The core features and perceived value of family support for ethnoracial homeless individuals with mental illness: Findings from the At Home/Chez Soi Project

by

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A thesis submitted in conformity with the requirements for the degree of Masters of Science
Institute of Health Policy, Management and Evaluation
University of Toronto

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Abstract

Objectives: To determine the core features and perceived value of family support for racialized homeless individuals with moderate mental illness.

Methods: Descriptive qualitative exploratory study using grounded theory method. Semi-structured individual interviews were conducted with participants in the intervention and control groups of the At Home/Chez Soi Project. One focus group each of family members and service providers caring for this group were conducted.

Results: Family relationships were valued and were often a source of emotional, financial, and instrumental supports. Several barriers to family support including negative past family experiences and geographical distance were identified. Findings cautiously supported family involvement in service provision, emphasizing consideration of consumer choice and autonomy, family dynamics, consumer needs, and family needs.
Conclusions: Families may play an important role in supporting the well-being of this population. Several important factors including consumer choice and autonomy may require consideration when engaging families in service provision.
Dedication

I dedicate this thesis to my wonderful family for their endless support, inspiration, and encouragement. You are the foundation that makes all things possible in my life.
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Chapter 1
Introduction

1 Introduction

1.1 Background to the Problem

Over 5000 homeless individuals use shelters in Toronto each night, and approximately a third of these individuals suffer from serious mental illnesses such as schizophrenia (Folsom & Jeste, 2002; Shelter Support and Housing Administration, 2010). One third of Toronto’s homeless population are immigrants and 10% of homeless Torontonians have been in Canada for less than 10 years (Mental Health Commission of Canada, 2010).

It is often assumed that homeless individuals do not have family contact or support (Lemos & Durkacz, 2002). However, family relationships are likely of particular importance for racialized homeless individuals. The literature suggests that ethno-cultural minority groups have strong family involvement in health care and health related decision making (Blackhall, Murphy, Frank, Michel, & Azen, 1995; Braun & Mclaughlin, 1998; Chow et al., 2010). In addition, the family centered care model, which presents families as critical to support and care, has been recently proposed in the literature as a best practice model for treating adults with mental illness (MacFarlane, 2011). However, the stigma associated with mental illness can be exacerbated by cultural beliefs of mental illness and may result in less availability of family support for racialized individuals (Hussain & Cochrane, 2002). Additionally, there are mixed findings on the influence of family support on mental health among homeless individuals, with families playing a role in both pathways into and out of homelessness (Canadian Institute for Health Information,
2007; Caton et al., 1994, 1995; Clarke, Williams, Percy, & Kim, 1995; L. Dixon et al., 1998; Horvitz-Lennon et al., 2009; Lam & Rosenheck, 1999; Tessler, Gamache, Rossi, Lehman, & Goldman, 1992; Toro et al., 1999).

As illustrated in Figure 1 below, existing literature suggests that family support can play a significant and often positive role in mental illness, homelessness and in the health of racialized communities. However, where these marginalized identities intersect, the role of family support becomes more complex and less clearly delineated.

![Figure 2 Model of existing literature regarding family support and homelessness, mental illness, and racialization respectively.](image)

Despite growing mental health and housing needs among people from racialized communities, in Canada there is a lack of culturally appropriate housing and support services for...
racialized individuals with mental illness (Schiff, Schiff, & Schneider, 2010). Existing services tailored specifically for racialized individuals with mental illness often emphasize family involvement in the care model (Chow, Law, & Andermann, 2009; Mount Sinai Hospital, 2012; Yang et al., 2005). Given this, family support appears to play a particularly important role in mental health service provision for racialized communities and may play a similarly important role for racialized homeless individuals with mental health problems. However, the extant literature on racialized individuals coping with the intersecting burdens of mental illness and homelessness is scant and the complex role that family support may play in this context has not been explored.

1.1.1 The At Home/Chez Soi Project

This study is a sub-study within the broader At Home/Chez Soi Project. The At Home/Chez Soi Project, funded by the Mental Health Commission of Canada aimed to produce policy relevant evidence and contribute to the development of best practices for future interventions addressing mental health and homelessness in Canada. The Toronto study included approximately 560 participants randomized into intervention or "care as usual" groups. The intervention consisted of housing and support services and had two subgroups, high and moderate, reflecting the level of service need. Participants in the care as usual group had access to health and social services available in the community, while the intervention group received a rent allowance paid directly to the landlord and the opportunity to choose their own housing such that it met minimum City of Toronto standards for acceptability. This intervention is provided within the Housing First model, which provides immediate access to permanent housing and support services. The model is based on a philosophy of consumer choice, without imposing treatment adherence or maintenance of sobriety from drugs or alcohol as a prerequisite to housing (Tsemberis, Gulcur, & Nakae, 2004). Additionally, within this model, treatment and support services are provided
off-site and are not attached to housing, in order to encourage independence, community integration, and maintenance of housing.

The intervention group was divided into three arms based on the treatment strategy. High needs participants were assigned to Assertive Community Treatment (ACT) while moderate needs participants were assigned to Intensive Case Management. This study focuses on the third arm of the intervention group which provided the Ethno-Racial Intensive Case Management (ER-ICM) intervention, tailored to moderate needs participants from ethnoracial minority groups.

1.1.2 ER-ICM Intervention

The Ethno-Racial Intensive Case Management (ER-ICM) program was delivered by Across Boundaries, a mental health center serving people of colour in the Greater Toronto Area with severe mental health problems (Across Boundaries, n.d.). This arm of the intervention combined the Housing First framework with an anti-racism and anti-oppression philosophy and practice. This intervention provided basic support services as provided within the ICM model but emphasized a holistic approach to mental health care. When working with individuals with severe mental health problems, this philosophy recognizes the interdependence of spiritual, emotional, mental, physical, social, economic, cultural, linguistic and broader environmental aspects of life as well as the social determinants of health.

Participants randomized to the intervention arm, who were eligible for ICM, and who identified as a member of an ethno-racial group, were given the choice to participate in the ER-ICM intervention arm. The ER-ICM intervention provided programs that integrate peer support, skills building, social and recreational activities, support groups, alternative and complementary therapies, art and music therapy, creative expressions, community kitchen, individual support
and community. Additionally, a main goal of this model was to assist participants to build their support networks, including working with their family and friends. The ER-ICM service was also provided in different languages using interpretation services based on participant need.

1.2 Statement of the Problem

There remains a major gap in the literature on the importance of family support for racialized homeless individuals with mental illness and the value of incorporating such support into formal service models for this population. The At Home/Chez Soi project provides the ideal opportunity to study the role of family support in the context of the intersecting burdens of mental illness, homelessness, and racialization.

1.3 Research Questions

The primary objectives of this study are to answer the following questions:

1. What are the core features of family support for racialized homeless individuals with mental illness?

2. How do consumers, family members, and service providers perceive the value of family support for this population?

3. How do consumers, family members, and service providers perceive the value of incorporating family support into formal services for this population?

1.4 Relevance

It is intended that this research will serve to enrich the body of knowledge on family support in the context of racialization, homelessness and mental health care. An understanding of consumer, service provider and family perspectives on family support for this population may
help develop new or improve existing models of care pertinent to providing housing and mental health care services for racialized homeless individuals with mental health problems.

1.5 Summary

The background to the problem under investigation was presented. An overview of the pertinent aspects of the At Home/Chez Soi project were also presented, with a specific focus on the third arm Ethnoracial Intensive Case Management intervention. The problem statement and the research questions that this study aims to answer were also presented. The following chapter will present an outline of the theoretical frameworks and relevant concepts utilized by this study.
Chapter 2
Frameworks and Concepts

2 Conceptual Frameworks and Concepts

2.1 Conceptual Frameworks

There are a number of frameworks and concepts that are central to this study. The frameworks that guide this study are intersectionality and family centered care philosophy. The concepts that are pertinent to this study are homelessness, mental illness, racialization, and family support. The following section will provide an overview of these frameworks and concepts and outline how they are utilized in this study.

2.1.1 Intersectionality

While racism, mental illness, and homelessness each contribute to experiences of stigma and discrimination, the experiences of marginalization derived from membership in each group is not simply aggregative. Rather, these independent social identities intersect and form qualitatively different meanings for individuals (Warner, 2008). Intersectionality provides both a theoretical framework and methodological tool to understand the effects of multiple identities, and has been a particularly powerful tool in understanding the impact of multiple identities, such as socioeconomic status, sexuality and ethnicity, on gender (Mahalingam, Balan, & Haritatos, 2008). Increasingly, this framework has been used in psychology and public health research, within both qualitative and quantitative designs (Hankivsky, de Leeuw, Lee, Vissandjee, & Khanlou, 2011; Warner, 2008).
Intersectionality suggests that an individual’s social location is formed by the intersection of two or more social constructions of privilege and/or oppression. This intersectional understanding of social location is important to comprehend an individual’s lived experience including their actions and outcomes (Murphy, Hunt, Zajicek, Norris, & Hamilton, 2009). Mahalingam, Balan, and Haritatos outline the three principles of intersectionality as follows: “a) no social group is homogenous; b) people must be located in terms of social structures that capture power relations implied by those structures; c) there are unique, non-additive effects of identifying with more than one social group” (2008).

Further, the intersectional framework has two major assumptions; firstly, “human experience is complex and consists of ‘multiple, layered identities, derived from social relations, history and the operations of structures of power’” (Association for Women’s Rights in Development, 2004; Murphy et al., 2009) and secondly, combining multiple identities does not additively increase one’s privilege or oppression, but rather produces “substantively distinct experiences” (Association for Women’s Rights in Development, 2004). Other scholars add that a major objective of intersectionality is the pursuit of social justice in areas such as poverty and various social marginalizations (Burgess-Proctor, 2006; Collins, 2000; Hankivsky & Cormier, 2009).

In asserting that multiple categories of identity interact simultaneously to form social location, the intersectionality framework avoids essentializing individual identity categories and homogenizing the experiences of all members of a given social group (Hankivsky et al., 2010). This emphasizes that different categories of identity have within-group diversity that is important to capture (Hancock, 2007). Additionally, since intersectionality recognizes that multiple social identities are not additive, but rather create qualitatively different meanings when they intersect,
this framework is able to capture meanings at various levels of difference including institutional and individual levels (Hankivsky et al., 2010).

Intersectionality is also able to avoid what Martinez characterizes as the “Oppression Olympics” whereby different social categories are perceived to be organized into a hierarchy of oppression and therefore, compete against other social categories to gain access to resources and opportunities (Martinez, 1993). Similarly, since intersectionality examines the intersection of multiple identities, it also acknowledges that individuals can simultaneously experience privilege and oppression based on the different components of their identity (Association for Women’s Rights in Development, 2004).

Collins’ “Matrix of Domination” further expands this view of simultaneity and emphasizes that multiple identities must be examined as social relations embedded in broader systems of oppression and privilege beyond the scope of demographics (Collins, 2000). The Matrix of Domination helps to explain how multiple intersecting oppressions are organized through various domains of power including structural and interpersonal domains (Collins, 2000; Dhamoon, 2011).

The current study is informed by and adopts the principles of intersectionality. While this study does not conduct a comprehensive intersectional analysis, intersectionality informs the context within which this study has been conducted, namely examining the role of family support for individuals who experience intersecting marginalizations of homelessness, mental illness and racialization. Additionally, this study is informed by family centered care philosophy, which is discussed in the next section.
2.1.2 Family-Centered Care

Many existing models of disease management frame the family as the unit of care. Williams and colleagues examining home and community care for older adults with multi-morbidity, suggest that “the true unit of care” should be framed as the individual and the caregiver or caregivers with “support for the [caregiver] being inseparable from care for the [individual]” (2009). This concept has also been discussed significantly in nursing literature where the family is conceived as the “unit of treatment” (Whall, 1986). In the family resilience literature, families are conceived of as the “functional unit” and significant evidence suggests that family psychoeducation approaches can both address the needs of families and improve patient outcomes overall (Becvar, 2013; Chow et al., 2010; Kulhara, Chakrabarti, Avasthi, Sharma, & Sharma, 2009; Sorrell, 2014). Despite the differences in the terms utilized, the importance of family caregivers and the support provided by these caregivers is recognized in a number of different health care contexts and is broadly encompassed by the Family Centered Care (FCC) model.

The core features of the FCC model are dignity and respect, information sharing, participation, and collaboration (Baas, 2012). This model has been applied to a number of different health care settings including pediatric, geriatric, and nursing care (Baas, 2012; Caty, Larocque, & Koren, 2001; I. Coyne, Costello, Neill, & Donnellan, 2013; Donahue, Kazer, Smith, & Fitzpatrick, 2013; Johnson, 2000; Surbone, Baider, & Kagawa-Singer, 2010; Zwelling & Phillips, 2001). Firstly, within FCC the family is recognized as playing a critical role in supporting people with mental health and addictions issues and promoting their wellness. Secondly, this model acknowledges that in the process of caregiving, families experience subjective and objective stressors that are potentially harmful for their mental health. Given this
potential, the FCC model states that “[families], in their own right, require the attention of health care professionals [12]” (Centre for Addiction and Mental Health, 2004).

The FCC principles are also echoed in a recent report by the Mental Health Commission of Canada which presents a national set of guidelines on supporting family caregivers of adults with mental illness. This report recognizes the importance of family and friends who most often take on caregiving duties and support individuals in their recovery process. Additionally, the report recognizes the system level stressors and caregiver burden that can compromise the health of the family member as well and emphasizes the need for a mental health system and services that “acknowledge the importance of family caregivers, support them in their caregiving role and recognize and respond to their needs” (MacCourt, Family Caregivers Advisory Committee, & Mental Health Commission of Canada, 2013).

The current study draws on these models to explore the role of family support in the specific context of mental illness, homelessness, and racialization and the salient factors related to family support and involvement in this context.

2.2 Definition of Concepts

2.2.1 Homelessness

Homelessness in health research often refers only to individuals in the shelter system and individuals living and sleeping on the streets (absolutely homeless) (Frankish, Hwang, & Quantz, 2005). The At Home/Chez Soi Project, “defines being homeless as not having a place to stay for more than 7 nights and having little chance of finding a place to stay in the next month” (Mental Health Commission of Canada, 2012). This also includes those that are absolutely homeless or
are precariously housed. The At Home/Chez Soi Project framework further outlines these terms as follows:

“Absolutely homeless means people who are living ‘rough’, which refers to places not usually used for sleeping (such as outside on the streets, in parks, in cars, or in parking garages); staying in shelters or hostels; or leaving an institution, prison, jail or hospital with no place to stay. Precariously housed refers to people who are staying in a Single Room Occupancy (SROs), rooming houses or hotels/motels and have had been ‘absolutely homeless’ at least twice’ (Mental Health Commission of Canada, 2012). This inclusive definition acknowledges that homelessness is a complex social phenomenon that presents in many forms. The At Home/Chez Soi Project’s definition of homelessness is adopted for this study.

2.2.2 Mental Illness

Mental health and illness are defined in many ways and vary greatly based on the context and objectives of using the term. For example, the term “mental health problem” may be seen by clients or consumers as less stigmatizing and may be the preferred term when discussing personal mental health experiences with clients. This study adopts the definition of mental health problems and illnesses presented by the Mental Health Commission of Canada, which refers to mental health problems and illnesses as, “clinically significant patterns of behaviour or emotions that are associated with some level of distress, suffering or impairment in one or more areas such as school, work, social and family interactions or the ability to live independently” (Mental Health Commission of Canada, 2009).

Additionally, this study examines participants with moderate mental health needs as defined in the broader At Home/Chez Soi Project. Moderate need was assessed in the At
Home/Chez Soi Project during the randomization process and using information about mental illness diagnosis, social functioning and service utilization. These factors were assessed using the Mini International Neuropsychiatric Interview and the Multnomah Community Ability Scale administered by mental health professionals to each participant. Participants identified as having moderate needs received Intensive Case Management in which case managers provide outreach and coordinated or navigated services for clients (Goering et al., 2011).

2.2.3  Racialization

Ethnicity, race, and culture are used interchangeably in this study, but with the recognition that these are socially constructed, historically situated categories and are dynamic and change over time (Hankivsky & Cormier, 2009). Ethnicity is defined by Rummens as “population groups or categories that are characterized by shared nationality, culture, or language” (Rummens, 2003). In contrast, race is often defined as a fixed descriptor of biological difference (Dein, 2006). This study makes use of the socially constructed conception of race which situates racial identity within a social and historical context (Hankivsky & Cormier, 2009). Culture is defined in this study as being experiential, “the actualization of racial, national, religious, or other group values, traditions, and cues” (Hankivsky & Cormier, 2009). In utilizing these terms, this study will apply an intersectionality framework and avoid essentializing or homogenizing the experiences of different members of the ethnoracial groups of interest. In addition, First Nations communities are not included in this conception of racialization, given the criticism that First Nations communities face unique challenges and discrimination not only due to structural racism, but also due to ongoing colonialism of these communities (Dua, 2008). As such, the broader At Home/Chez Soi project addresses the unique burdens and lived experiences of homeless First Nations individuals through the third arm of the Winnipeg site, delivered by Aboriginal Health
and Wellness (Goering et al., 2011). At the Toronto site, the ethno-racial intensive case management intervention “includes persons who are racialized but not First Nations People,” (Stergiopoulos et al., 2012).

### 2.2.4 Family Support

For the purposes of this study, family support is defined as instrumental or emotional support derived from kinship ties. Instrumental support includes, but is not limited to, financial and housing support, and provision of food and transportation (Hwang et al., 2009). Emotional support includes, but is not limited to, acceptance, understanding and empathy (Hwang et al., 2009; P. Williams, Barclay, & Schmied, 2004).

### 2.3 Summary

This chapter presented an overview of the theoretical frameworks and relevant concepts utilized by this study. The following chapter will present a literature review of the existing theoretical and research literature on mental health, homelessness, and racialized communities and family support within each of these contexts.
Chapter 3
Literature Review

3 Literature Review

This chapter examines the theoretical and empirical literature relating to the major concepts of mental health and homelessness, racialized mental health, and racialized homelessness as well as family support within this context.

3.1 Overview of Homelessness in Canada

According to Toronto’s 2013 Street Needs Assessment, over 5000 Torontonians are homeless on any given night (City of Toronto, 2013a). This figure includes those homeless individuals that are sleeping outdoors, are using shelters, are incarcerated or are using other health facilities, but does not capture the hidden homeless. The hidden homeless are individuals who cannot afford housing but are able to stay temporarily with friends or family, and therefore are often undetected when enumerating homelessness (Canadian Institute for Health Information, 2007). While there are significant challenges involved in enumerating homeless populations, point-in-time surveys like the Toronto Street Needs Assessment provide a snapshot view of a community that is inherently dynamic and transient (City of Toronto, 2013a).

Canada’s homeless population is made up of diverse groups including single men, single women, families and youth (Hwang, 2001). Additionally, in many urban centers throughout Canada, notably in Toronto, homeless populations often consist of recent immigrants (Chiu, Redelmeier, Tolomiczenko, Kiss, & Hwang, 2009). With respect to the overall Canadian population, individuals of Aboriginal or Native origin are overrepresented in Canada’s homeless population by a factor of 10 (Hwang, 2001). Homelessness is a complex social phenomenon and
is often linked with significant health issues including increased risk of HIV, tuberculosis, oral health, respiratory conditions, and mental health (Hwang, 2001).

