discussion within the group itself.

Appendix D: Informed Consent Letter**Homelessness and Mental Health: A Participant Action Research Approach****Consent to Participate in Research****Identification of Investigators & Purpose of Study**

You are being asked to participate in a research study conducted by John Rogers from James Madison University. The purpose of this study is to focus on homelessness and mental health and to address the gap between consumers of services and providers of services through a collaboration with the people who need those services. This study will contribute to the researcher's completion of his doctoral dissertation.

Research Procedures

Should you decide to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. This study consists of an initial interview that will be administered to individual participants at the day shelter. You will be asked to provide answers to a series of questions related to your experiences of homelessness and any mental health or substance use issues you may have experienced. The interview will be audio taped and transcribed, and your name will remain confidential. If you are willing to participate further in the study, you may join a working group of 6-7 other clients of the shelter which will meet weekly for approximately two months, with the goal of identifying and participating in steps to improve services for people experiencing homelessness and mental health issues.

Time Required

Participation in this initial interview will require approximately one hour of your time. The plan for the working group is to meet 8-10 times for 60-90 minutes each session. I

hope that you will attend at least 75% of the working group sessions. Any additional time that you might want to spend on the agreed action steps is at your discretion.

Risks

The investigator does not perceive more than minimal risks from your involvement in this study (that is, no risks beyond the risks associated with everyday life).

Benefits

Potential benefits from participation in this study include increased awareness knowledge about services in the community, the opportunity to have your voice heard in improving the services available to people who are underhoused and struggling with mental illness or substance use, and the empowering impact of working together in a group to bring about change. The study as a whole seeks to promote change through critical reflection and action by those most affected by the problem.

Confidentiality

The results of this research will be presented to the graduate psychology department at James Madison University as partial fulfillment of a doctoral degree in counseling and supervision. If accepted, it will also be published by James Madison University. The results of this project will be coded in such a way that the respondent's identity will not be attached to the final form of this study. The researcher retains the right to use and publish non-identifiable data. While individual responses are confidential, aggregate data will be presented representing averages or generalizations about the responses as a whole. All data will be stored in a secure location accessible only to the researcher. Upon completion of the study, all information that matches up individual respondents with their answers, including audio and/or video recordings, will be destroyed.

Participation & Withdrawal

Your participation is entirely voluntary. You are free to choose not to participate.

Should you choose to participate, you can withdraw at any time without consequences of any kind.

Questions about the Study

If you have questions or concerns during the time of your participation in this study, or after its completion or you would like to receive a copy of the final aggregate results of this study, please contact:

John Rogers

Dr. Amanda Evans

Department of Graduate Psychology

Department of Graduate Psychology

James Madison University

James Madison University

Roger2jd@dukes.jmu.edu

Telephone: (540) 568-6308

Evans3am@jmu.edu

Questions about Your Rights as a Research Subject

Dr. Taimi Castle

Chair, Institutional Review Board

James Madison University

(540) 568-5929

castletl@jmu.edu

Giving of Consent

I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory

answers to my questions. The investigator provided me with a copy of this form. I
certify that I am at least 18 years of age.

☐ I give consent to be (*video/audio*) recorded during my interview and at subsequent
focus group meetings. _____ (initials)

Name of Participant (Printed)

Name of Participant (Signed)

Date

Name of Researcher (Signed)

Date

Appendix E: Interview Questions

Note: parenthetical comments denote question themes.

1. Initial sensitizing concept:

Drawing on the lived experience of homelessness and mental illness, what practical recommendations can be generated to support individuals dealing with these challenges?

2. Initial interview questions.

- a. (Availability, future) I am putting together a team of people who have experienced homelessness and mental health challenges. Based on everyone's experiences and input, we are going to work together to come up with some practical and workable ways to improve the systems that we encounter. It will involve an initial one-on-one interview of about an hour, and then, for about two months, weekly group meetings that will last about two hours. Our work will end up in my doctoral dissertation, which will be published. I want to share more details but want to check in now and see if you would be interested in joining this project as a member of the group?
- b. (Availability, future) The type of research we will be doing together is called Participatory Action Research. It involves a group that is committed to identifying problems and developing practical solutions. This means that we work together in several ways, including planning our process, doing the work, and reviewing and publicizing our results. After hearing this, are you still interested in helping out?

- c. (Opinion, present/future) We will build our process together. What are your ideas on how you would like to work with a small group on the issues of homelessness and mental health?
- d. (Information, present/future) I am looking for others who would have the experiences and energy to help build our group. Who else here at the Haven that you would suggest I try to recruit to join us?
- e. (Opinion, present) The nature of our research method means we work together from the start, even on consent procedures to protect each other. Can we spend some time looking at a draft of this so that I can get your feedback and incorporate it? {go through consent form, make necessary changes, co-sign}
- f. (Grand tour, will pick up demographic, social, family, education and career.) Would you be willing to share your story with me? I'm curious about your life journey and how you came to be in this place.
- g. (Thematic tour, past) Can we go into some more detail about your experiences with the mental health care system, as you have encountered it? What has worked for you? What has been frustrating?
- h. (Thematic tour, past) I'm also curious about trying to get housing and social services. What has that been like?
- i. (Narrowed thematic interaction, past) How about times when mental health or substance issues seemed linked with housing issues?

Appendix F: Field Journal Sample

Date of field note entry:

Date and duration of meeting:

Site and setting (attach diagram):

Any relevant news affecting macro/micro context:

Principal Researcher name, noteworthy behavior:

Attendees, note new members or members not attending with description:

Discussion topics:

Sequence of activities:

Emerging or existing norms/rules observed:

Noteworthy statements:

Noteworthy nonverbals:

Patterns and frequency of interactions:

Decisions reached:

Areas for further discussion:

Artifacts produced or in development:

Notable moments:

Action-related discussions:

Ethical issues and decisions:

Consequences of any ethical issues and decisions:

PI's Thoughts, feelings, impressions:

Appendix G: Focus Group Meeting Summary Note

Date of meeting:

Any relevant news affecting macro/micro context:

Attendees:

Discussion topics:

Sequence of activities:

Decisions reached:

Areas of non-consensus:

Areas for further discussion:

Notable moments:

Action-related discussions:

Ethical issues and decisions:

Consequences of any ethical issues and decisions:

Notes from working group review of this summary:

Appendix H: Principal Researcher Fieldwork Journal Sample

Date:

Session number referenced (if any):

Critical reflection on session (PI performance, behaviors, biases, feelings, hunches):

PI reflection on what happened in session:

Assumptions to bracket:

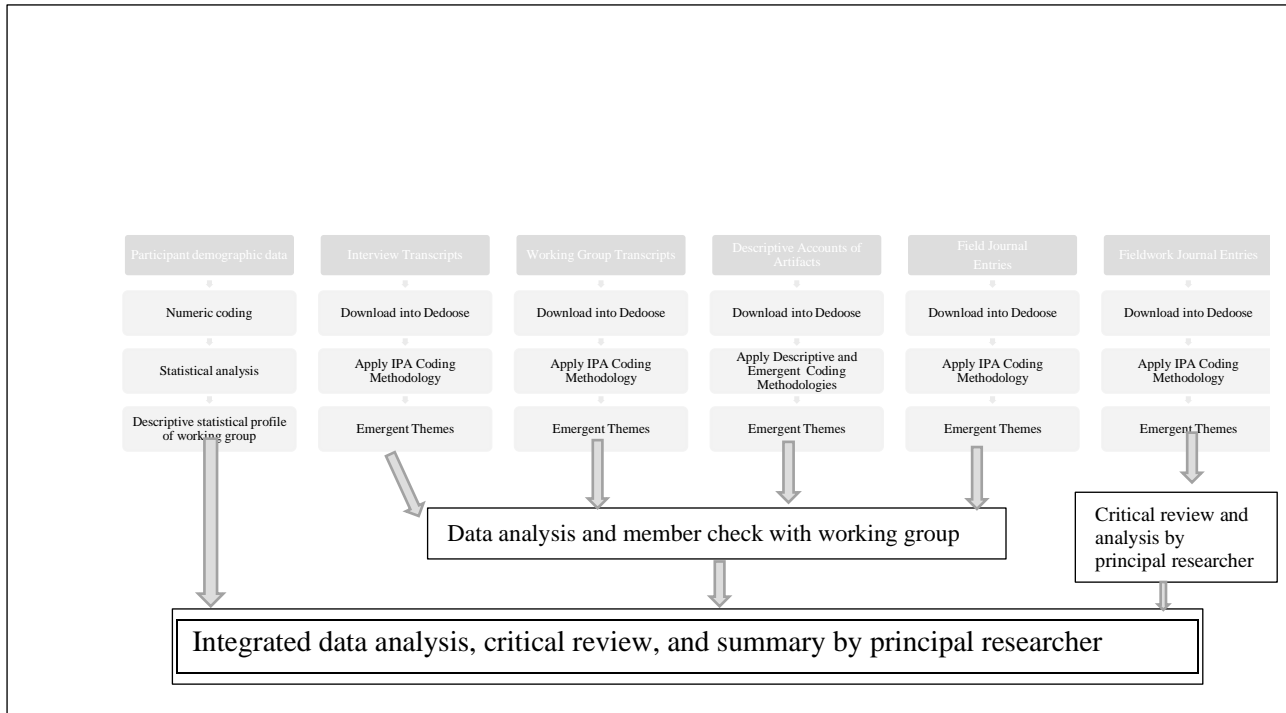
Theoretical issues

Methodological issues


Critical theory-related considerations, hypotheses, observations:

Analytical notes or interpretations:

Personal reflections: considerations from my own life and how they may have influenced my interpretation of events.

Appendix I: Data Analysis by Block**Figure 1: Data Analysis by Block**

Appendix J: Institutional Review Board Application

| | | |
|---|----------------------|---|
|  | PROTOCOL IRB Form | Protocol # 21-1930 Date Printed: 05/21/2020 |
|---|----------------------|---|

| | |
|---|----|
| Personnel Information | 1 |
| Subject Checklist | 2 |
| Study Location | 3 |
| General Checklist | 3 |
| Funding | 4 |
| Application Type Checklist | 4 |
| Exempt Paragraphs(s) | 4 |
| Summary, Purpose, Procedures | 6 |
| Background and additional procedures | 11 |
| Subject Population (a-f) | 17 |
| Subject Population (g-j) | 18 |
| Recruitment Process, Subject Compensation and Costs | 18 |
| Risks | 20 |
| Benefits | 21 |
| Procedures to Maintain Confidentiality | 21 |
| Consent Information | 23 |
| Assent Background | 24 |
| HIPAA | 24 |
| Drugs and Devices | 25 |
| Potential Conflict of Interest | 25 |
| Attachments | 26 |

Protocol Title:

Homelessness and Mental Health: A Participatory Action Research Approach

IRB Form

Draft

This Print View may not reflect all comments and contingencies for approval. Please check the comments section of the online protocol.

Questions that appear to not have been answered may not have been required for this submission. Please see the system application for more details.

1

***** Personnel Information *****

| | | | |
|--|-----------------------------------|----------------------|--|
| The Principal Investigator is an individual who conducts a research study. If the study is conducted by a team of individuals, the Principal Investigator is the responsible leader of the team. The Principal Investigator can create, view, edit, and submit the protocol. | | | |
| Name of Principal Investigator* | Degree (MD/PhD/BSN/etc.) | | Title |
| John Rogers | MA/EdS | | Doctoral Candidate |
| Email* | Phone | | Fax |
| roger2jd@dukes.jmu.edu | 4044336573 | | |
| Research Department | JMU Status Check ALL that apply* | | Mailing Address |
| Dept of Graduate Psychology | X | Faculty | |
| | | Staff | 705 Ingleside Lane Charlottesville, VA 22901 |
| | | Undergrad | |
| | | Grad | |
| ALL research personnel are required to complete Human Subject Research training from CITI within the last 3 years prior to engaging in any research-related activities. Go to CITI Program to complete. | | | |
| If training was not completed via the CITI training program, please provide verification by attaching your training records in the Attachments section of this module | | | |
| Training Details | | | |
| CourseID | Course | CourseCompletionDate | CourseExpirationDate |
| 36211 | Social/Behavioral Research Course | 9/13/2018 9:02:21 PM | 9/12/2021 9:02:21 PM |

OTHER INVESTIGATOR(S): An Other Investigator can view, edit, and submit the protocol. Click the Add button to add Other Investigators. Leave blank if you do not have an Other Investigator.