3.2 Homelessness and Mental Health

Mental illness is significantly more prevalent among people experiencing homelessness than among the general population (Stergiopoulos, Dewa, Durbin, & Chau, 2010). The weighted prevalence of schizophrenia among the homeless is 11% (Folsom & Jeste, 2002). Additionally, higher prevalence of schizophrenia among the homeless is associated with young age, being a single female or being chronically homeless (Hwang & Dunn, 2005). Affective disorders, which include manic or depressive episodes, are much more common among homeless individuals, with a lifetime prevalence ranging from 20-40%. Additionally, problems with alcohol are 6-7 times more predominant among the homeless than in the mainstream Canadian population (Hwang, 2001). Conversely, the presence of serious mental illness increases the risk of homelessness 10 to 20 times in comparison to the general population (Susser et al., 1997). As such, mental illness and addictions may be a pathway into homelessness. Similarly, homelessness may exacerbate existing mental health conditions or initiate the onset of mental illness. Thus, mental illness and homelessness are inter-related and often work in tandem to create barriers to care and recovery.

3.3 Racialization and Mental Health

Roughly 47% of Toronto’s population is comprised of racialized or visible minority individuals (City of Toronto, 2013b). Visible minorities are those "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour" (Statistics Canada, 2012). Recent research in the United States has highlighted mental health disparities between ethnoracial minority populations and the broader American population, highlighting that while prevalence
rates for mental illness are lower for visible minorities, mental illness tends to be more persistent
and results in greater disability among visible minorities (Primm et al., 2010).

3.3.1 The “Healthy Immigrant Effect”

However, some research suggests that immigrants to Canada tend to have better overall mental
health (Hyman, 2004, 2007). Compared to their Canadian counterparts, immigrants tend to have
lower prevalence of alcohol dependence and depression (Ali, 2002). Often, better immigrant
mental health is tied to the “healthy immigrant effect” model which suggests that immigrants
have better health overall than their native-born counterparts, but that this health advantage
declines over time (Hyman, 2004; Islam, 2013; Khanlou, 2007). However, immigrants who have
been in Canada for 15-19 years have similar rates of substance abuse and depression as their
Canadian counterparts, but curiously return to lower rates of depression at 20 or more years of
residence in Canada (Ali, 2002; Islam, 2013). With respect to suicide rates, Malenfant found that
immigrants have a significantly lower rate of suicide when compared to native-born Canadians
irrespective of gender or continent of origin, but that rates vary somewhat between different
immigrant groups when assessing suicide rates by country of origin (2004).

3.3.2 Migration related mental illness

In fact, the process of immigration itself and post-migration factors such as employment
insecurity, discrimination, and lack of social support are associated with significant stress for
new immigrants (Levitt, Lane, & Levitt, 2005; Statistics Canada, 2011). These migration and
post-migration factors may exacerbate existing mental health conditions or induce the onset of
new stress-related mental illnesses. Additionally, some research suggests that migrant category
may affect the types of stressors experienced by immigrants (Islam, 2013; Robert & Gilkinson,
2012). For example, refugees tend to report experiencing higher levels of stress and emotional
distress when compared to migrants arriving by family sponsorship who may have the benefit of social support derived from family reunification upon arrival (Khanlou, 2007; Robert & Gilkinson, 2012). Specifically, refugees who have experienced pre-migration trauma have been found to have an increased risk of mental illness (Boehnlein & Kinzie, 1995).

Thus, differences in mental health between immigrants and native-born Canadians are complex and time and context specific. As such, Khanlou and others call for a re-examination of existing paradigms around immigrant mental health and call for intersectional approaches to understanding the context-specific needs of heterogeneous immigrant communities, to better serve the diverse mental health needs of these groups (Islam, 2013; Khanlou, 2007).

3.3.3 Discrimination and Mental Health

While not all immigrants are members of a visible minority or racialized group, Asia remains the largest source country for Canadian immigrants (Statistics Canada, 2011). As such, immigrant communities are also often racialized and face discrimination-related barriers to mental health and wellness as well. Hansson et al highlight a number of factors that make immigrant, refugee, ethno-cultural and racialized (IRER) groups particularly vulnerable to mental health conditions including low socioeconomic status and income inequality. Break down of social networks in the process of migration may lead to isolation and can further exacerbate vulnerability to mental illness (E. Hansson, Tuck, Lurie, & McKenzie, 2010).

With respect to incidence of mental illness, Hansson et al demonstrate that the literature is mixed, with some studies suggesting that rates of depression are lower among first generation immigrants to Canada, highlighting the healthy immigrant effect (Ali, 2002; E. Hansson et al., 2010). However, studies examining specific IRER groups have demonstrated that depressive
symptoms are more prevalent among IRER groups compared to their non-IRER counterparts (Fenta, Hyman, & Noh, 2004; Mechakra-Tahiri, Zunzunegui, & Seguin, 2007). In a recent review Hansson et al report that the existing Canadian literature regarding IRER mental health has focused primarily on major metropolitan centres of three provinces despite a significant presence of racialized communities across Canada. They also suggest that existing literature does not capture the diversity of IRER groups in Canada (E. K. Hansson, Tuck, Lurie, & McKenzie, 2012).

3.3.4 Barriers to accessing mental health care

This concern was also emphasized in a review produced by Health Nexus and Health Equity Council which focused on health equity in racialized groups within Ontario and highlighted broad health disparities. With respect to mental health, the report demonstrated that community based research findings show that racialized populations experience discrimination, access barriers, and negative health experiences (Patychuk, 2011). Evaluating CCHS data, Gadalla also reported that South Asian individuals in particular have significant unmet mental health care needs due to a lack of access to services or lack of availability of services (2010). Some barriers to access include transportation and lack of child care services (Gadalla, 2010). In addition, health seeking behaviours may be affected by attitudes toward mental illness. Hussain and Cochrane highlight that cultural or religious beliefs regarding mental illness may deter health seeking behaviours as well (2002). Additionally, the health provider’s lack of understanding of cultural factors may play a role in barring health seeking behaviour (Miranda & Cooper, 2004).

The mental health problems of immigrants and visible minorities are exacerbated by lack of appropriate services, which accounts partially for lower usage overall of mental health services
by immigrants. As such, it is important to understand the complex relationship between mental health and racialized communities in order to better serve their needs.

3.3.5 The need for culturally competent service models

Several community-based organizations have begun to fill the growing need for culturally appropriate and relevant health services. Access Alliance Multicultural Health and Community Services Center is one such group that is focused on health promotion and increasing access to health services for immigrant and refugee populations in Toronto (Access Alliance Multicultural Community Health Centre, 2012). Another community organization, Across Boundaries, is a mental health center serving people of colour in the Greater Toronto Area with severe mental health problems (Across Boundaries, n.d.). Both adopt an anti-oppression/anti-racism framework which defines race and the experience of racialization as a social construct. The Ontario Human Rights Commission describes racialization by stating that, “society artificially constructs the idea of “race” based on geographic, historical, political, economic, social and cultural factors, as well as physical traits, that have no justification for notions of racial superiority or racial prejudice” (Ontario Human Rights Commission, 2012). The anti-oppression/anti-racism framework adopted by many community organizations serving racialized people is central to the programs and services provided by these organizations and highlights the significance of the experience of racialization and other “interlocking oppressions” on health broadly (Access Alliance Multicultural Community Health Centre, 2012).

Additionally, another Toronto-based study has focused on developing a cultural diversity model for the process of recovery from mental illness which looked at the lived experience of groups of service providers, consumers and families of consumers from Caribbean, Somali and Tamil communities in Toronto (Jacobson, Farah, & Toronto Recovery and Cultural Diversity
Community of Practice, 2010). The goal of this project was to develop relevant tools for serving ethnocultural minority groups with mental health problems, with the understanding that these populations have a unique social context which necessitates relevant and culturally appropriate services. An understanding of social support in the context of mental health, homelessness and racialization will help to shed light on the process of recovery in this context, particularly because there is a key gap in the literature with respect to the lived experience of those experiencing homelessness, mental health and also identify as ethnoracial minorities.

3.4 Racialization and Homelessness

Although surveys of street needs, such as the Toronto Street Needs Assessment, do not measure ethnoracial identity except Aboriginal identity, a recent study examining the unmet health needs and access to health care of homeless individuals in Toronto reported that nearly 45% of the homeless population in Toronto identifies as non-white, with 22% identifying as black, and 14% identifying as other race (Hwang et al., 2010). Unsurprisingly, data on racialized homelessness in Canada is scant.

3.4.1 New immigrants and housing instability

However, new immigrants and refugees to Canada are recognized as particularly vulnerable for homelessness (Golden, Currie, Greaves, & Latimer, 1999). Preston et al highlight increasing income inequality, the rising cost of owning and renting a home, and suburbanization of immigrant settlement as major factors that increase the housing challenges of new immigrants (2009). Housing stability is also emphasized as a significant first step in the settlement process but affordability is an increasing concern for refugees in particular (Murdie, 2010).
While housing stability is a major concern overall for recent immigrants and refugees, in a review of Canadian housing research, Hiebert and Mendez found that there is diversity between various ethnoracial groups with respect to housing stability. Recent immigrants from South Asian and East Asian countries had a much higher degree of homeownership in comparison to West Asian and Black immigrants, who reported having greater difficulty in locating housing (2009). As well, while the risk of homelessness is significant in this population, some evidence suggests that social capital among existing ethnoracial groups may decrease apparent rates of absolute and relative homelessness (Chan, Hiebert, Addario, & Sherrell, 2005). Thus, while immigrants and refugees are at increased risk of homelessness, the factors involved in procuring and maintaining housing for these groups and their diverse subgroups are complex.

3.4.2 Challenges of accessing housing services

Once homeless, immigrants and refugees face unique challenges related to their status in Canada including problems adjusting to a new language and culture and unique issues related to employment and legal problems (Access Alliance Multicultural Community Health Centre, 2003). In addition, the lack of culturally appropriate services and absence of services in a language that the client can comprehend makes the current shelter services inaccessible to many new immigrants and refugees (Access Alliance Multicultural Community Health Centre, 2003). Further, access to housing itself may be a challenge for racialized homeless individuals due to housing policies that ignore the effects of culture, language, and experiences of social isolation that racialized individuals experience (Greene, Chambers, Masinde, & O’Brien-Teengs, 2013).

Although immigrants and refugees may face additional challenges associated with being a racialized newcomer, interestingly, when examining stigma among diverse homeless populations, Forchuk et al found that stigma related to poverty and homelessness took
precedence over stigma related to racial or other categories of identity (2007). As such, while racialization has significant consequences to the housing stability and related challenges faced by racialized individuals, the stigma and discrimination associated with homelessness may outweigh issues of race and may be relevant to better understanding the lived experience of racialized homeless individuals.

3.5 The Importance of Family Support

3.5.1 Mental Illness and the role of family

Family members have been recognized as most often being the informal caregivers for individuals with mental health problems (Kirby & Keon, 2006). Family members may play a number of different roles in the lives of individuals with mental health problems, including acting as an informal case manager, supporting treatment and identifying and securing housing and income assistance (Decima Research Inc, 2004). They also provide crisis intervention, assist with system navigation, and act as an advocate for their relative within the health care system and when working with health professionals (Kirby & Keon, 2006; MacCourt et al., 2013; MacFarlane, 2011). Family members may also provide housing and assist their relative with daily living activities such as purchasing groceries, paying bills, and taking medication (Decima Research Inc, 2004; MacFarlane, 2011). The benefits of family involvement in such roles have been well documented. Among these benefits are decrease in rates of hospitalization, greater adherence to treatment, and increased rates of recovery (Azrin & Teichner, 1998; Goldstein & Miklowitz, 1995). Family involvement in mental health care can also be most cost-effective for the health care system, and lead to decreased utilization of the criminal justice system as well (MacFarlane, 2011). Overall, the mental health and addictions system is able to reduce costs due to the involvement of patient families in these roles (MacFarlane, 2011).
3.5.2 Racialized communities, mental illness, and the role of family

Ethno-cultural minority groups have strong family involvement in health care and health related decision making (Blackhall et al., 1995; Braun & Mclaughlin, 1998; Chow et al., 2010). Additionally, emerging mental health care models have incorporated family involvement into culturally appropriate mental health care programs for racialized individuals, suggesting that families play a central role in mental health care for this population (Yang et al., 2005). Programs such as the Multi-Family Psycho-education Group (MFPG) model emphasize family involvement as critical to the success of racialized clients and has been shown to reduce family burden and improve outcomes for family members of racialized individuals with severe mental illness (Chow et al., 2010). Other such models, including the Mount Sinai Hospital Assertive Community Treatment Team and the Across Boundaries mental health care program, recognize the importance of including the family within the unit of treatment when providing mental health services rather than treating the individual patient alone (Mount Sinai Hospital, 2012; Sarang et al., 2009).

3.5.3 Homelessness and the role of family

The role of family in the process of becoming homeless has been examined particularly for homeless youth (Mallett, Rosenthal, & Keys, 2005). A study exploring the factors leading to homelessness for Caribbean youth in Toronto found that family and relationship breakdown was the major pathway into homelessness (Springer, Roswell, & McPherson, 2006). Interestingly however, the same study noted that given the lack of legal and gainful employment available to these youth as well as the restrictions on social assistance, the major source of economic and emotional support are parents or guardians, especially mothers. Friends were also found to be a source of support, but the authors noted that in cases where family contact was reduced, there
was a trend toward “hard-core street involvement” (Springer et al., 2006). This suggests that while family breakdown can lead to homelessness, families may also have a positive role in emotional and economic stability.

This curious duality of the role of family in youth homelessness is beginning to be further explored. Mayock, Corr, and O’Sullivan demonstrated that even among youth who experienced difficult family environments that led to homelessness, the supportive role of their families and renewed trust and communication can be a facilitator for exiting homelessness (2011).

Lemos and Durkacz (2002) conducted a qualitative examination of the role of family and friends among homeless adults in the UK and found that despite negative past experiences with family, most homeless individuals still maintained some contact with family members and valued these relationships. However, this study did not specifically examine homeless individuals with mental illness and only 6 of the 26 participants in this study reported problems with mental illness and substance abuse.

Interestingly, studies looking at the role of family in mental health care and recovery for homeless adults have shown mixed findings. Homeless individuals with mental illness report less contact with their family members, fewer supportive family relationships, and greater conflict with their relatives than homeless individuals who do not have mental illness (Caton et al., 1994, 1995; Tessler et al., 1992; Toro et al., 1999).

Other studies show that most homeless persons with mental illness are in contact with their relatives, feel that they can rely on family members for support, and have relatives to whom they feel close or have supportive relationships (Clarke et al., 1995; L. Dixon et al., 1998; Lam & Rosenheck, 1999). Of note, the groups most likely to report greater family contact and
supportive relationships were youth, women, African Americans, and individuals who have been homeless for a shorter duration of time (Bates & Toro, 1999; Caton et al., 1994, 1995).

Furthermore, a recent study by Padgett et al. looking at individuals with mental health problems and experiencing homelessness showed that stronger social relationships including family ties did not necessarily coincide with positive outcomes. Additionally, they showed that family ties could be both sources of unconditional warmth and nurturing but also rejection and condemnation based on the individuals’ behaviour (Padgett, Henwood, Abrams, & Drake, 2008). Pickett-Schenk et al. in a study of 4,778 homeless persons with mental illness found that greater contact with relatives to whom participants feel close, more frequent telephone contact, and greater satisfaction with family relationships were associated with a greater number of nights in stable housing (Pickett-Schenk, Cook, Grey, & Butler, 2007). While there are limited and mixed findings regarding outcomes for homeless individuals with mental health and the presence or absence of family support, there is a gap in the literature with respect to the role of family support for racialized individuals who are experiencing homelessness and mental illness.

3.6 Summary

This chapter presented a literature review of the existing theoretical and research literature on mental health, homelessness, and racialized communities and family support within each of these contexts. The following chapter will provide an overview of the methodology of this study including a detailed audit trail to evaluate validity and reliability of the findings presented in subsequent chapters.
Chapter 4
Design and Methods

4 Design and Methods

This chapter provides an overview of the methodology employed for this study along with a discussion of the key components of the paradigmatic underpinnings of the methodology and the specific data collection methods utilized. A discussion of the analytic method used in data analysis is also presented in this chapter.

4.1 Paradigmatic Underpinnings

4.1.1 Qualitative Research – The interpretivist-constructivist paradigm

There is a multiplicity of approaches in qualitative research (Creswell, Hanson, Plano Clark, & Morales, 2007). While qualitative research aims to “describe and clarify experience as it is lived and constituted in awareness” (Polkinghorne, 2005) and is generally oriented toward naturalism (Green & Thorogood, 2009, p. 22), it is important to discuss the paradigm or philosophical foundations that guide the qualitative research being conducted.

This study utilizes the grounded theory method and adopts an interpretivist-constructivist approach. Interpretative approaches, in contrast to positivistic approaches, acknowledge that human beings “are complex, unpredictable, and reflect on their behaviour” (Green & Thorogood, 2009, p. 13). As such, interpretative approaches allow the researcher to gain a better understanding of human behaviour and the meanings that participants associate with particular phenomena (Green & Thorogood, 2009, p. 14). At its core, interpretive traditions “subscribe to the belief that our worlds are socially created” (Prasad, 2005, p. 14) and as such, reality is not seen as singular. Rather, interpretivists operate within the ontological assumption that there are multiple interpretations of any given phenomenon (Merriam, 2009, p. 8).
The interpretivist-constructivist approach is also considered the basic foundation of qualitative research as interpretivism is at the core of all qualitative research. Specifically, as outlined by Merriam, a basic qualitative study following the interpretivist-constructivist approach seeks to understand “(1) how people interpret their experiences, (2) how they construct their worlds, and (3) what meaning they attribute to their experiences” (Merriam, 2009, p. 23).

This approach is complementary to the intersectionality framework adopted for this study because intersectionality is also a relativistic model and emphasizes that intersecting social categories generate qualitatively different rather than aggregative meanings for individuals. Thus, the interpretivist-constructivist approach provides an appropriate paradigm within which the lived experiences of participants who are racialized and have experienced homelessness and mental illness can be elucidated. In addition, although this study utilizes the grounded theory method, it does not adopt some elements of classical grounded theory such as theoretical sampling. This selective application of components of grounded theory is discussed in detail below.

4.2 Methodological Requirements

4.2.1 Participant Sampling

Since qualitative research seeks to understand context-specific meaning, rather than to generate generalizable data, a non-probabilistic or purposive sampling approach is most appropriate (Merriam, 2009, p. 77). Typically, grounded theory utilizes the approach of theoretical sampling with the aim of achieving theoretical saturation (Corbin & Strauss, 2008). Many scholars have criticized the concept of theoretical sampling as impractical in applied health research given the constraints placed on researchers due to the requirements of funding agencies and research ethics boards which do not allow for an open-ended and iterative sampling process (Green &
Thorogood, 2009, p. 119). Morse further suggests that the very nature of health research which involves “the intimate, experiential, and interpersonal aspects of illness, into caring for the ill, and into seeking and maintaining wellness” produces significant methodological challenges for qualitative research and that methods must be adapted to the research conditions (Morse, 2012, p. 69). As well, for marginalized or hard to reach populations, the ideal of theoretical sampling may be unrealistic to achieve (I. Coyne & Cowley, 2006). In addition to criticisms of theoretical sampling, many scholars have also criticized the goal of theoretical saturation as being a potentially limitless pursuit (Green & Thorogood, 2009, p. 120). While some scholars have attempted to generate guidelines for data/thematic/theoretical saturation, overall, identifying precisely when this goal is achieved and when recruitment of participants can be halted is a major challenge (Bowen, 2008; Francis et al., 2010; O’Reilly & Parker, 2012). In contrast to theoretical saturation, some health researchers recommend using mixed sampling strategies to produce “information-rich cases” (Green & Thorogood, 2009, p. 120).