STUDY COORDINATOR(S): A Study Coordinator can view, edit, and submit the protocol. Click the Add button to add Study Coordinators. Leave blank if you do not have a Study Coordinator.

ADMINISTRATIVE CONTACT(S): An Administrative Contact can view, edit, and submit the protocol. Click the Add button to add Administrative Contacts. Leave blank if you do not have an Administrative Contact.

Administrative Contact

Name of Administrative Contact, Project Director, or Lab Coordinator

Degree (MD/PhD/BSN/etc.)

Title

Page 1 of 28

2

| | | |
|---|-----------------------------------|-----------------|
| Email* | Phone | Fax |
| Research Department | JMU Status Check ALL that apply * | Mailing Address |
| | Faculty | |
| | Staff | |
| | Undergrad | |
| | Grad | |
| ALL research personnel are required to complete Human Subject Research training from CITI within the last 3 years prior to engaging in any research-related activities. Go to CITI Program to complete. | | |
| If training was not completed via the CITI training program, please provide verification by attaching your training records in the Attachments section of this module | | |
| Training Details | | |
| No training data is available. | | |

OTHER PERSONNEL: Other Personnel can view, edit, and submit the protocol. Click the Add button to add Other Personnel. Leave blank if you do not have any Other Personnel.

Click Next to advance to every section of the protocol. When you click Next your changes will be saved. If the page does not load, right click with your mouse (Mac users control-click) and select Refresh/Reload.

Subject Checklist

Select All That Apply :

Children under 18 Pregnant women Fetuses/neonates Prisoners

Military personnel

☒ Adult Volunteers

☒ Economically/educationally disadvantaged

Individuals with impaired decision-making capacity University students
 University employees
 Illiterate

X Homeless

Public officials/candidates for public office

Institutionalized patients/residents

Persons incompetent to give consent (e.g., dementia, comatose, have legal guardians)

X Healthy Individuals

* * * Subject Checklist * * *

Page 2 of 28

Other (please specify):

3

Select All That Apply - NOTE: If your study location is not listed, or if you would like to list additional details about your location (e.g., specific school within a school district), please enter that information in the "Other" section.

On JMU's Campus Off JMU's campus

If research will be conducted off campus, please provide the proposed study location:

It is your responsibility to obtain permission from off-site location(s) prior to the start of your IRB approved research.
 Other (please specify)

Has this protocol been submitted to any other Institutional Review Board not listed above? N Is this a multi-site project? (A multi-site study is one where different PIs at different institutions are conducting the same study or N

aspects of the same study.)

Will JMU function as the coordinating center or lead institution? Y Please submit an IRB approval or Letter of Permission/Support from the Study Location or other IRB if applicable.

The proposed study location is on the premises of The Haven, a day shelter in Charlottesville, Virginia.

General Checklist

Select All That Apply :

Request to Rely on Another IRB - Please upload completed Request to Rely and associated documents in attachment section

IRB Authorization Agreement, Memorandum of Understanding, etc., where JMU's IRB is the Reviewing IRB. Please provide these documents in the Attachments section.

Class Project Interview Questionnaire/Survey

☒ Thesis or Dissertation Project

Radioisotopes/radiation-producing machines, even if standard of care (Radiation Safety)

Human blood, cells, tissues, or body fluids (Institutional Biosafety)

Tissues to be stored for future research projects

Tissues to be sent from JMU as part of a research agreement (i.e., Material Transfer Agreement)

Protocol involves studying potentially addictive drugs

Investigational drugs, reagents, or chemicals

Commercially available drugs, reagents, or other chemicals administered to subjects (even if they are not being studied)

Page 3 of 28

4

This study involves drugs or devices regulated by FDA

Cancer Subjects (e.g., behavior/prevention) or Cancer Tissues (e.g., blood, cells, body fluids) Protected Health

Information (PHI) will be viewed, created, accessed, used, or disclosed

HIPAA Authorization

Waiver or Alteration of Authorization

Activities Preparatory to Research

Limited Data Set and Data Use Agreement

Use and Disclosure of Decedents PHI without Authorization

Other (clarify in text box to the right)

Funding

☒ Please check if this project does not have any funding. Otherwise, please provide the requested information below.

Application type checklist

Not Human Subjects Research

☒ Exempt

Expedited/Full Board

* * * Exempt Paragraphs(s) * * *

There are eight categories of research activities involving human subjects that may be exempt from the requirements of the Federal Policy for the Protection of Human Subjects (45 CFR 46). According to JMU Policy, research that will be published or publicly presented outside of the classroom is not eligible for Exempt Review.

NOTE: The exempt categories below do not apply to research involving prisoners. For research subject to Subpart C (Additional Protections Pertaining to Biomedical and Behavioral Research Involving Prisoners as Subjects), the Final Rule changed the pre-2018 rule to allow the exemptions to apply to Subpart C for "research involving a broader subject population if the research only incidentally includes prisoners" (HHS 2017). Secondary research (using the information or biospecimens) with subjects who are prisoners is allowed by the Final Rule if the research is not seeking to examine prisoners as a subpopulation. The Final Rule allows subjects to continue in exempt research if they become prisoners during a study.

Select one or more of the following paragraphs applicable to your project:

Page 4 of 28

X 3.

- i. Any information obtained is recorded in such a manner that subjects CANNOT be identified, directly or through identifiers linked to the subjects; OR
- ii. Any disclosure of the subject's responses outside of the research could NOT reasonably place the subject at risk of criminal or civil liability or be damaging to the subject's financial standing, employability, educational advancement, or reputation; OR
- iii. Any information obtained is recorded by the investigator in such a manner that the identity of the human subjects CAN readily be identified, directly or through identifiers linked to the subjects, AND an IRB conducts a Limited IRB review to make the determination required by 45 CFR 46.111(a)(7) and the research is not subject to 45 CFR 46 Subpart D, which relates to there being adequate provisions for protecting privacy and maintaining confidentiality.

This exemption does not apply to children except for research involving observation of public behavior when the investigator does not interact with the children. Workplace meetings and activities, as well as classroom activities, are not considered "public behavior".

RESEARCH INVOLVING BENIGN BEHAVIORAL INTERVENTIONS in conjunction with the collection of information from adult subjects through verbal or written response (including data entry) or audiovisual recording, if the subject prospective agrees to the intervention and information collection, is exempt, IF

- X i. Any information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be identified, directly or through identifiers linked to the subjects, OR
- ii. Any disclosure of the subject's responses outside of the research could NOT reasonably place the subject at risk of criminal or civil liability or be damaging to the subject's financial standing, employability, or reputation; OR
- iii. Any information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be identified, directly or through identifiers linked to the subjects, and an IRB conducts a Limited IRB review to make the determination required by 45 CFR 46.111(a)(7).

In most cases, managers and staff in public agencies are not "public officials".

1. EDUCATIONAL PRACTICES: Research conducted in established or commonly accepted educational settings, involving normal educational practices that are not likely to adversely impact student's opportunity to learn required educational content of the assessment of educators who provide instruction. This includes most:

- i. Research on regular and special education instructional strategies; OR
- ii. Research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

This category does not apply to use of school records of identifiable students or interviewing instructors about specific students.

2. EDUCATIONAL TESTS (COGNITIVE, DIAGNOSTIC, APTITUDE, ACHIEVEMENT), SURVEY PROCEDURES, INTERVIEW PROCEDURES, OR OBSERVATION OF PUBLIC BEHAVIOR (INCLUDING VISUAL OR AUDITORY RECORDING): Research involving these procedures is exempt, IF one of the following is correct:

4. EXISTING DATA: Secondary Research involving collection or study of existing data, documents, records, or biospecimens, for which consent is not required is exempt, IF:

- i. The identifiable private information or identifiable biospecimens are publicly available; OR
- ii. Information, which may include information about biospecimens, is recorded by the researcher in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects, the investigator does not contact the subjects, and the investigator will not re-identify the subjects; OR
- iii. The research involves only information collection and analysis involving the investigator's use of identifiable health information when that use is regulated under 45 CFR parts 160 and 164, subpart A and E, for the purposes of "health care operations" or "research" as those terms are defined at 45 CFR 164.501 or for "public health activities and purposes" as described under 45 CFR 1.512(b); OR
- iv. The research is conducted by, or on behalf of, a Federal department or agency using government-generated or government-collected information obtained for non-research activities, if the research generates identifiable private information that is or will be maintained on information technology that is subject to and in compliance with section 298(b) of the E-Government Act of 2002, 44 U.S.C. 3501 note, if all of the identifiable private information collected, used, or generated as part of the activity will be maintained in systems of records subject to the Privacy Act of 1974, 5 U.S.C. 5521, and, if applicable, the information used in the research was

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collected subject to the Paperwork Reduction Act of 1995, 44 U.S.C. 3501et seq.

5. RESEARCH AND DEMONSTRATION PROJECTS CONDUCTED BY OR SUBJECT TO THE APPROVAL OF DEPARTMENT OR AGENCY HEADS: This research is exempt IF it is designed to study, evaluate, or otherwise examine:
 - i. Public benefit or service programs;
 - ii. Procedures for obtaining benefits or services under those programs; OR
 - iii. Possible changes in or alternatives to those programs, OR
 - iv. Changes in methods or levels of payment for benefits or services under those programs.

Such projects include, but are not limited to, internal studies by Federal employees, and studies under contracts of consulting arrangements, cooperative agreements, or grants. Exempt projects also include waivers of otherwise mandatory requirements using authorities such as sections 1115 and 1115A of the Social Security Act, as amended.

Note: Each Federal department or agency conducting or supporting research and demonstration projects must establish, on a publicly accessible Federal Web site or in such other manner as the department or agency head may determine, a list of the research and demonstration projects that the Federal department or agency conducts or supports under this provision. The research or demonstration project must be published on this list prior to commencing the research involving human subjects.

6. TASTE AND FOOD QUALITY EVALUATION AND CONSUMER ACCEPTANCE STUDIES: This research is exempt, IF:
 - i. Wholesome foods without additives are consumed; OR
 - ii. A food is consumed that contains a food ingredient at or below the level and for a use found to be safe by the Food and Drug Administration (FDA) or approved by the Environmental Protection Agency (EPA) or the Food Safety and Inspection Service (FSIS) of the US Department of Agriculture (USDA); OR
 - iii. A food is consumed that contains an agricultural chemical or environmental contaminant at or below the level found to be safe by the FDA or approved by the EPA or the FSIS of the USDA
7. STORAGE OR MAINTENANCE OF INFORMATION FOR SECONDARY RESEARCH FOR WHICH BROAD CONSENT IS REQUIRED: The protocol is eligible for exemption if:
 - i. It involves storage or maintenance of identifiable private information or identifiable biospecimens for secondary research use; AND
 - ii. All the identifiable information or identifiable biospecimens that are to be stored and/or maintained for secondary research have been or will be collected for another "primary" purpose; AND
 - iii. Broad consent for the storage or maintenance of their identifiable information or identifiable biospecimens for secondary research use will be obtained from ALL subjects; AND
 - iv. The protocol does not include any activities that do not qualify for exemption; AND
 - v. The protocol is not for an FDA regulated clinical investigation; AND
 - vi. The IRB conducts a Limited IRB Review and makes the determinations required by 45 CFR 46.111(a)(8)
8. SECONDARY RESEARCH FOR WHICH BROAD CONSENT IS REQUIRED: Research involving the use of identifiable private information or identifiable biospecimens for secondary research use is eligible for exemption, if the following criteria are met:
 - i. Broad consent for the storage, maintenance, and secondary research use of the identifiable private information or identifiable biospecimens was obtained in accordance with 45 CFR 46.116(a)(1) through (4), (a)(6), and (d); AND
 - ii. Documentation of informed consent or waiver of documentation of consent was obtained in accordance with 45 CFR 46.117; AND
 - iii. An IRB conducts a Limited IRB review and makes the determination required by 45 CFR 46.111(a)(7) and makes the determination that the research to be conducted is within the scope of the broad consent referenced in paragraph (d)(8)(i) of this section; AND
 - iv. The investigator does not include returning individual research results to subjects as part of the study plan. This provision does not prevent an investigator from abiding by any legal requirements to return individual research results.