Purposive or purposeful sampling seeks to select participants who will provide the most useful or relevant data to address the question of the research inquiry (Green & Thorogood, 2009, p. 118). Patton describes purposeful sampling as “selecting information-rich cases for study in depth,” (emphasis in original) which provide the most appropriate data to address the overall purpose of the research study (1990, p. 169). This study utilized a stratified purposeful sampling technique. This sampling strategy captures major variations by dividing the sample into relatively homogenous strata (Patton, 1990, p. 174). Miles and Huberman, in their typology of sampling strategies, suggest that stratified purposeful sampling aims to describe subgroups and facilitate comparison (Miles & Huberman, 1994, p. 28). This sampling method was particularly appropriate for this study because the third arm of the At Home/ Chez Soi project consisted of participants identifying as members of a variety of racialized communities. As well, participants
in the At Home project are divided into intervention and treatment as usual groups. As such, generating strata and then conducting purposeful sampling within each stratum provided a means of capturing the variation and stratification already present within the broader project.

4.2.2 Rigour

All research studies must be able to withstand evaluation and critique and have a degree of soundness with respect to their methods, findings, conclusions and assumptions made (Long & Johnson, 2000). To ensure rigour, and therefore reliability and external validity in qualitative research, Green and Thorogood suggest that research must be transparent, comparative, reflexive, and must maximize validity and reliability (2009, pp. 219–223). To achieve transparency in this study, a clear and sufficiently detailed account of protocols and procedures used is provided here. Comparison requires that there inter- and intra-case comparison of emerging themes. Comparison also allows the researcher to refine emerging theories and should also include comparison of study findings with prevailing theories in the field (Green & Thorogood, 2009, p. 222). Reflexivity is another key component to achieving rigour in qualitative research. Green and Thorogood provide good practice approaches that address reflexivity including methodological and theoretical openness, and awareness of the social setting of the research and of the broader social context within which the study is conducted. Essentially, these practices help to situate the researcher and participants, and accounts for theoretical and methodological assumptions made (Green & Thorogood, 2009, p. 223).

Beyond transparency, comparison, and reflexivity, validity and reliability are also important factors to consider when assessing rigour. To maximize validity or credibility, Green and Thorogood suggest providing supporting data for each interpretation made in the analysis. They also recommend analyzing “deviant” cases that may contradict the findings and accounting
for them. Further, the authors recommend including enough context for the reader to assess the validity of the findings. Beyond this, Green and Thorogood also suggest counting themes as a strategy to ensure validity. Reporting counts of themes provides an indicator of typicality and is a means to avoid anecdotalism in qualitative research (Green & Thorogood, 2009, pp. 220–222). Sandelowski further supports the use of counting for validity, suggesting that it avoids common pitfalls of qualitative research including over or under-weighting particular accounts that better fit the emerging findings (Sandelowski, 2001). However, Sandelowski also cautions analysts that count data can be misleading and can often be used out of context when reporting qualitative findings (Sandelowski, 2001). Given the potentially misleading nature of count data in qualitative findings, this study has avoided the count approach to validity while utilizing deviant case analysis and providing data to support interpretation to ensure validity.

Reliability is a highly contested concept in qualitative research, with a number of researchers suggesting that reliability examines the extent of repeatability of research findings and is therefore a distinctly quantitative concept (Merriam, 2009, p. 220; Stenbacka, 2001; Wolcott, 2005, p. 159). Others simply re-conceptualize reliability to fit within the interpretivist paradigm. For example, Green and Thorogood define reliability as “the likelihood that a similar piece of research would elicit similar kinds of themes” (2009, p. 221). Merriam, on the other hand, rejects reliability as a positivist notion that is problematic in social sciences due to the fact that human behaviour is not fixed or static, making repeatability infeasible. Instead, Merriam suggests that the salient question regarding qualitative research is “whether the results are consistent with the data collected” (2009, p. 221 emphasis in original). Therefore, reliability in qualitative terms is conceived as dependability and consistency. These terms were originally conceptualized by Lincoln and Guba (1985), but are widely supported in qualitative research (Golafshani, 2003; Seale, 1999). Thus, this study adopts the notion of consistency and
dependability in place of reliability and uses the audit trail approach to achieve consistency and dependability. The audit trail is a rich description of “how data were collected, how categories were derived, and how decisions were made throughout the inquiry” (Merriam, 2009, p. 223). This approach is similar to the strategy described by Green and Thorogood to account for transparency and validity, and thus provides a robust tool to ensure rigour in this study.

4.2.3 Generalizability and Transferability

Generalizability focuses on applicability of one study’s findings to other populations and makes use of a priori assumptions regarding the relationship between the selected sample and the larger population from which it is drawn. Generalizability in quantitative research is based typically on a random sample and only made within specific confidence intervals. As such, Merriam argues that, “we need to think of generalizability in ways appropriate to the philosophical underpinnings of qualitative research” and refers instead to Lincoln and Guba’s notion of transferability (2009, p. 224). Transferability is the reader-led process of applying findings from one context to other similar contexts (Barnes et al., 2012). This process is reader oriented because, as Lincoln and Guba explain, “the original inquirer cannot know the sites to which transferability might be sought, but the appliers can and do” (1985). While in social science research transferability is often used in place of generalizability, Green and Thorogood suggest that health researchers must address generalizability directly:

“First, if researchers are to make claims to their findings being useful, at whatever level, to health practice, they do have to consider the theoretical import of their findings: the extent to which they refer to some setting or population wider than that of the research itself. Second, and more pragmatically, the credibility of qualitative findings in non-social science
fields is often fragile, and qualitative research is easily marginalized as ‘interesting, but not research evidence’ because the generalizability is questionable.” (2009, p. 225)

Therefore, Green and Thorogood recommend three strategies to address generalizability in qualitative research; sensitizing concepts, conceptual generalizability, and transferability.

Sensitizing concepts are ideas derived from qualitative research in a relatively under-researched area. Emerging concepts regarding new ways of thinking or new perspectives on participants’ views can help sensitize the reader to new ways of thinking (2009, p. 225). The exploratory nature of this study in an under-researched area suggests that such sensitizing concepts relevant to better understanding the population of interest will emerge.

Green and Thorogood also emphasize the use of conceptual generalizability in qualitative research. Conceptual generalizability suggests that in qualitative research the theoretical usefulness of emerging concepts is significant. Thus, the focus is not on the particular themes that are context-specific, but on the overarching concepts which may have a direct impact on medical practice (2009, p. 226).

Finally, Green and Thorogood also include transferability as a means of addressing generalizability in qualitative research. While the application of transferability is modified here, it is still conceived as the extent to which findings from one site are applicable or transferable to other settings. According to Green and Thorogood, this is a policy/practice relevant question because policy makers and practitioners will want to know the applicability of the research findings to their specific settings. Determining transferability is a process of distinguishing between themes and concepts that are context specific and those that have wider applicability (2009, p. 226). This conception of transferability differs from the previously discussed
understanding of transferability as a reader-initiated process by which the thick description provided by the researcher is evaluated by the reader for appropriate applicability (Barnes et al., 2012). Rather, in using transferability as a tool for external validity (generalizability) of the study, the onus is on the researcher instead of the reader to demonstrate how context-specific findings can be applied to other settings. This study adopts Green and Thorogood’s approach to generalizability as their interpretation is directly pertinent to health research.

4.3 Data Collection

4.3.1 Designing Interview and Focus Group Guides

Interview and focus group guides were developed based on review of the literature and based on three pilot interviews conducted with racialized homeless individuals with mental illness. The guides were semi-structured with sufficient openness to capture participant-directed narratives, and structure to capture the main areas of interest.

These areas of interest included thoughts, feelings, and ideas regarding family relationships and experiences with family; supports derived from family including the available supports, the supports desired, and the supports rejected; the experience of mental illness, homelessness, and racialization and the dynamic effect of these experiences on family relationships; the ethnic, cultural, or racial group perceptions of mental illness, homelessness, and family; and a direct question regarding the perceived importance of incorporating family support into formal service provision for this population.

Data from the pilot interviews was used to refine the initial guide. In particular, consumers initially expressed difficulty and sometimes frustration when attempting to convey beliefs around homelessness and mental illness that their ethnic, cultural, or racial groups held. Cultural understandings of homelessness and mental illness were often too abstract for
consumers to relate to their experiences. Thus, the refined interview guide first began with common beliefs or ideas about mental illness in the family, then the community, and then the cultural group. Similarly, ideas about homelessness were discussed in terms of common beliefs in the family, then the community, and finally the cultural group. By beginning at the micro level and building to the macro level, participants were more easily about to convey cultural beliefs or perceptions around mental illness, homelessness, and family.

4.3.2 Selection of Participants for Semi-structured Interviews

Racialized participants from the At Home/Chez Soi study were recruited from both the ER-ICM intervention and “treatment as usual” groups of the study using a purposive sampling strategy (Green & Thorogood, 2009, p. 118; Merriam, 2009, p. 77). People of Caribbean, African, and South Asian descent were the three largest ethnoracial groups in the ER-ICM arm of the At Home study. Thus, participants for this study were selected from these three ethnoracial groups. Six participants from each of the three ethnoracial groups were recruited for individual semi-structured interviews. Of these, 30% (n = 6 participants) were women. This was done to account for the proportion of women who are homeless in Toronto (City of Toronto, 2013a). This also allowed for further documentation of the specific social location of racialized women experiencing mental health problems and homelessness, allowing for examination of a trend in the literature which suggests that women tend to have greater social support. Table 1 below summarizes the participant selection scheme utilized for the semi-structured interviews completed in this study.

Table 1. Participant selection scheme for qualitative semi-structured interviews with ethnoracial participants of ER-ICM and treatment as usual groups within the At Home/Chez Soi study.

<table>
<thead>
<tr>
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<th>ER-ICM Intervention</th>
<th>Treatment As Usual</th>
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### Selection of Participants for Focus Groups

This study also included two focus groups. Focus group participants were recruited using convenience sampling. Convenience sampling involves choosing individuals within an established subpopulation based on availability and willingness to participate (Higginbottom, 2004). One focus group consisted of service providers and one focus group consisted of family members. The sample size (8 participants) for each focus group was selected based on best practices in the literature and to ensure that a diverse range of participant views are incorporated (Tang & Davis, 1995).

### Eligibility Criteria

The study included adult (>=18 years of age) men and women who are already enrolled in the larger “At Home/Chez Soi” research study and who met the following criteria:

1. Self-identify as belonging to an ethno-racial minority group
2. Have been identified as “moderate needs” participants in the “At Home” study

Participants were selected from both the ER-ICM and the “treatment-as-usual” group in order to determine if there are differences in experiences with family support between racialized participants who are receiving the ER-ICM housing intervention within the At Home/Chez Soi Project and those who are not. Since the ER-ICM intervention emphasizes early involvement of family in the recovery process (Stergiopoulos et al., 2012), and since housing stability may allow

<table>
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<tr>
<th>Ethno-Racial Group</th>
<th>Male Participants</th>
<th>Female Participants</th>
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</thead>
<tbody>
<tr>
<td>Caribbean</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>African</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>South Asian</td>
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for participants to more easily reconnect to their families, family support is likely to be experienced differently by participants in the intervention group and those in the TAU group.

The service provider focus group participants were selected based on having at least 1 year of experience working with moderate needs ethnoracial homeless clients. The family member focus group participants were selected based on supporting or having had supported at least one relative who identifies as belonging to an ethnoracial minority group (racialized) and who is currently experiencing or has had experienced mental health and homelessness issues. As well, recruitment for all components of the study was limited to participants who are able to speak English.

4.3.5 Participant Recruitment Procedure for Semi-Structured Interviews

The research coordinator (RC) identified potential interview participants who fit the selection criteria and who were articulate, reflective, and willing to share their experiences (I. T. Coyne, 1997; Morse, 1991). This was determined based on previous interactions that the RC or other At Home/Chez Soi Toronto site team members had had with the participant. The research coordinator contacted potential interview participants through the community partner (Across Boundaries), through case workers, or directly contacted the participants (in such cases where rapport had previously been established between the RC and the participant). The research coordinator introduced the potential participant to this study and received verbal consent to share the participant’s contact information with the researcher. Once verbal consent was given, the researcher followed up with the participant by phone and extended an invitation to participate in a key informant interview. This invitation included an explanation of the purpose and objectives of the study, and a brief discussion of harms and benefits of participation. An extended conversation about these issues was carried out during the informed consent process.
4.3.6 Participant Recruitment for Focus Groups

Service providers for the focus group were recruited from the team of case workers at Across Boundaries who work with At Home/Chez Soi project participants. Participants for the family focus group were recruited through Across Boundaries because this agency engages with family members of the clients they serve. Family members engage as volunteers or directly in the case management process at Across Boundaries. As such, Across Boundaries was well poised to access family members of the population of interest who would be interested in participating in this study. Through the At Home/Chez Soi Research team, the researcher was introduced to a supervisor at Across Boundaries. The researcher outlined the study to the supervisor and explained the recruitment criteria. The supervisor then took the role of first point of contact with service providers and family members. The researcher was invited to attend a staff meeting to explain the objectives of the study and answer any questions the service team had regarding participation. Following this, a separate time was scheduled to conduct the service provider focus group.

Family members were identified through the supervisor and service team at Across Boundaries and were contacted first by the supervisor or a case manager with whom they have had previous interactions. The supervisor or case manager provided an overview of the study to the family member and requested permission to share contact information with the researcher. In cases where permission was given, the contact information was transferred to the researcher and the researcher contacted each potential participant. This was done to ensure that only interested participants were contacted by the researcher and that privacy was protected. The researcher made contact with potential participants through an email and/or phone invitation to participate in the focus group. This invitation included an explanation of the purpose and objectives of the study and a discussion of harms and benefits of participation. The potential participant was also
given the opportunity to ask any questions they had regarding the focus group and the study overall. The focus group was scheduled based on the availability of the majority of potential participants who had expressed interest in participating in the focus group and was conducted at Across Boundaries.

4.4 Data Collection Process

The interviews and focus groups ranged in length between 45 minutes and 120 minutes. The interview and focus group participants were asked a series of open-ended questions and probed to elicit participant perspectives on the role of kinship ties within the context of mental health, homelessness and racialization. Specifically, participants in the interviews were asked questions regarding their overall family relationship, family support, the effect of homelessness and mental health problems on their family relationships, the role of their family in coping with these challenges, ethnic, cultural, racial or traditional perceptions of family, and the role of family in mental health and homelessness service provision.

Participants in the family focus group were asked questions regarding their relationship with their family member, including any support provided or withheld, and the value of this support. Participants were also asked to discuss cultural perceptions or attitudes toward mental health problems, homelessness, and the importance of family relationships. As well, participants were asked questions regarding family engagement in service provision for racialized individuals with mental health and homelessness issues.

Participants in the service provider focus group were asked questions regarding client-family relationships, the types of supports family members provide for clients, and how these dynamics impact the work they do with their clients. Service providers were also asked questions
regarding cultural perceptions of mental health, homelessness, and family among their clients and were asked to discuss the value of family support for their clients.

All individual interviews were conducted at the Center for Research in Inner City Health. Focus groups were conducted at Across Boundaries because it is a familiar, convenient, and accessible environment for participants in the focus groups. As well, with the exception of service providers, all participants were provided with an honorarium in the amount of $25, light refreshments, and two-way public transit fare, recognizing the value of the time donated to the study. Service providers were given light refreshments during the focus group.

4.5 Data Analysis

Transcribing services were used to generate transcripts for all interviews and focus groups. One audio tape was transcribed by a special transcriptionist due to the participant’s heavy accent and nonlinear train of thought as a result of overt presentation of mental illness symptoms.

Transcripts were verified by the researcher using the original recording. This was particularly important given that many of the participants had accents that often led to misinterpretations or inaudible segments in the transcripts. The verified transcripts were then analyzed using Grounded Theory as outlined by Strauss and Corbin (Strauss & Corbin, 1998). Grounded theory is a flexible and iterative method that informs multiple stages of the research process. At the data analysis stage, Grounded Theory allows the researcher to fracture the data and explore new avenues for analysis and identify patterns and relationships in the data (Green & Thorogood, 2009, pp. 203–208).

Grounded Theory begins with open coding. This was achieved by reading and becoming closely familiar with the transcripts in their entirety and then attaching codes to the data. Both in
vivo codes that emerged directly from the data and conceptual codes that emerged through the analyst’s interpretation of the underlying phenomenon were used. Categories and sub-categories were developed iteratively as initial codes and concepts were grouped into more “abstract explanatory terms” (Strauss & Corbin, 1998, p. 114). Given the population that this study has examined, some participants presented with significant symptoms of their mental illness throughout the interview process. As such, this stage of analysis was particularly challenging when coding transcripts of interviews in which the participants presented with mental illness symptoms. When analysing these transcripts, senior investigators were consulted to determine the appropriateness of incorporating transcripts of this nature into the analysis. In such cases, the research team determined that while the overt presentation of symptoms of psychosis deterred from the reliability of the accounts given, the participant’s mental illness was one lens through which they understood their family relationships. As such, these accounts were deemed valuable to understanding the lived experience of the participants and were included in the analysis.

Open coding was followed by axial coding of the transcripts. Axial coding involves reassembling the fragmented data and exploring relationships that emerge across categories and sub-categories (Green & Thorogood, 2009, p. 204). Axial coding was guided by Strauss and Corbin’s analytic tool called “the paradigm”. This tool focuses on the context, the actions/interactions, and the consequences or outcomes of the actions/interactions, allowing the analyst to integrate structure with process and explore the complexity of the phenomenon of interest (Strauss & Corbin, 1998, pp. 127–128).

Selective coding was conducted following axial coding. During this stage in the analysis, theory building was facilitated by identifying a central or core category and refining the emerging theory. This was done by reviewing the scheme for logical consistency, adding to
underdeveloped categories, and removing excess concepts or categories. NVivo 10 software was used at all stages of the data analysis process to assist with data management and analysis. Analytic memos were also written throughout the analysis process to incorporate reflexivity and to record emerging interpretations of the data. Diagramming was also used extensively to help guide axial and selective coding as relationships were identified across and within major themes.

4.6 Ethics

This study adheres to the standard of ethics outlined by St. Michael’s Hospital and the University of Toronto. Approval was obtained from the Research Ethics Board of both institutions prior to participant recruitment and data collection. All potentially identifying data was anonymized and stored either on a secure password-protected institution server or password-protected USB flash drive. Numeric codes assigned to them upon randomization into the At Home/Chez Soi project were used for consumers. Personal data such as age was not collected for service provider or family member focus groups. Additionally, all names and identifying information mentioned during the interviews and focus groups were replaced with non-identifying pronouns during transcript verification.

4.6.1 Participant Informed Consent Process

Written consent was obtained from all participants prior to the start of key informant interviews and focus groups. Potential participants were given a copy of a consent form that provided detailed information about the study, the purpose of the interview or focus group, information on confidentiality and anonymity, details regarding audio recording, data storage, and security, and study contact information. The researcher further explained that participant anonymity is maintained by assigning a numeric code to each participant which is not associated with their name or other identifying information. The researcher reviewed the consent form with
participants before the start of the interview and each participant received a hard copy of the consent form for their records. Photocopies of signature pages were also provided to participants where requested.

Consent forms were crafted in an accessible, plain language format. The form was read aloud to ensure that all participants, regardless of literacy level, were given the information required for them to be able to give informed consent. Participants were also given ample opportunity after reviewing the consent form to ask questions. Additionally, with the consent of participants, all interviews were audio-recorded and transcribed verbatim. A clear explanation was provided in the consent form emphasizing that participation is voluntary, that participants are not required to answer any questions that they are uncomfortable answering and that they may stop the interview or withdraw from the study at any time without consequence.

4.7 Summary

This chapter presented a discussion of methodological considerations including the overarching paradigm and associated assumptions, the sampling and recruitment strategy, and the data analysis approach. Ethical considerations were also discussed here. Additionally, this chapter presented an in-depth account of the participant recruitment and data collection procedure, providing an audit trail for readers to use to assess the validity of the findings discussed in the following chapters.
Chapter 5
Results

5 Results

This thesis explores the importance of family for racialized homeless individuals with mental illness and the potential role that family can play in the process of service provision for this population. This chapter presents the findings from individual interviews with racialized homeless consumers experiencing mental health problems. As well, findings from the focus group of family members and the focus group of service providers are also presented here.

5.1 Participant characteristics

In this study, interviews were conducted with seventeen racialized individuals who have had or were currently experiencing mental health problems and homelessness. Of the seventeen participants, six were female and eleven were male. All participants were adults (above the age of 18). Participants ranged in age from 22 to 55 years of age at the time of interview (mean = 39 yo). Eight participants were in the ER-ICM arm, while nine participants were in the TAU arm of the At Home/Chez Soi Project. With respect to ethnoracial identity, six participants self-identified as Caribbean, six self-identified as African, and five self-identified as South Asian. Participants in the ER-ICM group had been in the intervention arm for an average of 812 days at the time that the interview for this study was conducted. Participants in the TAU group had been in the TAU arm for an average of 759 days at the time that the interview for this study was conducted.

The service provider focus group consisted of seven service providers and two student observers. The student observers did not directly participate in the focus group but completed informed consent forms and were given permission through verbal consent from the participating
staff members to observe the focus group. Of the seven service providers, five were female and 2 were male. All service providers were also racialized individuals.

The family member focus group consisted of five participants, of which three participants were women and two were men. All were racialized individuals. Two of the participants were also volunteers at the community agency.

5.2 Themes
The main themes that emerged across the interviews and focus groups are discussed with respect to the following categories:

1. The Complexity of Family Relationships
2. Supports Derived from Family
3. Considerations for Family Involvement in Formal Services

Participant numbering has been removed here to protect participant privacy, however, the results reported represent a diverse array of participant narratives, ensuring that no single participant voice is prioritized or feature more prominently in the analysis.

5.2.1 The Complexity of Family Relationships
The importance of family relationships was stressed by participants across all three participant groups. However, positive experiences were often childhood experiences or experiences with chosen family. Biological and/or matrimonial family relationships were largely negative including experiences of abuse and neglect. Failed family expectations exacerbated these negative experiences particularly for parent-child relationships. Overall, despite these negative experiences, the abstract idea of family was identified as important and many participants expressed a willingness and desire to build new family relationships or reconnect with old family
relationships. The themes of defining family relationships, experiences with family, unmet family expectations, and value in family unit inform this category.

5.2.1.1 Defining Family Relationships

The majority of consumers discussed family as being biological, most often including parents, siblings, spouses, and offspring. Consumers also sometimes discussed their extended family including grandparents, aunts and uncles, and cousins. While, family was predominantly defined as biological family, consumers commonly differentiated between different arms or parts of their family (maternal v paternal, matrimonial v family of origin), choosing to recognize one group of biological relations as family, while rejecting another group of biological relationships.

Non-biological families that consumers discussed included friends, members of faith groups and service providers at shelters or other community services that the consumer received. For many consumers, their biological family was a source of stress and strain and these negative past experiences impacted the way family was defined. In cases where consumers had had very negative experiences with biological family, they tended to emphasize non-kinship or non-biological relationships while excluding biological relationships:

“You know, I think I’ve made a decision that my biological family is probably not... like I’m not even sure like I really define them that way. I feel like I have like a chosen family and that is, I feel like I’m more inclined to say that that’s my family.”

This consumer’s experiences of abuse and homophobia from her family influenced her decision to reject her biological family. As well, consumers discussed the care and acceptance that they receive from non-biological family members that was not available from the biological family:
"I know that God is with me. He is my family. The family of God, the church, people in the church that care about me. Those are my real members of family. They're who I call my family now."

Within the family members’ focus group, differences regarding how family is defined emerged as well. Some participants in the family members’ focus group emphasized the nuclear family, citing lack of emotional and financial resources to care for and help those beyond the immediate family. Others strongly advocated for a broad definition of family, focusing on the idea of "one love," emphasizing that family should extend beyond the nuclear family unit to embrace the community as well:

“We are all one. Not because I bring four children. They are my family only. Everybody in my family."

Family members’ focus group participants often compared "families back home" to "families here" and agreed that Canadian society is increasingly individual focused, which is detrimental to communities. The service provider focus group participants also emphasized that family often extends beyond the nuclear, and spoke about this as a facet of culture:

“culturally, like, family is also extended family. Like, how do you define a family in Canada? So limited [Laughs] you know? There, you have to have everybody – the aunts, you know, the uncles.”

Further, they expressed that in the absence of close family relationships consumers often relied on the service provider exclusively for support. The distinctions made with respect to how family was defined, particularly by consumers, impacted the types of supports that consumers were willing to accept from family relationships (Category 2).
5.2.1.2 Experiences with family

While consumers discussed positive family relationships, most experiences with family relationships were negative and often described as emotionally abusive or unsupportive. These experiences impacted how family relationships were defined and the types of supports offered by family and accepted by consumers.

Positive family experiences discussed by consumers were described as nice or peaceful. Consumers also expressed a deep connection or attachment to family and the time spent with them:

“I: And what was that experience like being with your family?

P: Amazing. It’s like...it’s hard to explain how I feel. Like this...I just, I just want to be with them. Not, not separate.”

Concepts and feelings such as care, love, support, trust, attachment, happiness, forgiveness, togetherness, and reliability or "being there" were also attached to family. In addition, family was seen as a source of safety, security, or protection. Participants in the service providers’ focus group primarily described positive family experiences as being supportive relationships. Families that made the effort to reconnect with consumers were also described by service providers as positive.

Participants in the family focus group also associated love with family and emphasized the significance of love for their family members:

“But I think of love, too, when I think of family. Because I’m in love with my family...It's not like a man and woman in love. But I’m more fulfilled with being in love with my children.”
Despite having had some positive family experiences, consumers largely discussed negative experiences with family, which primarily centered on rejection and abuse, including physical and sexual abuse. Discussions of negative family experiences also focused on family breakdown and conflict. In some cases the family conflict was due to lack of understanding of the consumer’s mental illness, leading to a breakdown in trust in the relationship. In other cases this conflict arose due to culture clash:

“He’s trying to bring me up our culture, our style like our way of growing up but I’m like we’re in Canada here...Like I’m facing all these obstacles and challenging, and challenges in life and he didn’t have that...so yeah, me and my father we don’t see eye-to-eye”

Family neglect and/or rejection were also discussed by consumers as negative family experiences. Some consumers also stated that they chose to reject or break ties with their families as a result of these negative experiences and felt that they were better off without their family.

Further, consumers associated lack of support, lack of reliability (or "being there"), lack of understanding, lack of trust and safety, jealousy, resentment, sadness, and hatred with family relationships. Many consumers expressed a reciprocal lack of trust between themselves and their family members and discussed how traumatic experiences in the past make it difficult to trust or build connection with family or friends in the present. These negative family experiences also became triggering for consumers:

“it took me two weeks to get over the emotional trauma of spending that one day, maybe five hours with [my sister] and I just thought I can’t cope with this, like I can’t cope with the emotional baggage because it’s like many layers of hate, you know sibling things and family emotions and if I just give it one pocket of time, it takes me two weeks to get back to where I am in my place of living.”
A few consumers also stated that they had no negative experiences with their families. This was particularly true for those who created a distinction between different arms of their family and defined these arms separately. In the case of two female participants who had both arrived via spousal sponsorship to Canada, their relationship with their family of origin was very positive. The majority of their narrative focused on the family of origin and the supportive nature of these relationships. Upon further probing, however, these two participants both reluctantly mentioned that intimate partner violence had been a major factor in their decision to separate from their matrimonial family and enter the shelter system.

Service Providers echoed the idea that consumers sometimes choose to reject family ties due to lack of support. Further, participants in the service provider focus group discussed trauma and stress experienced by consumers that was related to negative family experiences:

“Her son was taken away by CS and her son went to her, to her parents. But she was adopted and she has not the greatest relationship with, with her own parents. So, I know that’s caused a lot of stress. She’s also experienced a lot of trauma because of it.”

5.2.1.3 Unmet Family expectations

Family expectations also coloured the interactions between consumers and their families and often contributed to negative family experiences. Particularly for younger consumers, family expectations of success with respect to education and employment placed significant pressure on their relationship and led to conflict. This conflict sometimes focused on the consumer’s mental illness or housing problems as well:

“I feel like that did put a strain because I think in my family there’s like a stress on like achievement...you know you have to be in the professions so the idea that I was taking time for my health and relying on like supportive housing, to do that I think was just like not understood.”
In some cases conflict arose because family members attempted to dictate or control the behaviour of consumers such as adherence to religious practices. In these cases, breakdown in family relationships or expulsion from the family home was a result of conflicting expectations of consumer behaviour.

Consumers also felt that their families demanded more energy and time from them than they could provide, in part due to a lack of understanding of the limitations that mental illness can impose on the lives of consumers. Further, consumers discussed the expectation of independence that family members placed upon them, asserting that financial dependence created strain in their relationships:

“My sister she doesn’t like anyone who is, um, well because I’m on ODSP and... no one that lives with her can collect ODSP or welfare then to live in the house so I have to find my own housing. That’s why I was living in the shelter for a while because she doesn’t want anyone collecting that in her house... you have to work to live at the house.”

5.2.1.4 Value in family unit

However, despite negative family experiences, most participant narratives emphasized that family relationships have a degree of permanence:

“I still care about them, I know they don’t care about me but, you know, if I do get in a better situation, you know, if any of them do come around, for sure I’ll welcome them. I doubt they’re going to come ... I do, I accept, you know, they’re my family, whatever happens.”
While doubtful of reconciliation, Consumer 9 expressed willingness to reconnect with his family members where reciprocity is present and asserted that the family relationship is permanent regardless of circumstances.

Further, many consumers expressed a desire to re-build broken family ties. In particular consumers who had children expressed a desire to improve their relationship with their offspring. However due to conflict with their former spouses and/or past negligence, they were not able to have the connection they desired. In addition, one consumer discussed the cultural and religious importance placed on the permanence of family, and the matrimonial relationship in particular:

“When I’m married we put mangalasutra [referring to the wedding necklace]... we religiously pray we’re together until we die we’re together. Any problem anything poor or rich or pain or sickness until die we want to live together, that’s what we talked... I don’t want to go to divorce because we pray we put mangalasutra our culture only one man and until die.”

Throughout his narrative, this consumer emphasized the importance of keeping his family intact and expressed a desire to re-build a relationship with them in the future. However, given his multiple negative experiences with family relationships and his family’s lack of willingness to reconnect, he was not hopeful that such reconciliation was possible.

The desire to improve family relationships and the challenges associated with reconciliation were also echoed by participants in the service provider focus group discussing their experiences with consumers:

“And then, too, the grandchildren now are involved as well. So, it’s like three generations and connecting them all together. So, it’s been positive. I’d say it’s positive. They want to be together, but they just have to figure out how we can do this now.”
Mutual desire and willingness to reconnect helped to facilitate reconciliation between consumers and their family members. Service providers further stated that, in some cases, systemic barriers such as challenges with the immigration system prevented consumers from reconnecting with their families, despite mutual willingness to reconnect.

Overall, many consumers suggested that family was important, despite the fact that personal experiences with family members were largely negative:

“I don’t have a very good family support, so to me, family is more of a bother to me but it’s better than nothing, you see? If you have family, it kind of gives you a sense of being. Like, it supports you. You can be less lonely. So, uh, family is very important to everybody.”

In the abstract sense, family appears to have inherent value to consumers in this population. Additionally, a female consumer experienced significant conflict with her matrimonial family, leading to homelessness, but had a positive relationship with her family of origin who lived in her native country. Despite these mixed experiences with family relationships, she emphasized the importance of family overall:

“[Laughs] Nobody is going to say that family is not important....Some people may say it, but not many. Maybe few people... No matter who your family member he is, even if he’s poor, he’s still your blood. You can’t throw him, uh, away. That’s why blood is thicker than water.”

As well, some consumers who had had negative family experiences still expressed a desire to build new family relationships. Overall, the core importance of family was emphasized by the majority of participants and family was viewed as an unbreakable relationship:

“It’s a relationship that you can’t really break you can’t divorce or you can’t do anything so that attachment, whether you’re getting along or not it’s still that attachment...family is always going to be there.”
Individual experiences with family members, and in some cases, cultural views of family, affect the ways in which this population of consumers define and engage with their family. However, despite negative past family experiences, all participant groups emphasized the importance of family relationships overall. However, an important distinction emerged between the abstract conception of family and the consumer lived experience regarding family relationships, which were largely negative. Given the permanence of the concept of family and the value participants placed on family, however, understanding how racialized homeless individuals with mental illness define their family relationships and how they engage with their family members, if at all, may be important.

5.2.2 Supports Derived from Family Relationships
Participants focused on support received from or offered by their families, which included emotional, instrumental, and financial supports. As well, participants discussed duties to family with a particular focus on reciprocal financial support. Participants also discussed negative perceptions and stigma related to dependence on support from family, particularly with respect to financial dependence. In addition, participants generally expressed an understanding of the limitations of family support due to caregiver burden. Some participants also discussed the role that service providers can play as a bridge between the consumer and their family members and re-enforce the supports provided by family. The main themes of emotional support from family, instrumental support from family, financial support from family, duties to family, and barriers to family support inform this category.
5.2.2.1 Emotional support from family

Emotional support from family was often perceived as positive and important. For consumers who became geographically separated from family in the process of migration, emotional support was of particular importance. As well, in some cases, emotional support from family was a means of mediating mental health issues:

“\textit{I just have my Mom, she really loves me emotionally when I was going through my hard times with my wife, she called me, encouraged me, hold on, son, don’t give up, you know what I mean? Don’t kill yourself, don’t commit suicide, don’t worry, things are going to be all right, do you know what I mean? I hold on to her words and, you know, things get better for me.}”

In addition, consumers and service providers both expressed that emotional support was more important to consumers than other types of support. One consumer expressed that financial support does not fix the situation but that emotional support from family is meaningful:

“\textit{Not so much money, money doesn’t really, you know what I mean, fix, fix the problem, just more of just really being there, letting me know that they care that much}”

A service provider emphasized the priority placed on emotional rather than financial support from family:

“\textit{I think most of the time, they are looking for that connection, the support, you know. More emotional support than money}”

Overall, consumers often sought emotional support from family and discussed positive family relationships as most often being a source of emotional support.
5.2.2.2 Instrumental support from family

Instrumental support from families most often included occasional housing or meals. In some cases, this was welcome, but mostly it was seen as a temporary support that did not yield long-term improvements in life circumstances. In some cases, consumers felt stigmatized for being homeless or mentally ill during the occasional visit with family:

“I mean, my godmother I was able to stay with her for a short time but the others, no they don’t really want me around, they can’t take me because I’m rambunctious.”

In a few cases, consumers expressed that family members intervened as advocates for the consumer in the midst of family conflict. Participants in the family members’ focus group were also in agreement that family members had a responsibility to be advocates for their loved one. Their discussion of advocacy focused on issues related to navigating the health care and the justice systems:

“Well, you have to advocate for your loved one, right?... Someone has to speak up, you know. Because if they see you have no one they treat you like garbage.”

Similarly, service providers felt that family support was able to fill in the gaps in the formal services they provide for consumers:

“Because we work 9:00 to 5:00, so you want family support in the evening and weekends to help support, you know?...If they’re hospitalized, if they’re incarcerated, you know, for that sake, you just want to know the family support is there to help them.”
Instrumental support from families most often included occasional housing or meals, consumer advocacy and assistance with system navigation and as a general safety net in the absence of formal supports like social workers.

5.2.2.3 Financial support from family

The absence of financial support from family was often a point of tension between consumers and their family members. This was perceived as the family being unwilling to help in a time of need:

“Once they used to come around and give me like $40.00 and stuff like that, like once in a blue moon, maybe once a year but it’s a different thing now...I feel like I really don’t need it [Laughs] because it’s not there all the time so I don’t really need it.”

However, receiving financial support had repercussions as well. Many consumers resented having to be financially dependent on family members. In a few cases, receiving any money from the family triggered significant trauma and emotional strain for the consumer:

“I know this sounds weird but I do feel like when my family gives me money, I get into some form of trouble. I feel that there’s, I feel a heavy negative thing near me...I feel like I get into a bit of rageful issues when I take money from them because I think that they’re angry, very angry when they give me...it’s a lot of negative emotions so I just, I just like feel safer if I don’t take their money.”

One participant expressed that she requested financial support from her family to supplement the lack of emotional support from them:

“I was reaching out to my biological family for financial support because I’d already tried to get psychological and emotional support and I wasn’t able to get that. So I knew in the back of my mind that that’s what I really wanted but in the absence of knowing how to obtain that that, I was asking for financial support so really I don’t want that from them. And I feel good about that”
While a number of different supports from family were available, emotional support was most often desired by consumers. Financial support, while needed, was not always welcome from family members and often created tension in the consumer-family relationship.

5.2.2.4 Duties to Family

Many consumers expressed that they had certain obligations to their family, primarily with respect to financial support. This was particularly common among male consumers and among participants who had family members still living in their native country. Despite their own precarious financial status, some consumers felt they had to provide for their families and expressed tremendous guilt for being unable to fulfill these family duties:

“I want to make them happy, you know... I want to show [my sons], I am your Dad, you know, it’s important you know. Still I think that they are fed up, you know. Some people they say my Dad buy this, buy the car, buy this. These guys look like oh...”

Additionally, while they did not view supporting their family as an obligation or duty, many consumers still expressed a desire to help their families. Consumers also expressed positive feelings about being able to provide financial support to family members.