Homelessness and Mental Health: A Participatory Action Research Approach

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* * * Summary, Purpose, Procedures * * *

Title (Please indicate if the protocol title is different from the proposal title)

Proposed Start Date: 07/01/2020 Proposed End Date: 04/30/2021

Project dates cannot exceed 1-year minus 1-day (Ex: 07/01/18 - 06/30/19)

1. Summary

a) Provide a brief summary of the scope of work of this project, using non-technical terms that would be understood by a non-scientific reader. This summary should be no more than 500 words.

On any given night, over 568,000 people are homeless in the United States (United States Department of Housing and Human Development [HUD], 2020). Mental health problems may co-occur with the phenomenon of homelessness. Studies estimate that the co-occurrence of homelessness and mental illness and/or substance use disorders ranges from 30-60% (Viron et al., 2014; Montgomery, Metraux, & Culhane, 2013; Fazel, Khosla, Doll, & Geddes, 2008). While causality is not well-understood, recent studies suggest that deinstitutionalization, poverty, lack of access to care, and the traumatic experience of homelessness itself are associated with frequency and acuity of symptoms of mental illness (Montgomery, Metraux, & Culhane, 2013, Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005).

While considerable resources have been directed toward the combined presentation of homelessness, mental illness, and/or substance use disorders, the perspectives of those experiencing this are rarely heard. The purpose of this study is to collaborate with a group of people who have experienced homelessness and mental illness in order to generate responses to the challenges they encounter. With a focus on the homelessness and mental health, the proposed study seeks to address the gap between consumers of services and providers of services through a collaboration with the people who need those services. While there is extensive research on homelessness and mental illness from a variety of perspectives, relatively few studies address this problem from the perspective of those most affected by it (Padgett, Gulcur, & Tsemberis, 2006, Zlotnick, Zerger, & Wolfe, 2013).

The proposed study will seek to identify, using Participant Action Research (PAR), practical solutions to the complex problems faced by this large and vulnerable population. PAR is a flexible methodology that is based on a collaboration among co-participants (McLeod, 2011). Using a recursive and dialectical process, PAR is oriented to promote change at multiple levels, including the for the co-participants, the principal researcher, and the systems examined by the research questions (McIntyre, 2008). The principal researcher will utilize a critical theory framework to inform the PAR study (Merriam & Tisdell, 2016).

2. Purpose

1. a) Describe the purpose for the proposed project as well as the hypotheses/research questions to be examined.
2. b) What do the investigators hope to learn from this project?

The purpose of the proposed project is to collaborate with a group of people who have experienced homelessness and mental illness in order to generate responses to the challenges they encounter.

The proposed study addresses one primary and several subsidiary research questions:

•What are the lived experiences of individuals who are homeless and are diagnosed with a mental illness? •What are the barriers that individuals who are homeless and are diagnosed with a mental illness

experience?

•Drawing on the lived experience of homelessness and mental illness, what practical recommendations

can be generated to support individuals dealing with these challenges?

•What themes from these lived experiences are salient in understanding the barriers these individuals

face?

•What forms of empowerment are developed through the PAR process for this group of co-inquirers?

This study may address a gap in research by applying a PAR methodology to a diverse group of people who experience homelessness, mental illness, and or substance use. Previous action research has contributed the voices and experiences of specific sub-groups (Moxley & Washington, 2012), but there remains an opportunity to bring PAR to bear on this problem. When policy solutions that have been developed and implemented from the top-down fail, despite decades of attempts, a research framework that questions frameworks of power and deterministic epistemologies has the potential to offer new and useful answers. When the suffering and chronicity of the homeless is reframed as structural violence (Bourgeois & Schonberg, 2009), it is possible to imagine the empowerment and creative value of a collaborative research process that raises the role of those subjected to institutionalized power. The proposed study seeks to promote change through critical reflection and action by those most affected by the problem.

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3. Procedures

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a) Describe in chronological order of event(s) how the activities will be conducted, providing information about all procedures (e.g. interventions/interactions with subjects, data collection, photographing, audio and video recording), including follow up procedures.

Research Procedures Setting

The proposed research project will be based at a day shelter for homeless people in the mid-Atlantic region of the United States. The shelter serves a combined population from a small city and the surrounding county of over 100,000, as well as guests who are in transit through the community. The shelter has been operating since 2010 and provides meals, personal hygiene services such as showers and laundry, computers, and rest areas. In addition, the shelter administers grants to provide housing assistance. The shelter describes itself as a low-barrier shelter, meaning that all are welcome, regardless of physical or mental state. House rules forbid weapons, drugs, alcohol, and abusive language or violence on site. The shelter provides services to approximately 80 guests each day.

Population and Sample Selection

Population

Co-participants in this project will be sourced from the shelter's client base, which implies a target population of 100-120 people, of whom approximately 80 visit the shelter on any given day. This clientele comes into the day shelter from a range of overnight situations, including sidewalks, doorways, or other ad hoc arrangements, encampments in wooded areas around the outskirts of town, night shelters including the Salvation Army and a floating night shelter operating out of church basements in colder months, temporary housing in hotels with friends, or in permanent housing. This offers a diversity of experiences with homelessness, including current, recent, recurring, and past homelessness.

The shelter's clientele is multi-dimensionally diverse. Approximately 50 percent of the typical daily population is African-American by race, with an equal representation of males and females. There is representation by Asian-Americans, Latinx-American, Arab- American, and Native American clients. Guests come from all age categories, including mothers with infants and young children, young adults, and the elderly. There is also diversity with respect to the LGBTQ+ community. From the standpoint of mental health, research indicates that there is a high probability that between one-third and one-half of the shelter's clients have a history of mental health issues, including substance use disorders (Montgomery, Metraux, & Culhane, 2013, Fazel, Khosla, Doll, & Geddes, 2008).

Sample Selection

Recruitment and Initial Interviews. The primary data for this study will be collected from clients of the shelter. Potential participants will be identified through three avenues: open recruitment by means of flyers posted inside the shelter, the principal researcher's familiarity with the shelter's clientele, and through a combined criterion and snowball sampling approach to referrals from clients known to the principal researcher and recommendations from senior staff members at the shelter. The realms of experience most salient to the proposed study and sought in the initial screening include a history of multiple episodes of homelessness, a history of mental illness and/or substance use disorder, and a history of interactions with social services agencies and health care systems as a result of these factors. Interviewees with this experience set who are willing to join the focus group will be eligible for participation in the action research project. One goal of the recruitment process is to achieve diversity in the working group. This, among other things, will support generalizability of findings (Merriam & Tisdell, 2016). The shelter's clients represent a diverse population with respect to age, race, gender, sexuality, and ethnicity, and it is anticipated that the working group will reflect this diversity.

Potential participants will be informed about the study through a pre-interview meeting with the principal researcher. In this setting, the principal researcher will provide a verbal description of the study, its purpose, logistical aspects, confidentiality considerations, and other details. In addition, a written summary of the project will be given to potential participants.

Potential participants who consent to an interview and who agree to participate in the working group will be given a verbal description of consent to participate, as well as a written consent form to review and sign.

Working Group Selection. Once potential participants have been identified, an initial interview will be conducted to ascertain suitability and interest in joining the working group. The criteria for suitability will include experiences of homelessness, mental health issues and/or substance use problems, and a willingness to participate in the working group. The semi-structured interview is widely-viewed as an appropriate instrument in qualitative research design (see, for example, Creswell & Clark, 2011). In order to optimize the group's cohesion while retaining a level of diversity of experiences, the anticipated size of the focus group is between 6-8 participants, including the principal researcher (Corey et al., 2014).

Instrumentation

Screening

The initial meeting with potential participants will utilize an interview. The semi-structured interview instrument was created by the principal researcher using an interview guide approach to organize themes and questions in order to address the relevant research questions (Zohrabi, 2013). This instrument was developed for usage with this unique application, given that the principal researcher is not aware of any previous PAR research study with these parameters. The instrument is categorized as a semi-structured oral

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interview with both open- and closed-ended questions (Merriam & Tisdell, 2016; Creswell & Clark, 2011). This interview has three primary objectives: 1) Creating knowledge that can be used to further the research process; 2) understanding the interviewee's past history in order to ascertain its relevance to the topic under study; 3) seeking the interviewee's participation in focus groups and related activities. The principal researcher reviewed and tested two drafts of the interview format as part of its development. It was refined and reviewed for format and content validity considerations by faculty advisors.

Focus Group

The instrument of focus group meetings will be employed as a form of co-inquiry and is considered appropriate as an element of Participatory Action Research (Herr & Anderson, 2015; McLeod, 2011; Reason & Bradbury, 2008). As the creative process occurs in the focus groups, key observations, findings, initiatives, and outstanding questions will be documented and reviewed together by reviewing field journal entries and through meeting summary notes, with areas of consensus and areas of non-consensus noted (Heron & Reason, 2008).

Audio Taping

Interviews and focus group sessions will be recorded using an audio taping and storage device with a backup system. These recordings will be transcribed, using a commercially-available transcription program, with transcriptions checked for accuracy by the principal researcher. This data will be kept in a password-protected file on a secure data storage system. Participant names will be encoded with a key list saved on a secure storage medium. This instrumentation is suggested as appropriate for interview and focus group data recording (Merriam & Tisdell, 2016).

Artifacts

Artifacts produced during the course of the study will be physically preserved in a locked cabinet in the principal researcher's possession and images will be digitally recorded and will be stored in a secure data storage medium.

Field and Fieldwork Journals

The principal researcher will keep two journals, a field journal and a fieldwork journal, both developed by the principal researcher. The former is used to record details from working group sessions, notes on logistics, schedules, and a methods log. The fieldwork journal is primarily a reflexive journal of thoughts, questions, and impressions of the principal researcher (Phillippi & Lauderdale, 2018; Merriam & Tisdell, 2016; Krefting, 1991; McLeod, 2011). These journals serve multiple functions; they are part of the principal researcher's epistemological journey through the PAR process, they are elements in the trustworthiness of the research, and they can be used as tools to enable forward progress with the focus groups (Herr & Anderson, 2015). Both journals types are suggested as appropriate instruments for action research methodologies (Herr & Anderson, 2015; McLeod, 2011; Reason & Bradbury, 2008).

Meeting Summaries

Summaries of focus group meetings will be prepared by the principal investigator using the meeting summary instrument produced by the principal researcher (Appendix J). This instrument was developed as an integration of formats suggested by multiple sources, (Merriam & Tisdell, 2016; Krefting, 1991; McLeod, 2011) These summaries will be reviewed by the focus group at the subsequent meeting. Meeting summaries will be stored electronically in a secure data storage medium. Meeting summaries are a recommended form of instrumentation for participant action research (McIntyre, 2008; Herr & Anderson, 2015).