Participants in the family members’ focus group also emphasized that they had a duty to care for their sick loved ones. Particularly in the case of parental relationships, participants emphasized that they had a responsibility to take care of their mentally ill child:

“I feel compelled... That it’s my responsibility... It’s nobody else’s responsibility... It’s my child... Sometime I feel overwhelmed, but what can I do?... I just have to keep going.”
Participants in the service provider focus group also expressed that consumers often felt a duty to provide financially for their family. Service providers emphasized that male consumers in particular felt pressured to abide by the cultural expectation or standard to adopt the provider role for the family irrespective of their personal financial struggles:

“Service Provider 1: I think some of it is cultural as well. Like, you know...
Service Provider 6: Of course, there's the stigma.
Service Provider 1: For men and all, they think, like, you know, um, 'I'm supposed to be the bread earner, taking care of the house. And I should be taking care of my children.'”

In addition to obligation felt toward family members, some consumers also stated that family has an obligation to help in times of need:

“I'm family, blood family, right? And if money is needed to do certain things, in terms of clothing...Food and shelter, I should get the help.”

This expectation of family support was most often discussed specifically with respect to parental relationships and mostly with respect to financial support. In one case, there was reciprocal financial support between the consumer and his mother who resided in his native country:

“Yes, well my Mom is a very poor woman, you know, so she really can’t afford to help me but sometimes she...out of her wages she’ll send me $200 or maybe $100... But I don't ask her for money most times I send her money because our country is a very hard country, you know, because of war and crime and, you know, stuff like that. So I’m the only one here that can support her. She’s good to me”
Financial support was a significant component of family duties and all participant groups discussed the reciprocal obligation to provide financial support to family. This obligation was also discussed as being culturally imbedded, and was particularly pertinent to male consumers who expressed a strong sense of duty to provide for their family members despite their own precarious financial circumstances. Feelings of guilt and inadequacy were also expressed by all participants as being associated with the sense of duty to provide financial support to family.

5.2.2.5 Barriers to family support

While family members were committed to caring for their loved one, they also discussed feeling helpless in the face of mental illness and emphasized the strain that caring for an individual with mental illness can have on their own health:

“*Their depression puts you in that state. Because you are become helpless, you know? No matter what you do, you still think there’s more to be done.*”

“It will break you…Because when my son got sick, I became so…I was so weak. I didn’t have…I didn’t know where to turn. Then I just started to get sick myself.”

The family focus group participants also discussed the pressures and multiple burdens that families face, making it difficult to provide the basic support that family members need:

“The economy, health, everything is stretched, so you have to keep focused and specifics. It’s may be a kid, two kids, husband or a wife. You cannot do the things that you even know is right. You can’t do it anymore, because you are stretched that much…Physically, economically, spiritually… I think that because that support lacking, is that sooner or later, there will be no family.”
Consumers also hesitated to reach out to family for financial support to avoid being a burden to family members. Specifically, consumers wanted to avoid burdening family members back home who were also struggling with daily life:

“I know what it is to live like in Guyana, it’s kind of hard. It’s not easy life over there and it’s very expensive so I don’t really ask them for money. In Canada you can survive...somehow or the other”

In discussing family burden, service providers emphasized the connection between family support and housing and mental illness stability. They suggested that families are more easily able to reconnect once the consumer has progressed in their recovery process, allowing families that were previously overburdened to slowly reintegrate into the consumer’s life and support their recovery:

“the person is not how the person used to be when he was using or when he was on the street. Now, they’re more stable and once the family see that, then they are supporting that client, that they want to be a support...So, they see the difference how they used to be before, because of the challenges, with mental health, with addictions. Now they're more stable and now they want to also get involved with them.”

In addition, the service provider focus group members suggested that while stable housing does not immediately solve addictions and/or mental illness, it provides a degree of separation between the family and the consumer which allows the family relationship to be re-built:

“But after he moved to his apartment, the addiction still continues. But then again, he’s not using up, you know, the family money, like, you know, that’s needed for day-to-day survival. So, the relationship got much better and now the family is involved.”
In many cases, consumers discussed that while some supports were available and offered by family members, they were unwilling to accept this support. Most often, consumers who had experienced abuse, abandonment, and rejection from their family in the past were unwilling to engage with family members and were unwilling to accept any supports offered from family members who had participated in the abuse. One female consumer, who had been abused by her husband, refused to reconcile with him when he and his family reached out to her:

“First, they want me to go back to him. And I refused. I said no, I don’t want to...It’s like opposite. I don’t want support from them. I, I don’t...I want to be free. Not, not touch with anything of him.”

Consumers also discussed physical barriers to family interactions which limited their ability to accept family support. Primarily, these were geographical barriers that resulted from migration. In the case of another female consumer, she had a very positive relationship with her family of origin but had migrated to Canada to get married. Conflict with her matrimonial family and the breakdown of her marriage resulted in her homelessness. Despite the positive relationship she maintained with her family of origin, the geographical distance between them limited the support she was able to receive from them:

“They’re just going to encourage me...I talk to my family, but to talk to someone on the phone is not like see your brother when you’re talking to him, right? Because even the calling card very expensive. You can’t talk too much. Not even 10 minutes. It’s going to cost you money.”

Service providers also discussed geographical distance as limiting the degree of contact and support that consumers could receive from family. In addition, stigma was noted by service providers as a major barrier to family support. Stigma related to mental illness and homelessness
were both discussed as factors preventing consumers from reaching out to family members for help, and preventing family members from offering assistance:

“And some of them afraid to ask that type of, of...or go to approach their family, because the family is already stigmatized them, saying that, “Well, you’re a user. And if I’m giving you money, you’re just going to blow it and waste it. You know? But they might need it to do, really, something else. But because of that stigma, it creates a barrier.”

In addition, the nature of the consumer’s mental illness also influenced family relationships and limited consumer willingness to accept support from their family. One consumer expressed that her illness was caused by voodoo spells that her sisters had cast on her. As a result, she felt she could not accept support from her family even if it improved her circumstances:

“She’s now married to Satan. And she’s doing everything to kill me...I’ve decided not to get any money from home, family. Because [my sister] puts her money there. Whenever she gives me money, I end up in a mental hospital, something like that.”

Overall, participants discussed a variety of supports provided by family relationships and emphasized the importance of emotional support for this population. Predominantly, emotional support provided from family members that have positive relationships with consumers were largely welcomed by consumers. In contrast, financial support from family was complex and primarily associated with guilt regarding dependence and feelings of inadequacy regarding unfulfilled family duties and expectations. Failure to meet family expectations, particularly related to education or religious behaviours, were also associated with family conflict and limited the family support available to consumers.
While both consumers and family members expressed a reciprocal sense of duty to care for and support family members, they also discussed various barriers to being able to support their loved ones, primarily related to caregiver burden and lack of resources to provide necessary support. Service Providers also emphasized the reciprocal burden of care experienced by consumers and family members and discussed stress due to both lack of support from the family, and stress from being unable to care for family and fulfill family duties. These burdens may serve as barriers to support from family members that are willing but are unable to provide support. Additionally, in cases where family support is available, consumer willingness to accept support may be limited by strained family relationships, geographical distance between the consumer and family members, and the nature of the consumer’s mental illness. Similarly, family perceptions of mental illness and homelessness, and the related stigma, also strained family relationships, making family support unavailable.

5.2.3 Considerations for Family Involvement in Formal Services

As discussed in Category 1, participants largely perceived family as an unbreakable relationship having inherent value. Unsurprisingly, most participants discussed family support for consumers as positive and discussed family involvement in service provision as important. However, participants identified several factors related to assessing the appropriateness of family involvement and how to manage this process of family inclusion into service provision. The main themes of views on family involvement, barriers to family involvement, and service providers as a bridge between family and the consumer inform this category.
5.2.3.1 Views on family involvement

Family members in the focus group were overwhelmingly positive and supportive of family involvement in service provision:

“Interviewer: Overall, do you think that family should be working closely with people like, you know, [service agency] to provide these services?

Family Member 4: Yes.

Family Member 3: I do.

Family Member 4: Yes 100%.

Family Member 2: Yeah.

Family Member 4: Great idea. Great idea.

Family Member 3: Definitely.”

In contrast, service providers and consumers were cautious about family involvement. Consumer 13 discussed family involvement as generally positive, but emphasized that some distance should be maintained between families and consumers with respect to service provision:

“Like having everybody kind of like working together, connecting, you know, would make things a lot more easier and you know but I don’t think it should be too close, do you know what I mean. They shouldn’t be like, you know, right there, front line but, you know, like having support is always good...just having them share information and just give information to like the service providers could make things a lot more better, you know, for the ones that are really in need of the service”

Similarly, despite encouraging others to accept help from their families, a male consumer felt that such a connection would not be possible with his family:

“If the family comes to offer you, you know just try your best just to get along with them and accept the offer they make. From my experience I doubt it. For me they don’t listen and care I think...it caused more problems so definitely for
me no, my family I wouldn’t recommend…My experience definitely with family is not an option right now."

Other consumers suggested that their family members need to overcome the resentments that they feel toward the consumer and be open to the care process before they would be willing to involve their family members in service provision:

“I just find them really depressing. I don’t, I don’t want them to be a part of any decision making. They’re just so depressing and they haven’t gotten over their own hate for me for my decision making that I’ve made in the past. They haven’t come out of that yet so if they could work on all their emotions and just be a little bit light and not heavy on my system right, then I wouldn’t have to hate them for getting involved ever.”

Similarly, some consumers suggest that they would only want family involvement in certain components of their care such as arranging amenities for their apartment, but not other aspects such as knowledge of their medications. In addition, despite having a positive relationship with his family, one consumer outright rejected the idea of family involvement in service provision stating that such involvement was unnecessary because service providers are sufficient to support his needs. Consumer narratives therefore emphasize the importance of consumer choice when considering family involvement in the process of service provision and the extent of this involvement.

Participants in the service providers’ focus group expressed that family involvement is mostly positive and healing even in cases where the relationship is strained:

“You know, I have to say, one thing about the whole family thing is for the most part, I’ve found that family involvement is amazing…It’s very healing. It helps with loneliness, with isolation. And it, it does wonders… even with those, where the relationships are a bit, like, a bit bad – I think the fact that family is still involved still helps.”
Service providers suggested that family can be supportive and family involvement can give consumers a sense of belonging, improve their self-confidence and instill a sense of pride when sharing their recovery successes with their family. Service providers also discussed that those consumers without family involvement are often more isolated, rely more heavily on service providers, and tend to have more incidents or crises around holidays or other occasions that would typically involve family gatherings.

Despite their overall positive views on family involvement, however, service providers also echoed the concerns of consumers, particularly with respect to consumer choice. In particular, service providers raised the issue of consumer consent when disclosing information to the family. As well, service providers discussed the possibility that too much family involvement could usurp the consumer’s autonomy in cases where service providers begin to communicate primarily with family members and secondarily with consumers:

“I think for a number of families involved, it becomes sort of...it becomes like that too, where, like, you, you could be in touch or be engaging more with the family than with the participant. And the mother could be like, ‘Well, this is what I think is best for him.’ And it’s, it’s sometimes hard to, like, you know, to balance that.”

Additionally, service providers suggested that the involvement of family often depends on family dynamics, the stage of consumer recovery, and the degree of support needed by the family itself:

“It depends on the dynamics of the family, you know? Um, some dynamics don’t look good, so there’s places you can’t really go. Maybe it’s better the client be by himself and not with family. And then there’s some dynamics where he’s...the client is well-, uh, incorporated with the family and, you know, it’s working pretty
well. So, it all depends on the dynamics. Yeah. But I think, overall, I mean, family should be engaging with the participant. I mean, I think it starts off with family first.”

Thus, consumers and service providers both expressed the importance of respecting consumer choice and consumer autonomy as a pre-requisite to engaging family members in the service provision process. This allows consumers to retain control of their care and only involve those individuals that they choose to incorporate into the care team.

5.2.3.2 Barriers to family involvement

Beyond concerns with consumer choice and autonomy, participants also discussed barriers to family involvement in service provision. A major barrier to family involvement that was discussed by both consumers and service providers was the lack of recognition and/or understanding of salient factors around mental illness and homelessness and their impact on consumers’ lives. Many consumers suggested that families perceived mental illness as an issue of character rather than an illness. One consumer also shared that a great deal of secrecy and shame surrounded the issue of mental illness in the family. As well, many consumers shared experiences of being rejected by their families due to mental illness:

“Because of my mental illness, they didn’t really believe everything that I told them, like they didn’t support me because they think that it’s actually my fault. So, you know, they treat me like, you know, it’s...you have to fix it, you know, we can’t, we can’t help you”

Similarly, consumers shared that family members often viewed them as being lazy or as a failure for becoming homeless:
“They obviously think you’re a failure because they are Pakistani. They don’t earn a lot of money but they do feel that you should have a career and work full-time and things like that so. You’re a failure if you’re in a homeless situation obviously and a failure if you don’t get married and you’re a failure if you have a disorder so that’s how I feel. That’s what I think they understand.”

This consumer described her family views on homeless and family expectations of success as being a cultural norm. However, most consumers discussed family views of homelessness and mental illness in general terms, without referencing specific racial or ethnic factors. Additionally a few consumers suggested that their family members would not want to engage in service provision at all because the relationship had deteriorated and the family was not involved in any aspect of the consumer’s life:

“They don’t want now, you know. That’s why there’s nobody involved. 50-50 there’s some people, even 75% they don’t want, how do I involve the other people?”

In contrast, participants in the family members’ focus group, who were largely active and well-engaged family caregivers, specifically discussed issues such as migration, lack of community support, and systemic barriers in the health and judicial systems as factors that can impact consumer mental health and wellbeing:

“Those who are ill, mentally, are coming from broken families. It’s not that the rich don’t people don’t want to get sick, but depression mostly hit people. Especially immigrants, too... People who come and...like you’re rooted up from somewhere and replant... Every gardener knows this – when you root something and replant it, it’s harder to grow that, if it grows.”

The family members in this focus group were significantly involved in the service agency and were actively engaged in caregiving for their ill relative, and may be more aware of and better informed as a result of their involvement. Alternatively, greater knowledge of causal
factors related to mental illness and homelessness may have encouraged these family members to offer support to their relative and facilitate family willingness to engage in the service provision process. Overall, family education regarding mental illness and homelessness may require consideration for this population.

Service providers also suggested that family attitudes toward mental illness and homelessness were largely negative and stigmatizing, limiting consumer willingness to engage with their families and family willingness to offer support:

“I have a, um, uh, like a Tamil client, who – when you look at his family background – uh, the brother is rich. He owns, uh, a textile industry. But because he’s not...does not have an insight to the mental health, he’s now thrown away the brother and telling him that, ‘Well, you are not allowed to come here.’ Uh, not seeing the, the entire family. And because he is acting as the provider, so he’s telling the entire family, ‘Don’t see this man, because this man is not good. He drinks. He smokes.’ You know? ‘He’s homeless.’ So, they look at all that and say, ‘Well, maybe he’s not worth to be part of the family. Until you get yourself right. And then you come back.’”

Additionally, all participant groups expressed that families were stigmatized by the broader community or culture by association to their ill relative. In some cases, this stigma caused families to distance themselves from the individual, serving as a barrier to family involvement in the consumer’s care. These findings suggest that when involving families in service provision, addressing the needs of the family may require education and open dialogue regarding salient social, systemic, and illness-related factors surrounding mental illness and homelessness as well as addressing the unique caregiver burdens that these family members experience in the process of caregiving such as social stigma.
5.2.3.3 Service providers as a bridge between consumer and family

While some service providers cautioned that families may connect directly and exclusively with service providers rather than engaging with consumers, participants predominantly discussed the importance of service providers as a bridge between consumers and their families:

“\textit{I had a counsellor, she phoned my brother, he hang up the phone. After I said don’t bother him. That’s all. But she phoned my Mom and she make me have relationship…Connect to my Mom and my Mom come back. Maybe later my brothers come back, I have two brothers.}”

In this capacity, service providers are able to connect consumers to family and help rebuild strained relationships. Participants in the service provider focus group also expressed that they often serve as a bridge between the family and the consumer:

\textit{“Service Provider 2: when family, um, they come with a different approach now that they know their family member has some support…Now the families come, come and support in different, in different ways now. They know that they…the family probably knows that they have us as well.\[Service Provider 6: \text{Yeah.}\] Service Provider 2: Right? They can reach out, too, you know? So, I think, you know, with our support, it, it really impacts the family, bringing them back together. Because…\[Service Provider 6: \text{It bridges them.}\] Service Provider 2: Yes, it bridges them back.”}

Service providers also expressed that family members were often grateful for the role that service providers play in helping their relative, giving overburdened families some relief:

“\textit{So, I decided to call the mom. And the first thing came out of her mouth was, like, uh, ‘I just want to thank you for what you’ve done for my, my son. I mean, we’ve tried so many things. Nobody’s really stuck with this person this long…for}”
a long time like what, what you did. ‘...So, they do appreciate you, the families. Because I know in the past, that family was, like, ‘I just can’t handle my son. He needs to be somewhere else, being taken care of.’”

When discussing support from service providers, participants in the family members’ focus group also emphasized that families are often isolated in caring for their loved one and need support in their role as caregivers. Family members discussed the important role that service providers can play in helping to overcome this isolation:

“Yeah. I got a lot of support from [service agency]. When I’m in the courthouse, sitting there by myself, I see members from [service agency], coming and sitting. You know. I get a lot of strength from them”

“We also need to know that we’re not alone...No matter what colour, class, creed you are, we all have the same issues. So, you’re not abnormal because of what’s going on. You’re not alone.”

Overall, consumers, service providers, and family members primarily support the idea of family involvement in service provision and suggest that there is a positive impact to family involvement. However, there are several important factors discussed by both consumers and service providers that are important to consider in this process. These include consideration of consumer choice including willingness to engage with family, family dynamics including consumer-directed definitions of family and the supports derived from these relationships, and family needs including education and support to overcome caregiver burden and social isolation. Participants also emphasized the supportive and bridging role that service providers can play in the process of family involvement.
5.3 Summary

This chapter presented the findings from individual interviews with consumers and focus groups with family members and service providers, respectively. The three categories of Defining Family Relationships, Supports Derived from Family, and Family Involvement in Service Provision were presented, along with the main themes that informed these categories. The subsequent chapter will discuss the implications of these findings, the limitations of this study and future work.
Chapter 6
Discussion and Conclusion

6 Discussion and Conclusion

This qualitative exploratory study examines the importance and role of family in service provision for racialized homeless individuals with mental illness. This chapter will summarize the key findings and discuss the policy and practice implications of these findings. The limitations of this study and future work are also discussed here.

6.1 Summary of Findings

Despite the common belief that homeless individuals lack family relationships, this qualitative exploratory study found that family is important to racialized homeless individuals with mental illness. Additionally, family relationships were sometimes shown to be the source of various supports for this population including emotional support, financial support and instrumental supports. These findings expand on previous work by Polgar, North and Pollio who examined informal caregiving for recently homeless adults and found that family members provide multiple types of support for their homeless adult relatives including housing, food, and financial support (2006).

While family is valued by consumers in this group, family experiences and the support derived from family relationships varied considerably. Positive consumer experiences with family were expressed across the three participant groups, but negative experiences including abuse, neglect, and abandonment by family members dominated consumer narratives. Family involvement in service provision for this population was overwhelmingly supported by participants in the family members’ focus group. However, consumer and service provider narratives expressed a cautious approach to engaging with family members when providing
services for this group. While consumers generally expressed that family involvement could be positive, they emphasized that such engagement with family would not be possible given the current state of their family relationships.

Consumer willingness to engage with family members was expressed by both consumers and service providers as an important prerequisite to family involvement in service provision, respecting consumer choice and autonomy. In cases where family relationships lacked trust and safety, consumers were unwilling to reconnect with family members. Additionally, even in cases where consumers and families were willing to engage with each other, geographical barriers and caregiver burdens such as lack of resources created barriers to family support. This supports work by Hawkins and Abrams which suggests that homeless individuals experiencing co-occurring conditions like mental illness and addictions do not have support available from their social networks because the members of their network often experience significant burdens themselves and are unable to take on supportive roles (2007). The family members of homeless racialized individuals with mental illness who participated in this study expressed similar problems related to limited resources, lack of community or social support, and the burden of caregiving for other dependents that limited their capacity to provide support to their relative. These factors serve as additional barriers to the availability of family support for this population. Where family support is available and consumers are willing to engage with family members, the findings from the current study suggest that the needs of the consumer, the family dynamics, and the needs of the family may need to be considered to facilitate family involvement that supports consumer well-being.

Finally, service providers were identified across all three participant groups as potentially playing the role of intermediary, to bridge family members and consumers together. Participant
narratives further suggest that service providers may facilitate family education and dialogue regarding mental illness and homelessness. Thus, service providers may play an important role in reconnecting consumers to their families and facilitating family involvement in service provision where desired.

6.2 Refining Family Centered Care for racialized homeless individuals with mental illness

As health care shifts to the community, there is an increasing emphasis on the importance of family and informal caregivers who take on multiple caregiver duties such as assistance with activities of daily living and health crisis intervention (Becvar, 2013; Whall, 1986; A. P. Williams, Challis, et al., 2009; A. P. Williams, Lum, et al., 2009). The importance of family for racialized homeless individuals coping with mental illness aligns with existing service models such as Family-Centered Care (FCC) and family psychoeducation programs (Centre for Addiction and Mental Health, 2004; Chow et al., 2010). These models emphasize the inclusion of families in the process of care provision and suggest that family plays a critical role in supporting and promoting the wellness of individuals. As such, FCC focuses on information sharing and collaboration between families, consumers and service providers (Centre for Addiction and Mental Health, 2004; Zwelling & Phillips, 2001). The FCC model also recognizes that families experience subjective and objective stressors in the process of caregiving that are potentially harmful for caregiver mental health and therefore require support as well (Centre for Addiction and Mental Health, 2004; MacCourt et al., 2013). FCC has been useful in a number of different care settings including pediatric care and mental health care and has been incorporated into several policy frameworks relevant to these settings (Centre for Addiction and Mental Health, 2004; Donahue et al., 2013; Institute for Family-Centered Care, 2010; MacFarlane, 2011; Surbone et al., 2010).
While it is often assumed that homeless individuals lack family support, the findings from the current study suggest that family is valued by racialized homeless individuals with mental illness, by family members of this population, and by the service providers serving this group. Further, the findings suggest that where consumers are willing to engage with family caregivers, family involvement in the care process for this group may be facilitated by service providers.

However, consumers and service providers included in this study emphasized the negative impact that family can play in the lives of consumers, contributing to experiences of abuse and trauma. Family breakdown and conflict have also been identified, particularly among homeless youth, as a pathway into homelessness (Ferguson, 2009; Mallett et al., 2005; Springer et al., 2006). In addition, consumer advocacy groups for survivors of mental illness and addictions have suggested that families have been a source of trauma and may be detrimental to consumer recovery (Goggins, 2009). Therefore, a necessary prerequisite to family involvement in service provision for this population is consumer willingness to engage with family members. Where consumer willingness is present, a cautionary approach to family involvement in service provision for this population is necessary to ensure consumer autonomy is respected and consumer recovery is enhanced rather than disrupted.

The findings from the current study suggest that family dynamics, consumer needs, and family needs, may require consideration when involving family in the process of service provision for racialized homeless individuals with mental illness.

6.2.1 Family Dynamics
Understanding the family dynamics depends in part on how family is defined by the consumer, which may include biological family members, friends, faith group members, and service
providers. While many consumers in the current study defined family as biological, in some cases consumers’ negative past experiences with family led to a shift from biological to chosen family, who were a source of emotional, financial and instrumental support as well. Interestingly, the chosen family in some instances manifested as including one arm of the biological or conventional family to the exclusion of another arm of the biological or conventional family. For example, some consumers in the current study prioritized or referred exclusively to the family of birth rather than the matrimonial family as being their true family while other consumers prioritized the maternal family over the paternal arm of their family. This adds an important nuance to the idea of chosen family that may require consideration when examining support networks. The chosen family as a major source of support has been documented in the literature, particularly for LGBTQ and homeless LGBTQ individuals (Muraco & Fredriksen-Goldsen, 2011; Sakamoto, Chin, Chapra, & Ricciardi, 2009). The findings from the current study expand on this work and demonstrate that variation also exists within different arms of the biological family.

Additionally, consumer-directed definitions of family are important to consider when engaging with racialized individuals in particular because previous research has reported that some ethnocultural minority groups have strong family involvement in health care and health related decision making due to the collectivist nature of these communities (Blackhall et al., 1995; Braun & Mclaughlin, 1998; Chow et al., 2010). In particular, the importance of family caregivers in the Indian mental health care system has been emphasized by a number of Indian health care professionals and researchers and is largely supported by the Indian Psychiatric Society (Avasthi, Grover, & Kate, 2013; Avasthi, 2010; Chadda & Deb, 2013; Kulhara et al., 2009; Shankar & Rao, 2005). In contrast, the findings in the current study demonstrate that although the importance of family was emphasized across all participant groups, consumers
largely had negative family experiences and had rejected or had been rejected by family members. Thus, while family is important to racialized homeless individuals with mental illness, collectivist understandings of family alone do not account entirely for consumers’ lived experiences as it relates to family relationships. Rather, consumer narratives suggest that experiences of mental illness and homelessness and the reciprocal impact of these experiences on family relationships primarily inform their lived experiences and the support derived from family relationships.

Furthermore, while this study examined the lived experience of racialized homeless individuals with mental illness, findings from this study demonstrated a marked absence of specific racial factors when examining consumer experiences. The intersectionality framework, which asserts that all identity categories are not simply additive, but create qualitatively different meanings for different individuals, mediated by “time, place, and historical and localized specificity,” may account for this absence (Hankivsky et al., 2010). In addition, previous work by Forchuk and colleagues demonstrated that racialized homeless individuals perceived discrimination and stigma related to class (i.e. homelessness stigma) as being more significant than discrimination based on race (Forchuk et al., 2007). Thus, the findings from the current study suggest that family is not always important or helpful with respect to mental health care for this population, despite self-identification as a racialized individual.

Additionally, the process of migration may alter family dynamics and strip recent immigrants of their family relationships, altering meanings associated with family and the perceived support available from family relationships (Edwards & Lopez, 2006; Ineichen, 2012; Khanlou, 2007; Kirmayer et al., 2011; Levitt et al., 2005; Simich, Beiser, Stewart, & Mwakarimba, 2005). Participants in the current study reported that geographically distant family
relationships were often positive and a source of emotional support, but that the physical distance between the consumer and their supportive family relationships created significant barriers to family contact and family involvement in the care process. Thus, migration may significantly alter and affect family dynamics and may also need to be considered when working with this population.

Overall, it is important to understand the various ways in which consumers define their family relationships and the dynamics created by these distinctions in order to better determine who may be involved in the care process and how to effectively engage with these individuals. Therefore, an understanding of family dynamics including how consumers define family relationships and the barriers to family support are important to consider when involving families in the process of service provision.

6.2.2 Consumer Needs
In the current study, trust and safety were found to be important facilitators of consumer willingness to engage with family members and accept support offered from relatives. These findings also align with recent research on homeless youth, which found that trust is a fundamental component of family reconciliation, and can in turn facilitate housing stability for this group (Mayock et al., 2011). Consumers in the current study also often expressed negative family experiences such as abuse, trauma, and conflict that have resulted in breakdown in trust and safety in family relationships. Given these difficult past experiences, some consumers expressed that any interaction with their family members is a triggering episode. In such cases where family interaction is damaging or unsafe for the consumer, alternative sources of support in the consumer’s social network may be sought out such as friends or faith group members who can engage with consumers in a positive and supportive manner.
Furthermore, findings from the current study show that there may be limitations to the types of supports consumers are willing to accept from family and the nature of information they are willing to share with family members. For example, consumers may accept emotional rather than financial support from family, and may not be comfortable sharing health-related information such as prescription drug use. While information sharing is central to the Family Centered Care model, given mental illness and addictions stigma and experiences of judgment and rejection by family members that many consumers and service providers discussed in the current study, freely sharing information may have significant consequences for the consumer’s well-being. Consumer-family relationships and the therapeutic relationship between service providers and consumers may also be negatively affected. By placing consumer choice and respect for consumer autonomy at the center of the process of family engagement, service providers may be better able to connect with families in meaningful ways to support consumer recovery and well-being.

6.2.3 Family Needs
The findings from the current study suggest that family needs should also be considered and that supporting family needs for this group involves consideration of two main issues. Firstly, family education and dialogue on mental illness and homelessness may be important to reduce stigma related to these issues. The importance of family psychoeducation to support family caregivers of individuals with mental illness is well documented for diverse communities (Bradley et al., 2006; Chow et al., 2010; W R McFarlane, 1997; Yang et al., 2005). Secondly, unique caregiver burdens related to the social location of consumer families may have important implications for the consumer-family relationship. Specifically, multiple marginalizations and community based stigma and isolation that family caregivers face as a result of caring for a mentally ill and homeless family member may require consideration. Experiences of stigmatization have been
reported in previous research examining the experiences of family caregivers of homeless adults (Polgar et al., 2006; Polgar, North, & Pollio, 2009). Similarly, caregiver stigma leading to social isolation has also been reported by informal caregivers of HIV patients (Akintola, Hlengwa, & Dageid, 2013; Mitchell & Knowlton, 2009; Mwinituo & Mill, 2006).

These findings suggest that informal caregivers for significantly marginalized groups may have additional concerns specific to their social location that can exacerbate the burden of providing care and may create barriers to providing support. Addressing these specific caregiver burdens may require greater intervention and support from service providers.

6.3 Practice and Policy Implications

6.3.1 The importance of consumer-directed family engagement

Despite substantial evidence supporting the efficacy of family centered care programs in various health care settings, there are several context-specific challenges related to implementation of FCC including role negotiations between family caregivers and health professionals, and consumer preference (I. Coyne, O’Neill, Murphy, Costello, & O’Shea, 2011). Drapalski and colleagues suggest that the underutilization of FCC services in mental health care highlights the need for greater consumer and family input on how these models are implemented and how families are engaged in this process (2009). The current study makes a unique contribution to this body of research by examining the perspectives of consumers, family members, and service providers serving this population to better understand family involvement in the process of care provision.

In addition, recent research by Cohen and colleagues examining consumer preference with respect to family mental health services for adults with mental illness found that the desire for family involvement in care was driven by consumer concerns regarding the impact of family
involvement and consumer perceived benefit of family involvement in this process (2013). The findings from the current study further demonstrate that while family is important for this group of consumers, given that family relationships for individuals experiencing the intersecting burdens of mental illness, homelessness, and racialization are often complex, consumer choice and preference are foundational to discussing family involvement in service provision.

Some service agencies working with homeless communities have begun to include discussions on family involvement in service provision (Sarang et al., 2009; Winland, Gaetz, & Patton, 2011). Across Boundaries, a mental health centre working with racialized homeless individuals, adopts a holistic service model which focuses broadly on the lived experience of the client, examining experiences such as racism, mental health stigma, poverty, culture shock, and family dynamics in tandem, and as they relate to the consumer’s health and recovery process (Sarang et al., 2009). Such an approach prioritizes consumer choice and secondarily assesses the availability and utility of supportive family relationships and friendships for consumer recovery. The findings from the current study support such a holistic model of care which emphasizes the importance of consumer choice and considers the context within which consumer-family relationships operate.

6.3.2 The role of the service provider

In cases where consumers are willing to engage with family, the findings from the current study suggest that service providers can play an important role in bridging consumers to their family members. Expanding existing service provider roles or generating a new service role may facilitate family engagement and involvement in service provision in a manner that supports consumer recovery.
Recently, Dixon and colleagues implemented a unique intervention for adults with severe mental illness which featured a Family Member Provider (FMP) who engaged first with consumers to understand the consumer context and assess consumer willingness to engage with family, and subsequently with families to engage in service provision. The FMP served as a bridge between the consumer and family members and improved consumer outcomes and family involvement (L. B. Dixon et al., 2014; Glynn, Dixon, Cohen, & Murray-Swank, 2008). Other studies featuring a similarly dedicated service provider role, found significantly higher consumer satisfaction with family relationships, family reconciliation, greater family education regarding mental illness, and improved housing stability for consumers (L. Dixon et al., 1998; Pickett-Schenk et al., 2007)

The findings from the current study support the role of the service provider as a bridge between family and consumers. As such, expanding the role of current service providers or incorporating a dedicated service provider focused exclusively on outreach and engagement with consumer families may improve current models serving racialized homeless individuals with mental illness. Incorporation of such a service provider role may help to assess the level of support needed by the family and reinforce the family’s potential caregiving role.

6.3.3 Considering the potential for caregiver burden

Beyond consumer-directed engagement with family members, the findings from the current study also suggest that family members may require additional support. Consumer and service provider narratives particularly emphasized mental illness and homelessness stigma as a barrier to family engagement. Family education regarding these issues may be a means of diminishing stigma and improving family and consumer willingness to engage in service provision. Such family psychoeducation programs have been effective for families of individuals with severe
mental illness, improving consumer outcomes and reducing family burden (Bradley et al., 2006; Chow et al., 2010; Drapalski et al., 2009; William R McFarlane, Dixon, Lukens, & Lucksted, 2003). Beyond stigma, both the service providers and family members in the current study identified and discussed specific caregiver burdens that family members face when caring for this consumer population such as a lack of financial resources. An understanding of the unique consumer and family context may be important for service providers to better assess and help to address the challenges faced by family caregivers of racialized homeless individuals coping with mental illness.

6.3.4 Integrating Consumer Choice and Family Centered Care into policy

The Housing First framework, specifically designed to address the needs of homeless individuals with mental illness, has gained support in recent years among policy makers across Canada (Canada NewsWire, 2014; Hewitt, 2013; Housing Matters BC, 2009; Ministry of Health and Long-Term Care, 2013). While the Housing First framework emphasizes consumer choice in obtaining housing and mental health treatment, and highlights the importance of community integration, there is little discussion on social support or family support within this model (Tsemberis et al., 2004).

Similarly, the Family Centered Care model also has significant evidence and support and has been implemented in a variety of health care settings (Health Canada, 2000; Johnson, 2000; MacFarlane, 2011; Surbone et al., 2010). Recently, the Mental Health Commission of Canada’s “National Guidelines for a Comprehensive Service System to Support Family Caregivers of Adults with Mental Health Problems and Illnesses” discussed the importance of FCC for respectfully incorporating family support into the recovery process for adults with mental illness.
Notably, the MHCC report includes family engagement, respect and dignity, choice, self-determination and independence, family caregivers’ distinct needs, and family caregiver sustainability as core principles (MacCourt et al., 2013). The guidelines regarding addressing family caregiver burdens and supporting caregiver needs are supported by the findings of the current study. However, consumer and service provider narratives suggest that consumer choice and autonomy are primary and serve as an important prerequisite to the process of engaging with families, which is also emphasized in the Housing First framework.

Policies recognizing the potentially negative or triggering role that families can play in the lives of racialized homeless individuals with mental illness and focusing first on consumer choice and autonomy in this process are important. Additionally, as policy makers continue to support Housing First and Family Centered Care models, the potentially supportive role that families can play in health care and health decision-making and the unique burdens that families experience in the caregiving process should be considered when developing policy and evidence based programs for this multiply marginalized population. Thus, policies designed to better serve racialized homeless consumers with mental illness will need to consider consumer choice and family needs unique to this consumer group.

6.4 Strengths and Limitations

There are several strengths and limitations to this study. The interpretivist-constructivist approach guiding this qualitative exploratory study allowed the researcher to identify and explore aspects of the lived experience of racialized homelessness individuals with mental illness, family members of this population, and service providers providing social services to this group. Further, informed by the intersectionality framework, this approached allowed the researcher to contextualize participant narratives within the intersecting social identities of racialization,
mental illness, and homelessness that can generate qualitatively different meanings for different individuals.

While the interpretivist-constructivist approach allows for generation of new concepts and theories, generalizability of findings cannot be determined in the current study. However, the emergence of sensitizing concepts specific to this population, the generalizability of concepts, and the transferability of findings add significant strength to the study (Green & Thorogood, 2009, p. 225). Given that racialized homeless individuals have been largely understudied and given the paucity of literature on family relationships among homeless adults in general, findings such as the importance of family, the culturally imbedded sense of duty to family and the barriers to family support that result from the process of migration are important sensitizing concepts specific to this multiply marginalized community. Furthermore, consideration of family dynamics, family needs, and consumer needs are important concepts that may be relevant to other multiply marginalized communities when incorporating families into the process of service provision.

In utilizing participant interview data, this study also relied on participants’ self-reports regarding family relationships. Given the particularly volatile nature of family relationships for this population, it is important to acknowledge that memories are fallible, and relationships are fragile and dynamic and will likely change over time (Hawkins & Abrams, 2007). As such, a single interview and focus groups may not capture the evolution of these volatile and dynamic family relationships.

Further, while this study draws upon the perspectives of multiple participant groups including consumers, family members, and service providers, the purposive and convenience
sampling strategies utilized also introduce certain limitations. In particular, the family members’ focus group was recruited through the service agency/ community partner and was a fairly self-selecting group. Two of the participants in this focus group expressed that they had volunteered with the service agency. Additionally, the group was highly involved in providing care for their mentally ill relative. As such, their views of family involvement in service provision for this population were unsurprisingly very positive. Though family members who are uninvolved would be a hard to reach group, their insights would add further depth and nuance to the emerging concepts in this study.

Finally, while the sample recruitment strategy stratified participants by gender, ethnic identity and intervention group, these were not found to be compelling lines of division among participant narratives. Largely the issues raised by consumers were similar across these groups. However, given the small sample size of this study and the lack of non-racialized comparison groups, the lack of differences that emerged between participant narratives in the stratified groups may be due to methodological limitations. Future research in this area may benefit from an expanded exploration of ethnicity, gender, and housing stability to determine if there are significant between group and within group differences in experiences with family.

6.5 Future Research

Future research on the efficacy of group-specific programs employing a dedicated family outreach worker or family support worker in the service provision process would provide insights into how service provider roles can be adapted to effectively serve this unique population. As well, quantitative comparative studies examining racialized and non-racialized homeless communities may provide greater direction regarding ethno-specific barriers, facilitators, and challenges regarding family involvement in service provision.
Quantitative survey data may also help to further illuminate resource-related caregiver burdens that emerged in the current study. A recent quantitative study by Polgar, North, and Pollio examined caregivers supporting a homeless family member with mental illness and reported important factors such as the number of hours dedicated to caregiving duties, which would help to better understand and address caregiver needs and support family caregivers for this population (2006). Future research should also attempt to engage with family members who have opted out of caregiving for this population to understand what factors may have influenced disengagement from this role. As well, examining matched consumer-family dyads could provide further insights into alignment of care goals, and challenges related to incorporating family involvement in the care process.