Data Collection

Screening

Screening interviews with potential participants will be held in a meeting room at the shelter. These meetings will include the principal researcher and the interviewee, with data collected by the principal researcher using the field journal and audiotaping via digital recording technology. The interview materials used will consist of a written set of preselected demographic questions as well as of thematic areas that can be used as the basis for discussion in the interview. It is intended that there will be one screening interview per prospective participant and that the interview will take approximately one hour.

A record of each interview including location, date and time, interviewee number, duration of interview, individuals in the room, and any unusual interview elements will be noted by the principal researcher in the field journal. Each interviewee will be given a randomly generated four digit code, and the key will be kept by the principal researcher in a password-protected Excel file with a paper copy kept in a locked file cabinet in the possession of the principal researcher. Audiotapes and digital transcripts of interviews will be kept in a password-protected digital file, accessible solely to the principal researcher, with the interviewee's name substituted for their four digit code. Following conclusion of the study, all interview records and the code will be stored as described above by the principal researcher for a period of not less than five years. At the end of this period, all audiotapes will be permanently deleted.

Focus Groups

Weekly focus group meetings will be held in the conference room at the Shelter, with tables and chairs arranged in a square so that all participants can see and hear one another. Participants will include focus group members, one of whom is the principal researcher. Observers will be permitted in the meeting only on unanimous verbal consent from the focus group members. The intention is to hold the meetings at mid-day and to provide participants with lunch, with a meeting duration of approximately 90 minutes. Meeting data will be collected by the principal researcher using the field journal and audiotaped by the principal researcher via digital recording technology. The proposed study envisions a total of 8-10 working group meetings.

Audiotapes and digital transcripts of focus group meetings will be kept in a password-protected digital file accessible solely to the principal researcher. Following conclusion of the study, all interview records and the code will be stored in this manner by the principal researcher for a period of not less than five years. The field journal will be created using pen and paper and will be kept in a locked file cabinet in the principal researcher's possession, and

after conclusion of the study, will be stored in this manner by the principal researcher for a period of not less than five years.

Artifacts

The PAR process generally leads to the production of artifacts through the action element of the process (Ludema & Fry, 2008). Such artifacts are produced by the working group, they will be collected by the principal researcher for safekeeping and the principal researcher will record digital images of these artifacts while they are being produced and as they are completed. Notes on the production of such artifacts will also be made by the principal researcher in the field journal. Following conclusion of the study, physical artifacts may be distributed to working group participants, community organizations, or other entities wishing to preserve or, with unanimous agreement of working group members, display them. Digital images of the artifacts will be kept by the principal researcher in a password-protected digital file, and after conclusion of the study, will be stored in this manner by the principal researcher for a period of not less than five years.

Principal Researcher Data

Personal impressions, thoughts, feelings, and other subjective experiences of the principal researcher will be self-reported in the fieldwork journal. This data can derive from any part of the research process, including interviews, focus group meetings, side conversations, as well as the integration of these experiences in the principal researcher's epistemological development (Heron & Reason, 2008). Entries can be made at any time and such entries will be dated. The journal will be produced by pen on paper. The fieldwork journal will be kept in a locked file cabinet in the principal researcher's possession, and after conclusion of the study, will be stored in this manner by the principal researcher for a period of not less than five years.

Participant Withdrawal

Participants will be free to exit the study at any time. If a participant misses two working group meetings, the principal researcher will meet with the participant to ascertain their intentions regarding further participation. Participants who wish to exit the program will be offered the opportunity to have a debriefing meeting with the principal researcher. Such debriefing meetings will be audiotaped using a digital recording device. The audiotape will be transcribed using a commercially available service, and the recording and transcription will be kept by the principal researcher in a password-protected digital file accessible solely to the principal researcher. Following conclusion of the study, all debriefing records will be stored in this manner by the principal researcher for a period of not less than five years. A record of debriefings will also be kept by the principal researcher in the field journal.

i) Be sure to identify what procedures are experimental and what are standard of care or established practice for the condition/situation.

The working group experience are considered experimental and established standards of care will be utilized for this procedure. During the planning, acting, and observing stages of the research, the principal researcher will be transparently reflexive regarding their power and positionality. This process element of critical theory brings power relationships into the here and now, as opposed to waiting until the data analysis stage (Merriam & Tisdell, 2016). PAR research presupposes a collaborative relationship, and through an authentic presence the principal researcher can model norms and behaviors that support a productive working group (Reid & Frisby, 2008). In keeping with this, the principal researcher in PAR bears the responsibility of demystifying the process and leveling power relationships (Grant et al., 2008).

Potential participants will be informed about the study through a pre-interview meeting with the principal researcher. In this setting, the principal researcher will provide a verbal description of the study, its purpose, logistical aspects, confidentiality considerations, and other details. In addition, a written summary of the project will be given to

potential participants. Potential participants who consent to an interview and who agree to participate in the working group will be given a verbal description of consent to participate, as well as a written consent form to review and sign.

The standard of care for working groups also incorporates protection of anonymity through substitution of codes for participant names on all transcripts and publicly-available documents, password-protected storage of all digital media, and secure storage of any non-digital media produced. Working group meeting rooms are to be private, with observers permitted only on unanimous consent of working group members. Working group members are free to leave meetings at any time and to exit the study at any time.

b) Explain who will conduct the procedures and where and when they will take place. Indicate the frequency and duration of visits/sessions as well as the subject's total time commitment for the study. Include how the data will be collected (i.e. in person or online).

The principal researcher will conduct the procedures, which will occur at the Haven's facilities in Charlottesville, Virginia, during the summer and fall of 2020. Interviews, which will take place during business hours, are expected to last not longer than 90 minutes, and it is expected that there will be 8-10 working group meetings, expected to last not longer than 90 minutes each, during business hours. A subject's total time commitment for the study is expected to amount to approximately 17 hours. The data will be collected in person.

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i) Indicate that the instruments used are in the public domain or provide appropriate documentation of permission to use each scale. Instruments used have been developed by the principal researcher or are publicly available commercial applications such as digital recording systems. Such publicly available applications will be purchased by the principal researcher.

For school-based activities where class time is used, describe in detail the activities planned for non-subjects and explain where both subjects and non-subjects will be located during the activities. Not applicable.

State if deception will be used. If so, provide a rationale and describe debriefing procedures. Submit a debriefing script in Attachments section. Deception will not be used.

Will audio or video taping of individuals occur? Will photographs of individuals be taken? Describe what will become of the tapes/photographs (e.g., shown at scientific meetings, erased, etc.). Audiotaping of interviews and working group meetings will occur. Photographs of individuals will not be taken. Audiotapes will be stored by the principal researcher on password-protected digital files and will be permanently deleted not more than five years following the termination of the research.

Will the proposed research involve the use of existing data/specimens? If so, check all that apply:

- i. The research involves data from publicly available sources.
- ii. That data will be recorded by the investigator in such a manner that subjects cannot be identified.
- iii. Any link to identifying information has been destroyed.

Background and additional procedures

Relevant Background: Discuss the present knowledge, appropriate literature and rationale for conducting the research. Include the rationale for the selected subject population.

Homelessness and Mental Illness

Manifestation and Frequency

Not only has homelessness increased in recent years (HUD, 2020), it is a problem with serious personal and social consequences. People who are unhoused experience higher rates of serious illness and mortality (Hodge et al., 2017), higher rates of incarceration (Greenburg & Rosenheck, 2010), and higher incidences of mental illness and substance use disorder than in the general population (Hwang, 2001; Viron et al., 2014). While the social consequences of homelessness are important, the focus of this study, and therefore the following review of the literature, is on the lived experiences of people experiencing both homelessness and mental illness.

In order to address a human problem of this magnitude, a clear idea of its prevalence and persistence is needed. In this respect, considerable research on homelessness and mental health has sought to quantify the extent and severity of psychiatric conditions within the homeless population. Through meta-analysis and epidemiological data, we can draw some general observations about prevalence and factors associated with homelessness. Analysis of nationwide epidemiological survey data points to a lifetime prevalence of homelessness for approximately five percent of the United States population (Greenburg & Rosenheck, 2010). This study also confirmed the association between mental health issue and homelessness, particularly in the case of substance use disorders (Greenburg & Rosenheck, 2010). Meta-analysis corroborates these findings and indicates a substantially higher incidence of substance use disorder among the homeless than was the case in the age-matched general population (Fazel et al., 2008). Meta-analysis also found a higher prevalence of serious mental illness among homeless samples than in the general population (Fazel et al., 2008).

In an effort to ask the obverse question and correct earlier methodological shortcomings, several nomothetic studies examined the incidence of homelessness among those with mental illness, (Montgomery et al., 2013). After controlling for various factors such as race, gender, socioeconomic status, and setting (Montgomery et al., 2013), these studies indicate that there is an increased risk of homelessness when psychiatric conditions exist, that this is exacerbated by the presence of substance use disorders (Folsom et al.,

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homelessness when psychiatric conditions exist, that this is exacerbated by the presence of substance use disorders (Folsom et al., 2005; Montgomery et al., 2013), and that individuals experiencing homelessness are higher users of hospital and other emergency services (North et al., 1993), particularly when homelessness and mental health issues co-present (Chun et al., 2016). While contributing breadth and statistical significance to our understanding of

conditions, research on prevalence and association do not address causality, leaving open the question of how to address root causes behind chronic homelessness and mental illness.

Perspectives on Causality

While homelessness and mental health conditions often co-occur, it is less clear why this is the case. One theory aligns with the concept of cumulative trauma and points to indications that episodes of homelessness contribute to higher frequency and severity of psychiatric symptoms and substance use (Castellow et al., 2013; Lippert & Lee, 2015). What are now commonly referred to as high ACES scores, representing adverse childhood incidences (Center for Disease Control and Prevention, 2020), along with low income, measures of personal trouble, and availability of social support are all correlated to the combined presentation of homelessness and mental illness (Booth et al., 2002; Greenburg & Rosenheck, 2010). In addition, being of color, male, single, and middle-aged are all associated with higher incidences of homelessness (Greenberg & Rosenheck, 2010; Burt et al., 2001; Martens, 2001).

Research on discrete populations offers interesting perspectives on the etiology of homelessness and mental illness. Studies suggest that at least two-thirds of youths and young adults experiencing homelessness meet criteria for a mental illness (Hodgson et al., 2013; Hodgson et al., 2014). Young adults who received crisis psychiatric services describe a Gordian Knot that binds homelessness, substance use, and mental illness into a trauma-laden nexus (Narendorf, 2017). Interviews and data from homeless young adults paint a picture of the intersection of broken family relationships, unavailable support systems, substance use, and trauma (Narendorf, 2017).

This theme of antecedents to homelessness was further developed in research that indicated that recently unhoused youths presented with a wider and more serious psychiatric symptomology than in the population as a whole, and that these symptoms increased as the duration of homelessness lengthened (Martijn & Sharpe, 2006). The significance of trauma along the pathway to homelessness for young people was also made clear, with over half of one group surveyed identifying a history of physical abuse (Martijn & Sharpe, 2006).

In seeking to understand pathways to co-occurring homelessness and mental illness, it is important to consider groups who are particularly marginalized. These include people experiencing incarceration, in part to address trenchant perceptions of vagrancy as a status associated with criminality (Moschion & Johnson, 2019). It is true that rates of homelessness and mental illness in those with criminal records are significantly above the general population (Greenberg & Rosenheck, 2008), and while causality is difficult to establish, studies suggest that incarceration is a predictor of homelessness (Moschion & Johnson, 2019). This defies the discriminatory narrative that becoming homeless leads to criminal behavior and that therefore people who are homeless merit a higher degree of public safety scrutiny (Malone & Malone, 2009).