6.6 Conclusion

This qualitative exploratory study aimed to explore the role of family support and family involvement in social service provision for racialized homeless individuals with mental illness. Guided by intersectionality and family-centered care frameworks, the lived experiences of this multiply marginalized community were explored through semi-structured individual interviews with consumers, and focus groups with service providers serving this group, and family members involved in caregiving for this population, respectively.

The findings from this study suggest that family is important to racialized homeless individuals with mental illness and a number of different supports may be available from family members including emotional, financial, and instrumental supports. However, several barriers to both the availability of support and consumer willingness to accept support from family members were identified. Overall, participant narratives cautiously supported family involvement in service provision for this population, prompting consumer-directed inclusion of
family caregivers, while respecting consumer choice. Furthermore, for successful family engagement and involvement in service provision, consideration of family dynamics (including who is included in the consumer’s definition of family), consumer needs (including ensuring trust and safety in the family relationship), and family needs (including education and support to overcome caregiver burden) were perceived as important. However, specific factors related to racial or ethnic category did not emerge in this study as significant to family involvement.

Service providers were identified as sometimes playing an important role in bridging consumers and family members. This finding supports previous work on the significance of specialized provider roles focused on family outreach and engagement to successfully facilitate family involvement in care of individuals with mental illness.

By examining the viewpoints of consumers, service providers, and family members (who may all play a role in the therapeutic alliance), this study presents a unique perspective on the role of family in service provision for racialized homeless individuals with mental illness. As policy and practice guidelines increasingly emphasize the importance of family support and involvement in community based mental health care, and as policy makers continue to support models like the Housing First framework and Family Centered Care, it is essential to better understand the nature of family relationships and barriers and facilitators of family support for multiply marginalized homeless consumers in order to better tailor mental health and housing services for this unique population.
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Appendices

Appendix A: Individual (Consumer) Interview Guide

**Individual Interview Guide: Family role in consumer experience of homelessness, mental illness, and racialization**

Thank you for attending this voluntary interview session. As you know, the purpose of this interview is for you to share your experience with homelessness, being a person of colour and having mental health issues and how this has affected your family relationships. We believe that this is important because the findings of this research can help enrich services for homeless people of colour with mental health issues. The interview will be no more than 1 to 1.5 hours in length.

Before we get started let’s review the consent form. Then you can decide if you want to participate in the interview.

[Interviewer reviews the information letter and consent form with the participant]

What questions do you have before we begin?
[After questions have been asked and answered, participant is asked to complete the consent form and give them to the interviewer]

**Overall family relationship**

In this first part of the interview, I’d like to ask you about family relationships.

1. When you think of family, what images, thoughts and feelings come to mind?
2. Who do you consider to be a part of your family?
3. When was the last time that you were with your family? What was that experience like? What about the times before that? What were those times like? **Probes:** How did you feel about being with your family? What did you do together? What would you like to have done?
4. Think about the best time you had with your family. What was that like? **Probes:** What images, thoughts, or feelings come to mind about that experience?
5. Think about the worst time you had with your family. What was that like? **Probes:** What images, thoughts, or feelings come to mind about that experience? If things had gone the way you want, what would have gone differently in that experience?

**Family support**

With the next set of questions, I’m interested in hearing about the support you are receiving from your family.
6. How do you keep connected with your family, if at all? **Probes:** Do you call them? Do they respond to your calls? Do they call you?

7. For example, if you get sick, or if you need help finding a place to live, do you go to your family for help? **Probes:** Do they help out in other ways (financial, housing, food, transportation, emotional)?

8. How do you feel about getting or not getting help from your family? **Probes:** build trust, sense of connectedness/family cohesion, sense of security, feelings of resentment, indebtedness, less independent/less control of your own life, shame, guilt, etc

**The experience of homelessness and mental illness and the effects on family relationships**

In this part of the interview, I’d like to ask you about your experience with mental health issues and homelessness and your family relationships.

9. You haven’t had a home of your own for a while. How has this influenced how you and your family connect to each other? **Probes:** Has it changed the way you relate with your family? Has it changed the help or support that you get from them?

10. You have dealt with mental health issues for a while. How has this influenced or not influenced how you and your family relate to each other? **Probes:** Has it changed the way you connect with your family? Has it changed the help or support that you get from them?

**Ethnic, cultural, or racial community perceptions of homelessness, mental illness and family relationships**

With the next set of questions, I’m interested in hearing about how homelessness, mental illness and family relationships are perceived in your ethnic, cultural or racial community.

11. In your family, what are some beliefs or attitudes about homelessness?
   a. Are these beliefs common in your extended family?
   b. Are these beliefs common in your ethnic, cultural or racial community?

12. In your family, what are some beliefs or attitudes about mental illness?
   a. Are these beliefs common in your extended family?
   b. Are these beliefs common in your ethnic, cultural or racial community?

13. Is your family a close-knit family?
   a. Is your extended family close-knit?
   b. Is this an important part of your ethnic, cultural or racial community?

**Overall perception – Service providers and the role of client families**

Finally, I would like to hear about your overall perception of family support for homeless people of colour with mental health issues.

14. Overall, should families work with services providers to support people of colour with mental health problems and homelessness?

That concludes the interview. Thank-you for your participation in this study.
Appendix B: Service Provider Focus Group Guide

Focus Group Guide: Service Providers of Racialized individuals experiencing or having had experienced Mental Health problems and Homelessness

Thank you everyone for attending this voluntary focus group session. As you know, the purpose of this focus group is for you to share your experience working with and providing services for individuals who have been or are currently homeless, have experienced or are currently experiencing mental illness, and identify as a person of colour. We believe that this is important because the findings of this research can help enrich services for racialized homeless individuals with mental health issues. The focus group will be no more than 1 to 1.5 hours in length.

Before we get started let’s review the consent form. Then you can decide if you want to participate in the focus group.

[Interviewer reviews the information letter and consent form with participants.]

What questions do you have before we begin?

[After questions have been asked and answered, participants are asked to complete the consent forms and give them to the facilitators.]

Let’s begin by introducing ourselves to the rest of the group.

[After introductions have been made] I am now going to start the tape recorder.

The purpose of today’s discussion is to focus on your experience with providing services for racialized clients with mental health issues and homelessness. I will give everyone a chance to respond to each question. If you don’t want to give your opinions or voice your experiences about the question, feel free to pass.

Icebreaker

Let’s begin by sharing our favourite colour. [Moderator shares first to put participants at ease]

Relationship between clients and family members

I will start off by asking generally about family relationships you’ve observed when working with racialized homeless clients with mental illness.

1. Think about 5 clients who have close family relationships, what are these relationships like? Probes: How do they engage with their family? What do they do? How do family members engage with them?

2. Think about 5 clients who have strained family relationships, what are these relationships like? Probes: What do they do differently than those with close family relationships?
3. When working with clients, what feelings, thoughts or images come up regarding families?

**Nature and impact of Family Support**

In this next set of questions, we will talk about different kinds of supports that kinship ties can provide and how these affected your clients.

4. Think of 5 clients who have asked family members for help. What kind of help do they ask for? **Probes:** financial, housing, food, transportation, emotional support

5. Reflecting on the same 5 clients, how have their families responded to them asking for help?

6. How did this affect your work with your client? **Probes:** Help or hinder? Encourage treatment adherence? Housing stability? Do different supports help or hinder clients in different ways?

**Ethnic, cultural, or racial tradition or background and family dynamics**

In the following set of questions, we will discuss how client’s ethnic, cultural, or racial traditions or background affects their family relationships.

7. Among your clients, what are some beliefs or attitudes about family relationships? **Probes:** Have these beliefs helped your client overall? Have these beliefs hindered your clients overall?

8. Among the clients or families you’ve worked with, what are some beliefs or attitudes about mental health? **Probes:** Have these beliefs helped your client overall? Have these beliefs hindered your clients overall?

9. Among the clients or families you’ve worked with, what are some beliefs or attitudes about homelessness? **Probes:** Have these beliefs helped your client overall? Have these beliefs hindered your clients overall?

**Professional client-service provider relationships and family involvement**

In this final set of questions we will discuss how client families affect professional relationships between yourself and your clients.

10. Among clients who are connected with their families, what roles do family members take on when they get involved with their relative?

11. Among clients who are connected with their families, how does family involvement affect the work you do? **Probes:** How does it affect your professional relationship with your client? How does it affect the services you provide? Is there overlap between your role and roles that family members take on? Does family involvement strengthen the relationship between you and your clients? Does it create tension between you and your client? Does it help or hinder you from providing services? Is it complimentary to the work you do? Is it conflicting?

12. Among clients who are not connected to their families, how does the absence of family involvement affect the work you do with your clients?
Overall perception – Service providers and the role of client families

13. Overall, should families work with services providers to support people of colour with mental health problems and homelessness?

**Probe:** What is the value of family support for this client group?

That concludes the focus group. Thank-you for your participation in this study.
Appendix C: Family Member Focus Group Guide

**Focus Group Guide: Family Members of Racialized individuals experiencing Mental Health problems and Homelessness**

Thank you everyone for attending this voluntary focus group session. As you know, the purpose of this focus group is for you to share your experience with having a family member who has been or is currently homeless, has experienced or is currently experiencing mental illness, and identifies as a person of colour. We believe that this is important because the findings of this research can help improve services for this group. The focus group will be no more than 1 to 1.5 hours in length.

Before we get started let’s review the consent form. Then you can decide if you want to participate in the focus group.

[Interviewer reviews the information letter and consent form with participants.]

What questions do you have before we begin?

[After questions have been asked and answered, participants are asked to complete the consent forms and give them to the facilitators.]

Let’s begin by introducing ourselves to the rest of the group.

[After introductions have been made] I am now going to start the tape recorder.

The purpose of today’s discussion is to focus on your experience with a family member who is a person of colour and has or has had mental health issues and issues of homelessness. I will give everyone a chance to respond to each question. If you don’t want to give your opinions or voice your experiences about the question, feel free to pass.

**Icebreaker**

Let’s begin by sharing where we are from and how long we’ve lived in Toronto. [Moderator shares first to put participants at ease]

**Overall Family Relationship**

I will start off by asking generally about family and family relationships.

14. When you think of family, what images, thoughts and feelings come to mind? **Probes:** Who do you consider to be a part of your family?

15. You all have a family member that has/has had issues with mental health and homelessness. How do you keep in touch with them? Do you call? Do they call you? When they’re sick or need help, do they get in touch with you?
16. Think about the best time that you spent with your family member, what was it like?  
**Probes:** What images, thoughts, or feelings come to mind about that experience? What about that time did you like the most?

17. Think about the worst time that you spent with your family member, what was that like?  
**Probes:** What images, thoughts, or feelings come to mind about that experience? What things could have gone differently?

**Cultural/Traditional perspectives or attitudes**

In this set of questions, we’ll discuss how homelessness, mental health and families are perceived in your cultural or traditional background or community.

18. In your family, what are some beliefs about homelessness? Are these beliefs common in your extended family? Are these beliefs common in your community?

19. In your family, what are some beliefs about mental illness? Are these beliefs common in your extended family? Are these beliefs common in your community?

20. Is your family a close-knit family? Is your extended family close-knit? Is this an important part of your culture or community?

**Nature of Supports Provided**

In this next set of questions, we will talk about different kinds of supports provided by family.

21. Think back to a time when your family member asked you for help. What was that experience like?  
**Probes:** What kind of help did they want? What kinds of support did you give them? What made you decide to help them?

22. Can you think of a time when your family member asked for your help and you did not help them?  
**Probes:** What made you decide not to help them that time?

**Value of Providing Supports and Value of Support Provided**

In this final set of questions, I would like to talk about the value of providing supports for your family members dealing with homelessness and mental illness.

23. When you help your family member, how does it change things for them?  
**Probes:** How does your support help them? How does your support hinder them?

24. How do you feel about helping your family member? How does helping them affect your life?  
**Probes:** financially, emotionally etc

25. When your relative asks for help, how does it change the way you relate with your relative? How does it change the way you relate to the rest of your family?  
**Probes:** Strengthen or weaken relationships? Brings family closer or pushes them away? Builds trust? Creates more dependency?

**Overall perception – Service providers and the role of client families**

Finally, I would like to hear about your overall perception of family support for homeless people of colour with mental health issues.
15. Overall, should families work with services providers to support people of colour with mental health problems and homelessness?

That concludes the focus group. Thank-you for your participation in this study.
Appendix D: Sample Informed Consent Form – Consumer

Letter of Information and Consent to Participate in a Research Study

Title of Research Study: ‘At Home’ Research Demonstration Project in Mental Health and Homelessness: The core features and perceived value of family support for ethnoracial homeless individuals with mental illness: Findings from the At Home/Chez Soi Project

Introduction

Before agreeing to take part in this research study, it is important that you read and understand this research consent form. It includes details that we think you need to know in order to decide if you wish to take part in this part of the study. If you have any questions, please ask a study staff person. You should not sign this form until you are sure you understand all of the information. Taking part in this research is completely voluntary. You may also wish to discuss the study with a family member, worker or close friend.

Investigators:

The individuals below can all be reached from Monday to Friday, 9:00 am – 5:00 pm

Principal Investigator:
Vicky Stergiopoulos, MD, MHSc
Centre for Research on Inner City Health, St. Michael’s Hospital
Tel: 416-864-6060 Ext. 3341

Research Coordinator:
Jeyagobi Jeyaratnam, MPH
Centre for Research on Inner City Health, St. Michael’s Hospital
Tel: 416-864-6060 Ext. 77378

Study Funding:

This study is funded by the Mental Health Commission of Canada
Purpose of the Research:

This research project is a part of the “At Home” Research Demonstration Project in Mental Health and Homelessness study. The primary objective of this component of the study is to examine family support for homeless individuals with mental health problems who self-identify as a member of a racialized group. This study will include a number of interviews with individual consumers in the At Home/Chez Soi project. There will also be one focus group of staff and one focus group of family members.

Description of the Research

In this part of the study, we are inviting you to take part in an interview that will be conducted by a member of the Toronto site research team. You have been invited to participate in this study because you identify as belonging to African, Caribbean or South Asian ethnoracial groups and are a part of the At Home/Chez Soi project. You have also been invited to participate because you are willing to share your experiences and are fluent in English.

You are being asked to participate in one individual interview that will last about 1 to 2 hours. The interview will be conducted one-on-one by a member of the research team. During the interview, you will be asked a number of questions about your experiences with homelessness, mental health issues, experiences of being a person of colour (racialization), and family relationships. With your permission, the interview will be audio recorded by the interviewer. The contents of the audio tape will be typed out (transcribed) to provide a written record of what was said during the interview. If you do not wish to be audio taped, you will not be eligible to participate.

Potential Risks

There are no significant risks to your well-being by participating in this interview. However, it is possible that if you have had a negative experience in your life, you may find yourself becoming upset as you remember that experience. If you find any question or the interview experience distressing, note that...
you do not need to answer any question that you do not wish to, and you can let the interviewer know if you would like to take a break or end the interview.

**Potential Benefits**

You may not benefit from participating in this study. However the results of the study may help us come up with ways to improve the implementation of programs for homeless individuals here in Toronto and other areas as well. Finally, the results of this study will contribute to current existing information on the value of family supports in programs for homeless people with mental health and issues relating to race.

**Protecting your Privacy**

All your study data including the information you provide during the interview will be identified only by a unique study ID number assigned to you. This includes the audio files and transcripts (written records) of your interview. Anything you say during the interview cannot be traced back to you. We may need to directly quote what you have said for the study write-ups and/or presentations, however, the quotations will not contain any information that will allow you to be identified.

This study also will include a focus group of family members. Your family member may or may not participate in this part of the research. Your responses will not be shared with your family member, whether your family member participates in this study or.

This study will also include a focus group of staff members from the At Home study. Staff members that have worked with you may or may not participate in this study. While a staff member may have helped connect you to this research study, your responses will not be shared with any staff members.

All study data will be stored on a secure (password protected) computer system at the Centre for Research on Inner City Health, at St. Michael’s Hospital, which is accessible only to members of the research team. Transcripts (written records) of the interviews will be stored in a locked filing cabinet at the Centre for Research on Inner City Health, at St. Michael’s Hospital. All audio files will be destroyed
after they have been transcribed and verified and paper transcripts will be destroyed by 7 years after the interview date.

**Study Results**

We plan to present the results of the research at professional and scientific conferences and to publish the findings in professional and scientific journals. However, it is also possible that the investigators may choose to not publish or make use of the results from this study.

**Reimbursement of Participants**

If you agree to participate in the study, you will be paid back for any reasonable expenses related to your participation including time spent in this interview. You will receive the amount of $25 and two TTC tokens.

**Participation and Withdrawal**

Your participation in this study is purely voluntary and you have the right to decide whether you want to participate or not. Your decision to take part or not will not affect in any way the services you receive through the larger “At Home” project. If you with withdraw from the study, we will not transcribe any of your responses to the interview. You have the right to withdraw your response to any question or to the entire interview without penalty. You can stop the interview at any time, and you will still receive compensation even if you don’t answer all of the interview questions. If you decide to stop the interview or withdraw from the study at any time, the information that you have provided us in the larger At Home project up until that time will still be kept for research purposes, however, all responses to this interview will not be transcribed or used for this study.

During the interview there may be things that have been discussed which you may have concerns about. If you have any questions or concerns about yourself or your family, the interviewer will distribute to all
participants a list of names and phone numbers of people and agencies in your community that can assist with any questions or concerns that you might have.

**Research Ethics and Board Contact**

If you have any questions regarding your rights as a research participant, you may contact Dr. Bob Hyland, Chair, St. Michael’s Hospital Research Ethics Board at (416) 864-6060 ext 2557 during business hours.

The Research Ethics Board at St. Michael’s Hospital may need to review records for monitoring purposes. As part of this review, someone may contact you from the Research Ethics board to discuss your experience in the study.

**Study Contacts**

If you have any questions about this study, contact Jeyagobi Jeyaratnam, Research Coordinator, Center for Research on Inner City Health, St. Michael’s Hospital at 416-864-6060 Ext. 77378
‘At Home’ Research Demonstration Project in Mental Health and Homelessness: The core features and perceived value of family support for ethnoracial homeless individuals with mental illness: Findings from the At Home/Chez Soi Project

Consent:

I acknowledge that the research study described above has been explained to me and that any questions that I have asked have been answered to my satisfaction. I have been informed of my right to choose not to participate in the study. As well, the potential risks, harms and discomforts have been explained to me and I also understand the benefits of participating in the research study. I understand that I have not waived my legal rights nor released the investigators, sponsors, or involved institutions from their legal and professional duties. I know that I may ask now or in the future any questions I have about the study or the research procedures. I have been assured that information will not be released or printed that would disclose my personal identity without my permission unless required by law. I have been given enough time to read and understand the above information.

By signing this consent, I agree to participate in this study. I will be given a signed copy of the entire consent form, including this signature page.

X__________________________________________________________
Signature of Participant Name (Printed) Date

X__________________________________________________________
Signature of Study Person Explaining Study Name (Printed) Date

I agree to have the interview tape-recorded.