Another method of understanding homelessness and mental health issues is to explore elements that help people find pathways out. Deductive methods suggest that factors including being female, relatively unencumbered by debt and with minimal judicial history are associated with escape velocity (Christensen and Vinther, 2005). This is substantiated by qualitative studies indicating that the availability of a support system, opportunities for self-expression, access to services, high measured levels of self-efficacy, and spirituality are also supportive of pathways out of chronic homelessness and mental illness (Epel et al., 1999; Patterson & Tweed, 2009).

Homelessness and Marginalization

The nexus of homelessness and mental illness results in marginalization, discrimination, and vilification (Narendorf, 2017; Donley & Jackson, 2014). People who are unhoused evoke stereotyped expectations of coldness, incompetence and lack of status and evoke emotions of disgust and contempt (Fiske, 2012). Mental illness is highly

stigmatized, with those diagnosed with serious mental illness are widely perceived as unstable and dangerous (Alexander & Link, 2003). A host of ironically-termed quality of life laws passed in many municipalities make it illegal to perform acts including begging or laying down in public spaces, thus spatially discriminating against people experiencing homelessness (National Healthcare for the Homeless Council, 2013). One way of assessing the degree of marginalization here is to apply a capabilities framework of basic human freedoms (Kerman & Sylvestre, 2020). Measured against such standards, people are marginalized not only during episodes of homelessness and mental illness, but also once housed (Kerman & Sylvestre, 2020). Powerlessness is a dominant theme in this population (Smith, 2013), particularly in the face of scapegoating, othering, and exclusion from public spaces (Bullock et al. 2017). This powerlessness can be accompanied by a sense that one's identity is being created and defined by others (Donley & Jackson, 2014), contributing to a negative valence in the composition of self-worth and agency. Discrimination in housing is widely reported as a barrier to exit from homelessness (Benbow et al., 2011), as many landlords require evidence of employment to secure a lease, and many employers exhibit prejudice against individuals without a fixed residence (Shaheen & Rio, 2007).

As noted above, subgroups of this population have increased levels of intersectionality and as a result may experience additional forms of discrimination and oppression. Women who are unhoused are particularly vulnerable to sexual exploitation (Narendorf, 2017), experience higher rates of sexual assault and other forms of physical violence than women who are housed (Stermac & Paradis, 2001). Youths recently aging out of foster care can experience abandonment and loss of financial and social support

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(Narendorf, 2017). Among individuals experiencing incarceration, Fox et al. (2016) found that victimization was the primary mitigating factor between mental illness and homelessness. They suggest initiatives to address substance use and community support services to address these significant mediating factors (Fox et al., 2016). Invisibility, particularly for homeless women, is another aspect of marginalization that perpetuates the conditions of homelessness and mental illness (May et al., 2007). While women comprise a large percentage of homeless individuals (HUD, 2020), females are rarely seen sleeping on the streets or panhandling (May et al., 2007). This invisibility, borne of fear of exploitation, often places women outside the services provided by, for example, mobile outreach programs.

When viewed through the lens of critical theory, a review of research methodologies makes clear the institutional and normative forces behind continued marginalization for this population. For example, one commercialized product in wide use among recovery groups for people experiencing homelessness was described as developed using principles of Participatory Action Research (Joy, 2011). Despite containing epistemological elements of PAR, the product developers used a predetermined set of parameters as the basis for focus group meetings (Petersen et al., 2014, Joy, 2011). This is illustrative of the way that a qualitative framework such as PAR can become subsumed in an expert-driven approach that marginalizes the voices of those experiencing the phenomenon under study.

Models of Care

The corpus of research has added to our understanding of the degree to which homelessness, mental illness, and substance abuse are intertwined. It has not resolved issues of causality or persistence, and taken as a whole, results in analytical circularity. This absence of a root cause contributes to a wide range of models of care available to people who are homeless and experiencing mental illness (Martin, 2015). These models form a continuum, with treatment first models, which classically require sobriety and medication compliance, at one end and housing first

models, which are often no- or low-barrier to entry, at the other (Rogers, 2018). There is an active debate over treatment first versus housing first models, with some federally-sponsored and faith-based programs oriented toward the former, and many community-based programs evolving toward the latter (Rogers, 2018). In recent years, research in this area has supported a housing-first model of care, particularly when housing services are surrounded by social and health-care services (U.S. Interagency Council on Homelessness, 2010). A major focus in this research has been on usage rates of social and medical care systems, and indications are that housing first models contribute to higher levels of outpatient visits and correspondingly lower usage of emergency services as well as more stable housing (Gilmer et al., 2010; Burt, 2012).

Evidence-Based Perspectives

As decades of deinstitutionalization transitioned people with mental illness to community-based care, service models oriented toward this population replaced inpatient institutions (Zlotnick et al., 2013). The customer-orientation informing this approach was expected to result in higher satisfaction and better outcomes (Watson, 2012), and research supports this proposition. For example, when people experiencing homelessness were randomly assigned to a choice-based treatment program or to traditional treatment, the choice-oriented program resulted in higher compliance with treatment plans, lower use of services, and higher reported satisfaction (Shern et al., 2010). A similar result was obtained in comparing participants in a program oriented toward sustained employment and housing versus people not participating (Burt, 2012).

In the United States, federal funding for research, pilot programs, and sustained operations is often conditional on evidence-based models (U. S. Interagency Council on Homelessness, 2010). Under federal law, all grants offered by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) must incorporate specified measurement tools (U.S. Department of Health and Human Services, 2020). Given this mandate and the economic incentives associated with it, there has been a sustained focus on seeking to quantify outcomes by using, for example, side-by-side comparisons of treatment modalities. Research along these lines has generated mixed findings, with rates of substance use showing no significant difference (Kertesz et al., 2009) but measures of agency suggesting stronger outcomes from housing first programs (Watson, 2012; Henwood et al., 2015). In terms of stable housing, the conditional nature of treatment first programs, which predicate housing on continued abstinence, makes side-by-side comparisons inherently difficult (Watson, 2012). Nonetheless, a number of studies, including controlled models, indicate that housing first programs result in significantly higher rates and duration of rehousing compared with both treatment first models and other continuity of care models, which are variants of treatment first (Tsemberis, 1999; Kersey & Weiner, 2009).

Experiential Perspectives

To deepen our understanding of the nexus of homelessness and mental illness, mixed-method and ideographic studies address the lived experiences of this population. While much of the research on models of care focuses on outcome metrics such as use of outpatient services, relapse, and residential stability, another increasingly popular avenue is to orient toward experiential measures of client satisfaction with services. Research findings in this area are less conclusive than is the case as primary conditions such as housing status and mental health (Helfrich & Chan, 2013; Rayburn, 2013). Life skills training is one example of a programmatic feature that did not produce conclusive evidence of improved outcomes (Helfrich & Chan, 2013). Methodological challenges may explain these findings, and there remain opportunities for further research in this area.

In the search for understanding the “what” and “why” elements of successful care systems, a pragmatic lens has proven useful. One mixed-methods study utilized a realist review method through a team whose members were

drawn from the academy and the community (O'Campo et al., 2009). The team identified six strategies that they expected to improve mental health and, to a lesser

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extent, reduce substance abuse (O'Campo et al., 2009). Watson (2012) used symbolic interactionism as a framework and measured, with interviews and focus groups, the experiences of homeless people and service providers in four different care models. To measure the impact of models of care, Rowe et al. (2016) used thematic analysis to organize information from focus groups, interviews, and field observation of workers in multiple versions of assertive outreach programs in New England. This approach identified four main themes, three of which related to care provider capabilities, and one related to availability and breadth of services (Rowe et al., 2016).

Long-term qualitative research in this subject area is rare, but two studies are worth noting. Rayburn's (2013) work with homeless drug users in New Orleans who participated in a rehousing and substance use treatment program yielded mixed results. From the perspective of nearly two decades after its completion, the Rayburn (2013) hypothesis that social bonding theory would identify factors such as partnership, employment, and faith as explanatory for lasting success was supported by interviews with participants, but this was not supported by the accompanying quantitative analysis (Rayburn, 2013). Perhaps the longest retrospective approach available came from a study that combined a timeline narrative and action learning framework to review 25 years of integrated services to homeless and mentally ill people in India (Narasimhan et al., 2019). Their findings, based on interviews and reviews of documents, recommend that program design focus on exemplars including dynamism, responsiveness, innovation and resonance with users (Narasimhan et al., 2019).

Other studies have sought to document the interactions between users and systems of care based on objective criteria. This dimensional approach provides evidence that programs may succeed in helping those enrolled to survive their circumstances but are less successful in helping them to thrive. This was the primary finding of a study that utilized, possibly for the first time with this population, a capabilities approach (Kerman & Sylvestre, 2020). A representative parameter used was "having the opportunity to live a normal human life and not die prematurely" (Kerman & Sylvestre, 2020, p. 416). The depth of problem-saturated descriptions of failed systems, policies, and of the hopelessness that chronic homelessness engenders defies reduction to a simple set of outcomes.

Another way to assess models of care is from the perspective of critical theory. Viewed through the lens of intersectionality, systems of care that emphasize the peer support, gender-oriented services, culturally competent agency leadership, and flexibility are valued by users of them (David et al., 2015). For mothers in homeless shelters, socially constructed roles resulted in marginalization and loss of agency (Glumbikova, 2019). In this sense, the rules and norms imposed by institutions combine with invisible bias in perpetuating oppression and silencing the voices of those the agencies were intended to serve (Swick & Williams, 2010).

Still another method of bringing user experiences to bear in the design of services delivery combines participatory research with expert implementation. Here, people with experiences of homelessness and mental health issues help generate recommendations which are then reviewed and operationalized by professionals. In one such study, a team of African-Americans who had experienced homelessness and mental illness collaborated with service providers and investigators through a series of focus groups (Corrigan, 2017). The resulting recommendation to introduce peer navigators was implemented and its results were evaluated (Corrigan, 2017). A variation of this approach that used the framework of a gap analysis resulted in the identification of a need to integrate a level of care model into the provision of services for this population (Stergiopoulos et al., 2010).

Participatory research has also been a helpful lens in identifying best practices and delivery gaps in service models. Spatial experiences of lostness, temporal dislocations that are experienced as nonexistence, and other states described by study participants offer a counterbalance to the often highly structured nature of programs for people who are homeless (Petrusak et al., 2017). The institutional and societal biases noted above and examined through critical theory are echoed in PAR research involving people experiencing homelessness, but not co-occurring mental illness, that sought to push back against this framework through an editorial campaign (De Oliveira, 2018).

Several themes emerge when we summarize the research on models of care. Systems that provide low barriers to housing resolve the problem of homelessness, but do not necessarily alleviate symptoms of mental illness unless they are integrated with additional services (Gilmer et al., 2010; Burt, 2012). Regardless of the delivery model, institutionalized forms of oppression persist, and the voices of those being served need to be heard in order to address this population's needs beyond simple survival (David et al., 2015; Kerman & Sylvestre, 2020).

Counseling those who are homelessness with mental illness Settings and Roles

Counselors may establish professional relationships with people who are homeless and dealing with mental illness in their roles working with marginalized populations (McBride, 2012). Homeless shelters, community mental health centers, free clinics, street outreach programs, and public psychiatric hospitals are among the wide variety of sites that provide services to this community. Part of multicultural competency, as it pertains to this population, includes understanding and supporting their complex needs (Baggerly & Zalaquett, 2006; McBride, 2012). This may include a working knowledge of local social services agencies, housing coordinators, medical providers, and similar connections. Counseling work with the homeless may also entail employment-oriented support, substance use, family dynamics, and other wide-ranging subjects. This theme has been woven into a doctoral-level counselor educator program as part of social justice training, with positive results (Clements-Hickman et al., 2019).

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Counseling Considerations

Considerable research suggests that mental health counseling for people experiencing homelessness can drive improved functioning, particularly for young adults (Morton et al., 2019; St. Arnault & Morali, 2019; Sun, 2012). Using the lived experiences of people from this population as a touchstone has generated helpful considerations for counselors (McBride, 2012). To be effective, counselors must incorporate these clients' likely needs on the lower portions of Maslow's hierarchy, including housing, employment, safety, and social connection (McBride, 2012).

A counseling approach that responds to these needs can incorporate action as a form of empowerment (ACA, 2014; McIntyre, 2011). In this sense, counselor-led working group can be viewed as a therapeutic experience (Corey et al., 2014). A community-based participatory project designed to support homeless youth in Los Angeles used this approach (Garcia et al., 2014). The project was reported to have helped empower, engage, and create change agency among the participating youths, and it serves as an illustration of the potential of PAR to create an impact (Garcia et al., 2014).

In reviewing the literature from the perspective of counseling, we see that counselor educators can help prepare students for work with this population, and that there are many clinical settings where counselors will have such opportunities. To explore the group context further, there are studies that take an explicit participatory perspective (van Draanen et al., 2013) and others that add an action step such as PhotoVoice as the means to empower

residents to influence their health and wellness (Corrigan, 2017; Cheezum, 2019). Nonetheless, there is virtually no research that contains both the participant and action steps in PAR by engaging people who experience homelessness and mental illness. This leaves unmet the research opportunity to generate therapeutic growth and empowerment through the action element of PAR.

Summary and Implications

As a result of decades of quantitative research, we know that homelessness, poverty, mental illness, and substance use disorders co- occur with greater frequency and chronicity than in the general population (Martin, 2015). What is less clear is the nature of causality, cyclicity, and recovery. Research on models of care, both qualitative and quantitative, points to housing first with integrated services as the gold standard in terms of outcomes (Rogers, 2018). There is limited research based on critical theory or utilizing Participatory Action Research methodology in order to generate empowerment and change models through an inductive process. The opportunity to test such a framework with a group of people who are homeless and experiencing psychiatric issues remains open.

b. Describe the statistical methods of the research and plans for analysis of the data (i.e. planned statistics, justification of sample size, etc.).

Sample Size

In order to optimize the group's cohesion while retaining a level of diversity of experiences, the anticipated size of the focus group is between 6-8 participants, including the principal researcher (Corey et al., 2014).

Preparation of Data for Analysis

The principal researcher will prepare recorded data from spoken conversations sources noted above for analysis by cross-checking mechanical transcriptions against digital recordings for accuracy and completeness. Corrections to the transcriptions will be made in order to download these transcriptions into a commercially available data analysis software package. The field and fieldwork journals will be reviewed by the principal researcher for accuracy and completeness on a weekly basis. Artifacts produced by the working group will be reviewed by the working group for accuracy and completeness.

Data Analysis

Demographic Data

Demographic information from initial interviews of working group members will be manually entered by the principal researcher into a commercially available statistical program. Descriptive statistical data will be produced to provide a demographic profile of the working group.

Transcription and Data Analysis Software

Voice recordings will be transcribed using a commercially available transcription software (Microsoft Word). Interview transcriptions will form one block of data to be analyzed, and transcriptions of working group meetings will form a second block of data to be analyzed. Transcriptions will be loaded into a commercially available data analysis software package. Field journal entries will be transcribed by the principal researcher and loaded onto the data analysis software by the principal researcher. These entries will form a third block of data to be analyzed. Artifacts will be catalogued and linked electronically to digital images of the artifact. This collection of artifacts will form a fourth block of data to be analyzed. Fieldwork journal entries will be transcribed by the principal researcher and loaded onto the data analysis software by the principal researcher. These entries will form a fifth block of data to be analyzed.

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Initial Data Review

The blocks of data will be reviewed by the principal researcher for completeness, accuracy, and chronological ordering. Any errors, gaps, duplications, or other needed corrections to the data blocks will be made by the principal researcher. The principal researcher will prepare and preserve marginal notes on transcripts based on the initial data review and will prepare an initial emergent qualitative codebook for each of the four blocks of data (Creswell & Clark, 2011).

Data Coding Procedure

Data from the five blocks will be classified, coded, and analyzed. Coding will be facilitated through the Dedoose computer program, conducted by the principal researcher. The coding will occur sequentially by block (Appendix K). The first block of data, consisting of interview transcripts, will be coded in two formats. For demographic information such as ethnicity, gender identification, number of episodes of homelessness, and hospitalizations, pre-set numeric codes developed by the principal researcher will be used. For additional information such as experiential descriptions, attitudes, beliefs, and goals, descriptive emergent codes will be developed by the principal researcher.

The results of collecting and analyzing this first block of data will be a demographic and experiential profile of the initial pool of prospective focus group members, as well as a thick history for the final members of the working group. While primarily descriptive, this data has the potential to generate insights into patterns, similarities, and themes in the group that comes together to participate in the action research project. This can contribute to interpretations and insights and adds to trustworthiness by helping quantify the degree of variation in the sample (Merriam & Tisdell, 2016).

For the second, third, and fourth blocks of data, analysis will be facilitated through the Dedoose computer program and conducted by the principal researcher. This coding process will utilize interpretative phenomenological analysis (IPA). As a theoretical and practical approach, IPA is in concordance with the principles underpinning participant action research by focusing on the lived experience of the process and people conducting it (Merriam & Tisdell, 2016). Applied to PAR, this phenomenological coding and analysis will incorporate the how of the experience, including the processes, stages, actions, and outcomes (Merriam & Tisdell, 2016).

The fifth block of information is sourced from artifacts produced by the working group. This data will be loaded as digital images or descriptions thereof, onto Dedoose and will be coded by the principal researcher using a combination of descriptive information such as type of artifact and use of emerging codes. These codes will then be organized into themes that will be reviewed by the working group and included in the summary analysis.

Group Review of Themes

In PAR, one facet of data analysis is conducted by the working group through a recursive, braided process that in itself is a form of meaning-making (McIntyre, 2008; Herr & Anderson, 2015). The epistemological core of PAR is that knowledge comes through action (Pedler & Burgoyne, 2008). The proposed study will both generate actions to analyze and engage in a recursive process of analytic inquiry. The group will inquire about knowledge and meaning that has emerged from their processes and actions (McIntyre, 2008).

In PAR, analysis of action steps occurs through a purposeful reflective cycle designed to critique, learn and build from these actions (Herr & Anderson, 2015). Analyzing this information will be conducted collectively through group reviews of themes, implications and forward movement (Herr & Anderson, 2015).

This feedback loop is a primary form of data analysis within PAR (Cahill, 2007). As transparency and genuine

collaboration are determinants of the quality of data analysis in this stage (McIntyre, 2008), the lead investigator will emphasize sharing of information and resources with co-participants throughout the process as part of the collective data analysis. To enable this collective data analysis, bullet point written summaries of previous sessions will be presented and discussed at each focus group meeting. This information will be reviewed against the research questions and may generate additional lines of inquiry (Merriam & Tisdell, 2016).

In addition, the IPA coding of data blocks 2-4 and descriptive coding of data block 5 will generate themes which will be organized, categorized, and recorded by the principal researcher and reviewed with the group during the final working group meetings (Merriam & Tisdell, 2016; Swantz, 2008).

Summary Data Analysis

In PAR, data analysis incorporates not only the action step of what happened, but also a review of how it happened (Merriam & Tisdell, 2016). The research questions posed at the outset will be directed toward positive changes in conditions that are important to the co-participants. Accordingly, a summary analysis conducted democratically by the working group will address the pragmatic value of the project itself (McCleod, 2011). This analysis will be conducted by co-participants in the course of the focus group, as well by the principal researcher through a review of coded transcripts. Findings will be reviewed by co-participants for completeness and accuracy. The results of these sessions will be a summary analysis prepared by the principal researcher and reviewed by the working group.

The second element of summary data analysis will be conducted by the principal researcher. Using a critical theoretical lens, the principal researcher will interpret the data from the contextual perspective of structural systems and normative dynamics of power (Merriam & Tisdell, 2016). Particular attention will be paid to the themes emerging from the fieldwork journal in order to illustrate elements of positionality and power dynamics as observed and experienced by the principal researcher. Findings and conclusions from this second axis will be shared and discussed with working group participants.

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Alternative Procedures: Describe any alternatives to participating in the research (e.g., standard of care treatment, etc.). Any standard treatment that is being withheld must be disclosed. This information must be included in the consent form.

Will subjects be followed after their active participation is complete? **N** If yes, explain why and describe how:

Will subjects have access to the study treatment/procedure after completing the study? **N** If yes, explain why and describe how:

Do any of the following apply:

- i. Will subjects be audio recorded? **Y**
- ii. Will subjects be videotaped? **N**
- iii. Will subjects be photographed? **N**

If yes to i, ii or iii, explain the collection process and use in the context of this research of such media.

(Explicit consent must be obtained for use of these methods for Expedited and Full Board studies.)

Individuals declining to participate will continue to be afforded all services available at The Haven, and participation in the proposed study will not result in the withholding of any standard treatment or services.

Interviews and focus group sessions will be recorded using an audio taping and storage device with a backup system. These recordings will be transcribed, using a commercially-available transcription program, with transcriptions checked for accuracy by the principal researcher. This data will be kept in a password-protected file on a secure data storage system. Participant names will be encoded with a key list saved on a secure storage medium. This instrumentation is suggested as appropriate for interview and focus group data recording (Merriam & Tisdell, 2016).

***** Subject Population (a-f) *****

How many subjects do you intend to enroll and/or how many subject records do you intend to access?

Subjects

Minimum # of Subjects **4**

Maximum # of Subjects **10**

Records N/A

Minimum # of Records Maximum # of Records

Inclusion and Exclusion Criteria (e.g., Participants must have 20/20 vision, Participants must be 30-45 years of age, etc.)

Identify inclusion criteria. **Minimum age: 18**

Identify exclusion criteria. **None**

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c) What is the rationale for studying the requested group(s) of participants?

The realms of experience most salient to the proposed study and sought in the initial screening include a history of multiple episodes of homelessness, a history of mental illness and/or substance use disorder, and a history of interactions with social services agencies and health care systems as a result of these factors. Interviewees with this experience set who are willing to join the focus group will be eligible for participation in the action research project. One goal of the recruitment process is to achieve diversity in the working group. This, among other things, will support generalizability of findings (Merriam & Tisdell, 2016). The shelter's clients represent a diverse population with respect to age, race, gender, sexuality, and ethnicity, and it is anticipated that the working group will reflect this diversity.

4. d) If women, minorities, or minors are intentionally excluded, a clear compelling rationale must be provided. Examples for N/A not including minors: disease does not occur in children; drug or device would interfere with normal growth and development; etc.
5. e) State if any of the subjects are your students, employees, or laboratory personnel. Please explain how subjects will be N/A protected from coercion and undue influence.
6. f) Expertise is required for all personnel listed on the project. Please describe the expertise you have, or have access to, which prepares you to conduct research in this location and/or with this subject population, including specific qualifications (e.g., relevant coursework, background, experience, and training). Also, explain your knowledge of local community attitudes and cultural norms and cultural sensitivities necessary to carry out the research (e.g., differences with U.S. culture).

5. Subject Population

7. g) Will bilingual or multilingual subjects be recruited? [N](#)
8. h) Will non-English speaking subjects be recruited? [N](#)

If yes, state language(s) spoken (other than English):

9. i) Will subjects be less than 18 years of age? [N](#)
10. j) Describe any planned screening procedures. Attach your screening document(s) (e.g., health history questionnaire) in the Attachment

Section (#16).

*** * * Recruitment Process, Subject Compensation and Costs * * ***

The principal researcher has completed all required coursework toward the degree of doctor of philosophy in counselor education and supervision in the graduate psychology department at James Madison University. This coursework includes research techniques, inferential statistics, and mixed-methods research. In addition, the principal researcher previously completed a thesis on homelessness and models of care in partial fulfillment of an educational specialist degree at James Madison University. The principal researcher has worked as a volunteer and as a resident in counseling for a combined total of over six years at The Haven, and is deeply familiar with local community attitudes, cultural norms and sensitivities necessary to carry out the research with this population. There are no planned screening procedures. Potential participants over the age of 18 years are welcome to be interviewed by the principal investigator.

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6. Recruitment Process:

a) Describe the step-by-step procedures for identifying and recruiting potential research subjects or requesting pre-existing data or materials.

- - List any specific agencies or institutions that will provide access to prospective subjects.

- - Identify who will contact prospective subjects and how.

Co-participants in this project will be sourced from the shelter's client base, which implies a target population of 100-120 people, of whom approximately 80 visit the shelter on any given day. This clientele comes into the day shelter from a range of overnight situations, including sidewalks, doorways, or other ad hoc arrangements, encampments in wooded areas around the outskirts of town, night shelters including the Salvation Army and a floating night shelter operating out of church basements in colder months, temporary housing in hotels with friends, or in permanent housing. This offers a diversity of experiences with homelessness, including current, recent, recurring, and past homelessness.

The primary data for this study will be collected from clients of the shelter. Potential participants will be identified through three avenues: open recruitment by means of flyers posted inside the shelter (Appendix D), the principal researcher's familiarity with the shelter's clientele, and through a combined criterion and snowball sampling approach to referrals from clients known to the principal researcher and recommendations from senior staff members at the shelter. The realms of experience most salient to the proposed study and sought in the initial screening include a history of multiple episodes of homelessness, a history of mental illness and/or substance use disorder, and a history of interactions with social services agencies and health care systems as a result of these factors. Interviewees with this experience set who are willing to join the focus group will be eligible for participation in the action research project.

Once potential participants have been identified, an initial interview will be conducted by the principal researcher to ascertain suitability and interest in joining the working group. The criteria for suitability will include experiences of homelessness, mental health issues and/or substance use problems, and a willingness to participate in the working group. The semi-structured interview is widely-viewed as an appropriate instrument in qualitative research design (see, for example, Creswell & Clark, 2011).

b) Planned Subject Identification Methods:

N/A

Chart/database review Class participants

X Circumstance (e.g., homelessness) Organization mailing lists

X Other (please specify): PI's familiarity with population

c) Planned Recruitment Materials/Methods:

N/A

Phone Scripts

Television ads

Letters to prospective subjects Oral Scripts

Internet ads/postings

Face to face interactions Other (please specify):

Direct advertising

Living conditions (e.g., nursing home residents) From PI's own class/lab

X Referrals

JMU Subject Pool

X Flyers/posters

Letters to providers/schools/organizations Newspaper ads

Radio ads

PowerPoint presentations

Email

JMU Subject Pool

**All advertising must be submitted for review in its final printed/recorded form.
Note: Attach copies of ALL recruitment materials in the Attachment Section.**

7. Subject Compensation and Costs:

All compensation provided to participants must comply with the JMU Financial Procedures

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1. a) Will subjects receive compensation for participation? Total amount (in dollars or equivalent) **NO**
2. b) Form of Compensation:

Cash

Check Prepaid card Voucher

c) Describe the compensation plan, including when subjects will be paid and whether payment will be prorated.

d) For random drawings include the number of prizes, nature and value of each prize.

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5. e) If extra course credit is offered be sure to address the alternative means by which students can accrue extra course credit should they not wish to participate in the study.
6. f) Will subjects or their health care providers be required to pay for any study related procedures or products?

i. If yes, explain:

g) Who is responsible for costs incurred due to injury/harm?

8. Risks

Minimal risk means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

a) PI's evaluation of the overall level of risk:

X Minimal (everyday living)

> Minimal (greater than everyday living)

b) Describe all known risks or discomforts associated with study procedures whether physical, psychological or social (e.g., pain, stress, invasion of privacy, breach of confidentiality) noting probability and magnitude of potential harm. Specify the risk(s) associated with each research procedure or test.

Random drawing Course/extra credit Reimbursement only

Other (please specify)

There is a moderate probability that participating in the interview may expose individuals to psychological stress as they relate information regarding their circumstances. There is a moderate probability that participation in the working group may expose members to mild psychological or social stress due to the interactive and action-oriented nature of the process.

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Describe the procedures or safeguards in place to protect against or minimize potential risks (e.g., referral to psychological counseling resources).

How will subjects be assessed for adverse events?

Is there a plan to monitor study data for subject safety? N If yes, discuss who will monitor the study data and describe the monitoring plan:

Benefits

Discuss any potential benefits that would justify involvement of subjects in this study.

- i. Direct benefits to subjects: (if applicable)
- ii. Indirect benefits to society:

Explain how the potential benefits justify the potential risks involved in participation in this research.

*** Procedures to Maintain Confidentiality ***

The principal investigator is responsible for safeguarding against risks and is trained to identify and de-escalate psychological and social stress. Additional resources are available to participants through no-cost community counseling services.

Subjects will be assessed by the principal researcher during and subsequent to the interview, as well as through observation and follow-up, if needed, with working group members following group meetings.

10. Procedures to Maintain Confidentiality

Which of the following types of data will you work with:

Identifiable Information is considered to be identifiable when it can be linked to specific individuals by the investigator(s) either directly or indirectly through coding systems, or when characteristics of the information obtained are such that by their nature a reasonably knowledgeable person or investigator could ascertain the identities of individuals. Therefore, even though a dataset may have been stripped of direct identifiers (names, addresses, student ID numbers, etc.), it may still be possible to identify an individual through a combination of other characteristics (e.g., age, gender, ethnicity, and place of employment).

Anonymous Data are anonymous if no one, not even the researcher, can connect the data to the person who provided it--no identifying information is collected from the individual. Investigators must be aware, however, that even if no direct identifiers (name, address, student ID, etc.) are collected, identification of a participant may be possible from unique individual characteristics (indirect identifiers). For example, a participant who is a member of a certain ethnic group or who was studied because of distinctive personal accomplishments or medical history might be identifiable from even a large data pool.

De-identified If the dataset has been stripped of all identifying information and there is no way that it could be linked back to the subjects from whom it was originally collected (through a key to a coding system or by any other means). Note: This also applies if the source of

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from whom it was originally collected (through a key to a coding system or by any other means). Note: This also applies if the source of the data is identifiable but the data collected is not.

X Coded This refers to data that have been stripped of all direct subject identifiers, but in this case each record has its own study ID or code, which is linked to identifiable information such as name or medical record number. The linking file must be separate from the coded data set. This linking file may be held by someone on the study team (e.g. the PI) or it could be held by someone outside of the study team (e.g. researcher at another institution). A coded data set may include limited identifiers under HIPAA. Of note, the code itself may not contain identifiers such as subject initials or medical record number.

If information derived from the study will be provided to the subject's personal physician, a government agency, or any N/A other person or group (other than the research team), describe to whom the information will be given and the nature of the information, if applicable.

Explain how you will protect subjects' privacy. Note: Privacy refers to persons and their interest in controlling the access of others to themselves. For example, based on their privacy interests people want to control:

The time and place where they give information.

The nature of the information they give.

The nature of the experiences that are given to them. Who receives and can use the information.

For example, persons might not want to be seen entering a place that might stigmatize them, such as a pregnancy-counseling center that is clearly identified as such by signs on the front of the building. Please keep this definition in mind as you respond to this item.

Describe how you will maintain the confidentiality of subjects' information. Note: Confidentiality pertains to the treatment of information that an individual has disclosed in a relationship of trust and with the expectation that it will not be divulged to others (without permission) in ways that are inconsistent with the understanding of the original disclosure. Please keep this definition in mind as you respond to this item.

Interviewees and working group members will be drawn from clients at The Haven and all meetings will be held on premises in private rooms. Participants will be informed verbally and in writing that their participation is voluntary and can be terminated by them at any time, that they are not required to share any information, and they will be given written and verbal descriptions of the experiences involved in the proposed study. Participants will also be advised of who will receive and can use the information generated by the proposed study.

c)

Interviews and focus group sessions will be recorded using an audio taping and storage device with a backup system. These recordings will be transcribed, using a commercially-available transcription program, with transcriptions checked for accuracy by the principal researcher. This data will be kept in a password-protected file on a secure data storage system. Participant names will be encoded with a key list saved on a secure storage medium. This instrumentation is suggested as appropriate for interview and focus group data recording (Merriam & Tisdell, 2016).

Artifacts produced during the course of the study will be physically preserved in a locked cabinet in the principal researcher's possession and images will be digitally recorded and will be stored in a secure data storage medium. Following conclusion of the study, physical artifacts may be distributed to working group participants, community organizations, or other entities wishing to preserve or, with unanimous agreement of working group members, display them.

Each interviewee will be given a randomly generated four digit code, and the key will be kept by the principal researcher in a password-protected Excel file with a paper copy kept in a locked file cabinet in the possession of the principal researcher. Audiotapes and digital transcripts of interviews will be kept in a password-protected digital file, accessible solely to the principal researcher, with the interviewee's name substituted for their four digit code.

Audiotapes and digital transcripts of focus group meetings will be kept in a password-protected digital file accessible solely to the principal researcher. Following conclusion of the study, all interview records and the code will be stored in this manner by the principal researcher for a period of not less than five years. The field journal will be created using pen and paper and will be kept in a locked file cabinet in the principal researcher's possession, and after conclusion of the study, will be stored in this manner by the principal researcher for a period of not less than five years.

The fieldwork journal will be kept in a locked file cabinet in the principal researcher's possession, and after conclusion of the study, will be stored in this manner by the principal researcher for a period of not less than five years.

Use of names, identifying features, or other likenesses will be contingent on the co-participant's express written consent.

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N/A

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4. d) Who will have access to study records or specimens? Please identify specific team members by name.
5. e) If you plan to use existing data, records or specimens, what is the source of the data/records/specimens, and how will you access them? NOTE: "Existing" means data or specimens collected (i.e., on the shelf) prior to the IRB application submission. It includes data or specimens collected for research and non-research activities. If not applicable, type N/A in the space provided below.
6. f) How will subjects be asked to provide their permission for release of identifiable data collected as a part of this proposed research (e.g., pictures, recordings, responses to research questions), now or in future? Explain and include appropriate statements in consent materials. If not applicable, type N/A in the space provided below.
7. g) If using existing data/biological specimens, will the researchers have access to a code linking the data to personally identifiable information? If not applicable, type N/A in the space provided below.
8. h) If the data is coded, explain where the key to identifiers will be stored, how it will be protected, and who will have access to it. If not applicable, type N/A in the space provided below.
9. i) Explain why, where, in what format, and for how long data/specimens will be retained.

11. Consent Information

11 a & b only apply to Exempt applications. If this application for this protocol is not marked Exempt, please answer N/A to questions a) and b) below.

1. a) How will subjects be informed of procedures, intent of the study, and potential risks to them?
2. b) How will subjects be informed they may withdraw at any time without penalty?

Note: Attach, in the Attachments Section, written and/or verbal instructions the subject will receive.

John Rogers, principal investigator

Amanda Evans, chair of dissertation committee Deborah Sturm, member of dissertation committee Eric Cowan, member of dissertation committee

Use of names, identifying features, or other likenesses will be contingent on the co-participant's express written consent. Such consent will be taken by the principal investigator through direct contact with the subject.

N/A

Participant names will be encoded with a key list saved on a secure storage medium accessible solely by the principal investigator.

Digital data will be retained by the principal investigator on password-protected digital storage media for not more than five years following the end of the proposed study. Other data including field and fieldwork journals and artifacts will be stored by the principal investigator in a locked file cabinet in the principal investigator's possession for not more than five years following the end of the proposed study. The duration of records maintenance is to comply with any and all laws, codes, and professional guidelines regarding preservation of research data.

Please provide consent process background information below.

Potential participants will be informed about the study through a pre-interview meeting with the principal researcher. In this setting, the principal researcher will provide a verbal description of the study, its purpose, logistical aspects, confidentiality considerations, potential risks, and other details. In addition, a written summary of the project containing this information will be given by the principal investigator to potential participants.

The principal investigator will inform, both verbally and in writing, that they may withdraw from the interview or working group at any time without penalty.

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12. Assent Background

(You do not have the option to modify this page if you did not select this option on the Subject Checklist).

Assent Document: A form or script of the information that will be conveyed to the child about the study. In general, researcher must obtain the affirmative agreement of children ages seven years and older for their participation. Assent forms should be written at a level understandable to the child. If the study includes a broad age range of children, more than one assent form may be needed (i.e., an assent form suitable for a 17 year old is not usually suitable for a 7 year old child).

Assent Waiver: No child assent will be sought at all. This means that the IRB is asked to waive the requirement for child assent. Among other circumstances, this option is appropriate when the capability of the child to understand the research is too limited or when the research holds out a prospect of direct benefits that is important to the health or well-being of the child.

All minors must provide an affirmative consent to participate by signing a simplified assent form, unless the Investigator(s) provides evidence to the IRB that the minor subjects are not capable of assenting because of age, maturity, psychological state, or other factors.

See sample consent/assent forms at <http://www.jmu.edu/researchintegrity/irb/forms/index.shtml>

Provide assent process background information, in the space below, for each Assent Form, Alteration Form (i.e., Cover Letter or Verbal Script), and Waiver.

13. Health Insurance Portability and Accountability Act (HIPAA)

The HIPAA Privacy Rule establishes the right of an individual to authorize a covered entity, such as health plan, health care clearinghouse or health care provider, to use and disclose his/her Protected Health Information (PHI) for research purposes.

The Privacy Rule defines the elements of individual information that comprise PHI and establishes the conditions under which PHI may be used or disclosed by covered entities for research purposes. It also includes provisions to allow an individual's PHI to be disclosed or used in research without the person's authorization (i.e., IRB Waiver of HIPAA Requirement Authorization).

Protected Health Information (PHI) is health information with one or more of the following identifiers. For more information see: http://privacyruleandresearch.nih.gov/clin_research.asp or consult HIPAA Privacy Rule for Research

Research which involves the use of de-identified data is exempt from HIPAA requirements. In order to be de-identified data, NONE of the subject identifiers listed below can be collected, used, reviewed, recoded, accessed or disclosed.

Please review the following list and indicate if any of the information will be collected from any medical records for the purpose of this research project.

1. Names
2. Social Security Numbers
3. Telephone Numbers
4. All geographic subdivisions smaller than a state, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code, if according to the current publicly available data from the Bureau of the Census;

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- i. The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and
- ii. The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.
5. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older.
6. Fax Numbers
7. Electronic Mail Addresses
8. Medical Record Numbers (MRN)

- You must attach a data collection sheet identifying the data points being collected from the MRN

9. Health Plan Beneficiary Numbers
10. Account Numbers
11. Certificate/License Numbers
12. Vehicle Identifiers and Serial Numbers, including License Plate Numbers
13. Device Identifiers and Serial Numbers
14. Web Universal Resource Locations (URLs)
15. Internet Protocol (IP) Address Numbers
16. Biometric Identifiers, including Finger and Voice Prints
17. Full Face Photographic Images and any Comparable Images
18. Any other unique identifying number, character, or code (note this does not mean the unique code assigned by the Investigator(s) to code the research data)

14. Drugs and Devices

You do not have the option to modify this page if you did not select this option on the Subject Checklist.

15. Potential Conflict of Interest

Please refer to the Help screen for definitions of terms and the link to the JMU Conflict of Interests policy.

Conflict of Interest: Please check Yes or No for each item below.

1. a) Does the research involve a drug, device, or biological invented by you, an immediate family member or other research personnel?
2. b) Is the research sponsored by an entity with which you, an immediate family member, or other research personnel have a paid consulting or advising relationship?
3. c) Will you, members of your immediate family, or other research personnel receive special compensation or increased compensation if the research generates a favorable outcome?
4. d) Will you, members of your immediate family, or other research personnel receive any money, gift or anything of monetary value above and beyond the actual costs of enrollment, conduct of the research, and reporting on the results, including, but not limited to, finders fees, referral fees, recruitment bonuses, and an enrollment bonus for reaching an accrual goal or similar types of payments?

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payments?

5. e) Do you, members of your immediate family, or other research personnel have any other interests or relationships (including volunteer services) that might constitute a conflict of interest or an appearance of conflict of interest in connection with the research project?
6. f) Will the payment you receive for services provided during the conduct of the research (e.g., investigator and research personnel time and tests) be inconsistent with fair market value for those services?

Significant Financial Interest: Please check Yes or No for each item below.

7. g) Will you, your immediate family members or other research personnel receive salaries, royalties and/or other payments for services (e.g., consulting fees, honoraria, research design, management position, independent contractor, service on advisory or review committees, board membership seminars, lectures or teaching engagements when totaled together exceeded \$5,000 during the previous 12 months or are expected to exceed \$5,000 over the next 12 months)? This excludes reasonable costs of conducting the research, as specified in the research agreement.
8. h) Do you, your immediate family members, or other research personnel hold any ownership interests including stocks, bonds, or stock options that exceed \$5,000 and/or that constitute more than a five percent (5%) ownership interest in the sponsoring organization? This does not include any interests held solely by reason of investment in a business by a mutual, pension or other institutional investment fund over which the investigator and/or his or her immediate family do not exercise day-to-day control of investment decisions.

Minimizing Risks and Disclosure to Subjects

i) Have you disclosed any actual, potential or perceived conflicts of interest in the consent form? Research Personnel are required

to disclose all such conflicts to all research participants in the research consent form.

j) What steps, if any, have you taken or will you take to manage the conflict of interest and minimize the risks associated with any actual, potential or perceived conflicts of interest arising out of this research?

If you checked Yes to any statement (a-h, except f) above, please identify the research team member(s) below and provide details concerning the potential conflict of interest.

By submitting this form, you are attesting that you have read the Conflict of Interests Disclosure for Sponsored Programs Policy # 2203 and agree to abide by its terms. You are agreeing to update this disclosure form when new or changes in conflict of interest arise, and that you will comply with any conflict management plan required by the Conflict of Interest (COI) Committee to manage, reduce, or eliminate any actual or potential conflict of interest for the duration of research.

Link to JMU's Conflict of Interest Policy: <https://jmu.edu/JMUpolicy/policies/2203.shtml>.

16. Attachments

Attach relevant -

documents here. These could include:

Collaborating Investigator's IRB approval and approved documents

Conflict of Interest information

Debriefing Script

Grant/Sub-contract

HIPAA Authorization Form from HIPAA-covered entity

Interview/Focus Group Questions

Investigator's Brochure

Letters of Agreement/Cooperation from organizations who will help with recruitment Methodology section of associated Thesis or Dissertation project

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- - Questionnaires
- - Recruitment Material (e.g., flyers, email text, verbal scripts)
- - Sponsor's Protocol
- - Surveys
- - Other files associated with the protocol (you can upload most standard file formats: xls, pdf, jpg, tif, etc.)

To update or revise any attachments, please delete the existing attachment and upload the revised document to replace it.

| Document Type | Document Name | Attached Date | Submitted Date |
|---|---|---------------|----------------|
| Interview/Focus Group Questions | Interview Questions for IRB | 05/21/2020 | |
| Letter of Agreement/Cooperation | Informed Consent Rogers | 05/21/2020 | |
| Recruitment Material (e.g., flyers, ads, e-mail text) | Flyer | 05/21/2020 | |
| Cooperating Institution's IRB Approval | Site Permission Letter | 05/21/2020 | |

Obligations

Obligations of the Principal Investigator include the following:

Provide all subjects a copy of the signed consent form, if applicable.

Modifications - Changes in any aspect of the study (for example, project design, procedures, consent forms, advertising materials, additional key personnel or subject population) will be submitted to the IRB for approval before instituting the changes.

Training - Human subject training certificates, including those for any newly added personnel, will be provided for all key personnel. Training must be updated every three years.

Final Report - The IRB will be notified when the study is complete.

I certify that I have reviewed this application, including attachments and that all information contained herein is accurate to the best of my knowledge. I agree to report any substantive changes to the information contained in this application immediately to the JMU IRB.

I agree to not enroll any subjects or collect any data intended only for research use prior to issuance of an IRB approval.

I understand that I am fully responsible for the execution and management of this study and that I am responsible for the performance of any subinvestigators or key personnel including their adherence to all of the applicable policies and regulations.

This study will not begin until the investigator receives written final approval or determination of exemption.

Submit the Continuing Review Form in order to maintain active status of the approved protocol. This form must be submitted to the IRB prior to the date of expiration.

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Submit the Protocol Violation Form to report protocol Deviations/Violations or the Event Reporting Form to report Adverse Events (AEs) or Unanticipated Problems that occur in the course of the protocol.

☒ The Principal Investigator has read and agrees to abide by the above obligations.

Please click 'Next' to check for completeness to your right to continue to the next step. If the protocol is complete and ready for submission,

please click "Submit Form" to your right to submit your protocol for IRB Review. If the project involves multiple students (must select one):

The Principal Investigator certifies that signed email consent has been obtained from all student researchers and is on file. N/A - this project does not involve multiple students.

05/20/2020 NEW FORM CREATED John Rogers

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Table 1: Working Group Meeting Schedule

| <i>Meeting Date</i> | <i>Meeting Time</i> | <i>Attendees</i> |
|---------------------|---------------------|---|
| 9/16/20 | 1:00 pm | Participants 1,2,3,4, principal researcher |
| 9/23/20 | 1:00 pm | Participants 2,3,4,5, principal researcher |
| 9/30/20 | 1:00 pm | Participants 1,2,3,4,5, principal researcher |
| 10/7/20 | 1:00 pm | Participants 1,2,3,4, principal researcher |
| 10/14/20 | 1:00 pm | Participants 1,3,4, principal researcher |
| 10/21/20 | 1:00 pm | Participants 2,3,4, principal researcher |

Table 2*Emerging Data Themes*

 Impact of human connection

Services for people experiencing homelessness

Experience of addiction/mental illness

Experience of homelessness

Independence

Giving back

The experience of the current study

Chaotic childhood

Action project

Accomplishment, positivity

Isolation, loneliness

Support system

Patience, small steps

Relationship with family

Meanings of yes, no, maybe

Shame

Ingratitude, expecting handouts

Extended periods of homelessness

See me, love not acts

Exploitation

Hard work

Rejection

I'm still human

The shock of change

Racism

Note. Themes are listed by number of references, listed from greatest to least.

Table 3*Primary Codes*

| |
|--|
| Personal achievement and agency |
| The positive impact of personal connection |
| Meaning-making through this project |
| The trauma of mental illness and addiction |
| The trauma of homelessness |
| Systems of care and institutions that are helpful |
| I need to protect and nurture my wellness and recovery |
| Patience and small steps |
| We all need help sometimes |
| Domestic chaos |

Table 4*Major Themes and Sub-headings*

| |
|--|
| The Trauma of Homelessness, Addiction and Mental Illness |
| Domestic Chaos as a Contributor |
| The Trauma of Homelessness |
| The Trauma of Addiction and Mental Illness |
| Power of Personal Connection |
| We All Need Help Sometimes |
| Help When Times are Dark |
| Help from a Trusted Person |
| Help Me by Seeing Me |
| My Support System Keeps Me from Falling Back |
| I Have Become a Helper |
| Organizations Can Help |
| Personal Agency and Achievement |
| I Need to Do This My Way |
| I Can Survive This |
| Patience and Small Steps |
| Staying in My Lane |
| I Have Power |
| I Need to Protect and Nurture My Recovery |
| Meaning Through Action |
| Empowerment |

Opportunity

Community

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