Yes__________ No__________ Initials____________
Consent Form – Declaration of Assistance

‘At Home’ Research Demonstration Project in Mental Health and Homelessness: The core features and perceived value of family support for ethnoracial homeless individuals with mental illness: Findings from the At Home/Chez Soi Project

Study Participant’s name (Print): ______________________________________________________

Assistance Declaration

☐ ______ Initials (check and initial here if not applicable)

The participant was assisted during the consent process as follows (check as applicable)

☐ Witness Declaration and Signature:

If a participant is unable to read independently for any reason or unable to sign, a witness should be present during the entire informed consent discussion and sign below. The witness may be a family member who is able to read.

By signing the consent form I attest that the information was accurately explained to and apparently understood by the participant and that consent was given freely.

X______________________________
Signature of Witness

______________________________
Name of Witness (Printed)

______________________________
Date
Appendix E: Sample Informed Consent Form – Service Provider

Letter of Information and Consent to Participate in a Research Study

Title of Research Study: ‘At Home’ Research Demonstration Project in Mental Health and Homelessness: The core features and perceived value of family support for ethnoracial homeless individuals with mental illness: Findings from the At Home/Chez Soi Project

Introduction

Before agreeing to take part in this research study, it is important that you read and understand this research consent form. It includes details that we think you need to know in order to decide if you wish to take part in this part of the study. If you have any questions, please ask a study staff person. You should not sign this form until you are sure you understand all of the information. Taking part in this research is completely voluntary. You may also wish to discuss the study with a family member, worker or close friend.

________________________________________

Investigators:

The individuals below can all be reached from Monday to Friday, 9:00 am – 5:00 pm

Principal Investigator:

Vicky Stergiopoulos, MD, MHSc
Centre for Research on Inner City Health, St. Michael’s Hospital
Tel: 416-864-6060 Ext. 3341

Research Coordinator:

Jeyagobi Jeyaratnam, MPH
Centre for Research on Inner City Health, St. Michael’s Hospital
Tel: 416-864-6060 Ext. 77378

Study Funding:

This study is funded by the Mental Health Commission of Canada
Purpose of the Research:

This research project is a part of the “At Home” Research Demonstration Project in Mental Health and Homelessness study. The primary objective of this component of the study is to examine family support for homeless individuals with mental health problems who self-identify as a member of a racialized group. This study will include a number of interviews with individual consumers in the At Home/Chez Soi project. There will also be one focus group of staff and one focus group of family members.

Description of the Research

In this part of the study, we are inviting you to take part in one focus group session with eight people who all work in the At Home project as service providers. You have been invited to participate in this focus group because you have at least one year of experience working with moderate mental health care needs ethnoracial homeless clients. You have also been invited to participate because you are willing to share your experiences and are fluent in English. The focus group will last about 1 to 2 hours. During the focus group, you will be asked a number of questions about your experiences with working with clients who have been or are currently homeless, have experienced or are currently experiencing mental illness, and identify as belonging to a racialized group or identify as a person of colour and their families. With your permission, the focus group will be audio recorded by the interviewer. If you do not wish to be audio taped, you will not be eligible to participate.

Potential Risks

There are no significant risks to your well-being by participating in this focus group. However, it is possible that if you have had a negative experience related to your work with the homeless, people with mental health or racialization issues or in your personal life, and you may find yourself becoming upset as you remember that experience. If you find any question or any part of the focus group experience very unpleasant or distressing, you do not need to answer any question that you do not wish to, and you can let the interviewer know if you would like to take a break or withdraw completely from the focus group.
Potential Benefits

You may not benefit from participating in this study. However the results of the study may give us information on ways to improve programs for homeless individuals here in Toronto and other areas as well. Finally, the results of this study will contribute to current existing information on the value of family supports in programs for homeless people with mental health and racialization issues.

Protecting your Privacy

All your study data including the information you provide during the group discussion will be identified only by a unique study ID number assigned to you. This includes the audio files and transcripts (written records) of the group discussion. All information provided during the focus group will be kept confidential and private. We may need to directly quote what you have said in our study reports or presentations, however quotations used will not contain any information that allows you to be identified. There is a slight risk that direct quotations may be linked back to you but efforts will be made to avoid this by paraphrasing information if needed.

All audio files and transcripts of digitally recorded focus groups will be stored on a secure (password protected) web-server at the Centre for Research on Inner City Health, at St. Michael’s Hospital, which is accessible only to members of the research team. Transcriptions of the focus groups will be stored in a locked filing cabinet at the Centre for Research on Inner City Health, at St. Michael’s Hospital. All audio files will be destroyed once they have been transcribed and verified) and paper transcripts will be destroyed by 7 years after the focus group date.

Study Results

We plan to present the results of the research at professional and scientific conferences and to publish the findings in professional and scientific journals. Note that the investigators may choose to not publish or make use of the results from this study.

Reimbursement of Participants
If you agree to participate in the study, you will be paid back for any reasonable expenses related to your participation in this focus group including time spent for the focus group.

**Participation and Withdrawal**

Your participation in this study is purely voluntary and you have the right to decide that you do not want to take part in the research. Your decision to take part or not will not affect your work with the At Home study in any way. If you withdraw from the study, we will not transcribe any of your responses to the focus group. You have the right to withdraw your response to any question without penalty. You can stop participating in the focus group at any time. During the focus group there may be things that have been discussed which you may have concerns about. If you have any questions or concerns about yourself or the work that you do for the project, you can talk to the interviewer who can provide you with details on who you can approach to address your questions or concerns.

**Research Ethics and Board Contact**

This study has been reviewed and approved by the Research Ethics Board at St. Michael’s Hospital. If you have any questions regarding your rights as a research participant, you may contact Dr. Bob Hyland, Chair, St. Michael’s Hospital Research Ethics Board at (416) 864-6060 ext 2557 during business hours.

The Research Ethics Board at St. Michael’s Hospital may need to review records for monitoring purposes. As part of this review, someone may contact you from the Research Ethics board to discuss your experience in the study.

**Study Contacts**

If you have any questions about this study, contact Jeyagobi Jeyaratnam, Research Coordinator, Center for Research on Inner City Health, St. Michael’s Hospital at 416-864-6060 Ext. 77378
‘At Home’ Research Demonstration Project in Mental Health and Homelessness: The core features and perceived value of family support for ethnoracial homeless individuals with mental illness: Findings from the At Home/Chez Soi Project

Consent:

I acknowledge that the research study described above has been explained to me and that any questions that I have asked have been answered to my satisfaction. I have been informed of my right to choose not to participate in the study. As well, the potential risks, harms and discomforts have been explained to me and I also understand the benefits of participating in the research study. I understand that I have not waived my legal rights nor released the investigators, sponsors, or involved institutions from their legal and professional duties. I know that I may ask now or in the future any questions I have about the study or the research procedures. I have been assured that information will not be released or printed that would disclose my personal identity without my permission unless required by law. I have been given enough time to read and understand the above information.

By signing this consent, I agree to participate in this study. I will be given a signed copy of the entire consent form, including this signature page.

X
Signature of Participant
Name (Printed)
Date

X
Signature of Study Person Explaining Study
Name (Printed)
Date

I agree to have the focus group tape-recorded.

Yes No Initials
Consent Form – Declaration of Assistance

‘At Home’ Research Demonstration Project in Mental Health and Homelessness: The core features and perceived value of family support for ethnoracial homeless individuals with mental illness: Findings from the At Home/Chez Soi Project

Study Participant’s name (Print):__________________________________________________

Assistance Declaration

☐ _______ Initials (check and initial here if not applicable)

The participant was assisted during the consent process as follows (check as applicable)

☐ Witness Declaration and Signature:

If a participant is unable to read independently for any reason or unable to sign, a witness should be present during the entire informed consent discussion and sign below. The witness may be a family member who is able to read.

By signing the consent form I attest that the information was accurately explained to and apparently understood by the participant and that consent was given freely.

X_________________________ ___________________________ _____________________
Signature of Witness Name of Witness (Printed) Date
Appendix F: Sample Informed Consent Form – Family Member

Letter of Information and Consent to Participate in a Research Study

Title of Research Study: ‘At Home’ Research Demonstration Project in Mental Health and Homelessness: The core features and perceived value of family support for ethnoracial homeless individuals with mental illness: Findings from the At Home/Chez Soi Project

Introduction

Before agreeing to take part in this research study, it is important that you read and understand this research consent form. It includes details that we think you need to know in order to decide if you wish to take part in this part of the study. If you have any questions, please ask a study staff person. You should not sign this form until you are sure you understand all of the information. Taking part in this research is completely voluntary. You may also wish to discuss the study with a family member, worker or close friend.

Investigators:

The individuals below can all be reached from Monday to Friday, 9:00 am – 5:00 pm

Principal Investigator:

Vicky Stergiopoulos, MD, MHSc
Centre for Research on Inner City Health, St. Michael’s Hospital
Tel: 416-864-6060 Ext. 3341

Research Coordinator:

Jeyagobi Jeyaratnam, MPH
Centre for Research on Inner City Health, St. Michael’s Hospital
Tel: 416-864-6060 Ext. 77378

Study Funding:

This study is funded by the Mental Health Commission of Canada
Purpose of the Research:

This research project is a part of the “At Home” Research Demonstration Project in Mental Health and Homelessness study. The primary objective of this component of the study is to examine family support for homeless individuals with mental health problems who self-identify as a member of a racialized group. This study will include a number of interviews with individual consumers in the At Home/Chez Soi project. There will also be one focus group of staff and one focus group of family members.

Description of the Research

In this part of the study, we are inviting you to take part in one focus group session that will be conducted by a member of the Toronto site research team. You have been invited to participate in this focus group because you are supporting or have supported at least one relative who is currently experiencing or has experienced homelessness and mental health issues and has identified himself/herself to be of African, Caribbean or South Asian origin. You have also been invited to participate because you are willing to share your experiences and are fluent in English.

The focus group will involve 8 people who are supporting or have supported relatives with homelessness issues like you. The session will last about 1 to 2 hours. You will be asked a number of questions about your experiences with your family member who has been or is currently homeless, has experienced or is currently experiencing mental illness, and identifies as belonging to a racialized group or identifies as a person of colour. You will also be encouraged to discuss these experiences with other individuals participating in this focus group. With your permission, the focus group will be audio recorded by the interviewer. This will allow us to keep an accurate record of what has been discussed. The contents of the audio tape will be typed out (transcribed) for analysis. If you do not wish to be audio taped, you will not be eligible to participate.

Potential Risks
There are no significant risks to your well-being by participating in this interview. However, it is possible that if you have had a negative experience in your life, you may find yourself becoming upset as you remember that experience. If you find any question or the focus group experience distressing, note that you do not need to answer any question that you do not wish to, and you can let the interviewer know if you would like to take a break or end the interview.

**Potential Benefits**

You may not benefit from participating in this study. However the results of the study may help us find ways to improve the way programs and services for homeless people are run here in Toronto and other areas as well. Finally, the results of this study will contribute to current existing information on the value of family supports in programs for homeless people with mental health and issues relating to their race.

**Protecting your Privacy**

All your study data including the information you provide during the focus group will be identified only by a unique study ID number assigned to you. This includes the audio files and transcripts (written records) of your interview. Anything you say during the interview cannot be traced back to you. We may need to directly quote what you have said for the study write-ups and/or presentations, however, the quotations will not contain any information that will allow you to be identified.

Although a staff member connected you to the research team, no staff members will be informed about anything discussed during the focus group. They also will not have access to the audio files or transcripts that are produced from the focus group. They may have access to presentations or reports that are developed from the discussions, but you will not be identified in these reports and your responses will not be linked to you. As well, if your family member is involved in the At Home/Chez Soi study in any way, they also will not be informed about anything discussed in the focus group. They also will not have access to the audio files or transcripts that are produced from the focus group. They may have access to presentations or reports that are developed from the discussions, but you will not be identified in these reports and your responses will not be linked to you.
All study data will be stored on a secure (password protected) web-server at the Centre for Research on Inner City Health, at St. Michael’s Hospital, which is accessible only to members of the research team. Transcriptions of the interviews will be stored in a locked filing cabinet at the Centre for Research on Inner City Health, at St. Michael’s Hospital. All audio files will be destroyed once they have been transcribed and verified and paper transcripts will be destroyed by 7 years after the focus group date.

Study Results

We plan to present the results of the research at professional and scientific conferences and to publish the findings in professional and scientific journals. However, it is also possible that the investigators may choose to not publish or make use of the results from this study.

Reimbursement of Participants

If you agree to participate in the study, you will be paid back for any reasonable expenses related to your participation including time spent in this focus group. You will receive the amount of $25 and two TTC tokens.

Participation and Withdrawal

Your participation in this study is purely voluntary and you have the right to decide whether you want to participate or not. If your relative is participating in the At Home project, your decision on whether or not you participate will not affect the participation of your relative and the services he/she receives under the At Home Project.

You have the right to withdraw your response to any question without penalty. You can stop the focus group at any time, and you will still receive compensation even if you don’t answer all of the questions. During the focus group there may be things that have been discussed which you may have concerns about. If you have any questions or concerns about yourself or your family, the interviewer will
distribute to all participants a list of names and phone numbers of people and agencies in your community that can assist with any questions or concerns that you might have.

**Research Ethics and Board Contact**

If you have any questions regarding your rights as a research participant, you may contact Dr. Bob Hyland, Chair, St. Michael’s Hospital Research Ethics Board at (416) 864-6060 ext 2557 during business hours.

The Research Ethics Board at St. Michael’s Hospital may need to review records for monitoring purposes. As part of this review, someone may contact you from the Research Ethics board to discuss your experience in the study.

**Study Contacts**

If you have any questions about this study, contact Jeyagobi Jeyaratnam, Research Coordinator, Center for Research on Inner City Health, St. Michael’s Hospital at 416-864-6060 Ext. 77378
‘At Home’ Research Demonstration Project in Mental Health and Homelessness: The core features and perceived value of family support for ethnoracial homeless individuals with mental illness: Findings from the At Home/Chez Soi Project

Consent:

I acknowledge that the research study described above has been explained to me and that any questions that I have asked have been answered to my satisfaction. I have been informed of my right to choose not to participate in the study. As well, the potential risks, harms and discomforts have been explained to me and I also understand the benefits of participating in the research study. I understand that I have not waived my legal rights nor released the investigators, sponsors, or involved institutions from their legal and professional duties. I know that I may ask now or in the future any questions I have about the study or the research procedures. I have been assured that information will not be released or printed that would disclose my personal identity without my permission unless required by law. I have been given enough time to read and understand the above information.

By signing this consent, I agree to participate in this study. I will be given a signed copy of the entire consent form, including this signature page.

X____________________________  ___________________________  ________________
Signature of Participant  Name (Printed)  Date

X____________________________  ___________________________  ________________
Signature of Study Person Explaining Study  Name (Printed)  Date

I agree to have the interview tape-recorded.

Yes_____________  No_____________  Initials___________
Consent Form – Declaration of Assistance

‘At Home’ Research Demonstration Project in Mental Health and Homelessness: The core features and perceived value of family support for ethnoracial homeless individuals with mental illness: Findings from the At Home/Chez Soi Project

Study Participant’s name (Print): ________________________________

Assistance Declaration

☐ _______ Initials (check and initial here if not applicable)

The participant was assisted during the consent process as follows (check as applicable)

☐ Witness Declaration and Signature:

If a participant is unable to read independently for any reason or unable to sign, a witness should be present during the entire informed consent discussion and sign below. The witness may be a family member who is able to read.

By signing the consent form I attest that the information was accurately explained to and apparently understood by the participant and that consent was given freely.

X______________________________ ____________________________ ____________
Signature of Witness Name of Witness (Printed) Date
Appendix G: Ethics Approval Notices

UNIVERSITY OF TORONTO

OFFICE OF THE VICE PRESIDENT, RESEARCH

PROTOCOL REFERENCE # 27466

March 9, 2012

Dr. Stephen Hwang
DEPT OF MEDICINE
FACULTY OF MEDICINE

Ms. Gayathri Naganathan
DEPT OF MEDICINE
FACULTY OF MEDICINE

Dear Dr. Hwang and Ms. Gayathri Naganathan,

Re: Administrative Approval of your research protocol entitled, "The core features and perceived value of family support for ethnoracial homeless individuals with mental illness: Findings from the At Home/Chez Soi Project"

We are writing to advise you that the Office of Research Ethics (ORE) has granted administrative approval to the above-named research protocol. The level of approval is based on the following role(s) of the University of Toronto (University), as you have identified with your submission and administered under the terms and conditions of the affiliation agreement between the University and the associated TAHSN hospital:

- Graduate Student research - hospital-based only
- Storage or analysis of De-identified Personal Information (data)

This approval does not substitute for ethics approval, which has been obtained from your hospital Research Ethics Board (REB). Please note that you do not need to submit Annual Renewals, Study Completion Reports or Amendments to the ORE unless the involvement of the University changes so that ethics review is required. Please contact the ORE to determine whether a particular change to the University's involvement requires ethics review.

Best wishes for the successful completion of your research.

Yours sincerely,

Daniel Gyewu
REB Manager

OFFICE OF RESEARCH ETHICS
Matherich Building, 12 Queens Park Crescent West, 2nd Floor, Toronto, ON M5S 3S8 Canada
Tel: +1 416 946-3273 • Fax: +1 416 946-5763 • ethics.review@utoronto.ca • http://www.research.utoronto.ca/for-researchers/administers-ethics/
February 14, 2012

Dr. Vicky Stergiopoulos,
Department of Psychiatry, Centre for Research on Inner City Health Program,
St Michael's Hospital

Dear Dr. Stergiopoulos,

Re: REB # 11-296 - The core features and perceived value of family support for ethnoracial homeless individuals with mental illness: Findings from the At Home / Chez Soi Project

REB APPROVAL:
Original Approval Date: February 14, 2012
Annual/Interval Review Date: February 14, 2013

Thank you for your application submitted on October 17, 2011. The above noted study has been reviewed through an expedited/delegated process (not by Full Board review). The views of the St. Michael's Hospital (SMH) Research Ethics Board (REB) have been documented and resolved.

The REB approves the study as it is found to comply with relevant research ethics guidelines, as well as the Ontario Personal Health Information Protection Act (PHIPA), 2004. The REB hereby issues approval for the above named study for a period of 12 months from the date of this letter. Continuation beyond that date will require further review of REB approval. In addition, the following documents have been reviewed and are hereby approved:

1. Protocol
2. Consumers Consent Form version dated February 02, 2012
3. Family Members Consent Form version dated February 02, 2012
4. Service Providers Consent Form version dated February 02, 2012
5. Consumers Recruitment Email version dated February 13, 2012
6. Family Members Recruitment Email version dated February 13, 2012
7. Service Providers Recruitment Email version dated February 13, 2012
11. Family Member Initial Contact Script version dated February 13, 2012
12. Service Provider Initial Contact Script version dated February 13, 2012

Furthermore, the following documents have been received and are acknowledged:

1. Study Budget
2. At Home Study Community Resources Information Guide

During the course of this investigation, any significant deviations from the approved protocol and/or unanticipated developments or significant adverse events should immediately be brought to the attention of the REB.

Please note that if a Clinical Trial Agreement is required, it must be submitted to the Office of Research Administration for review and approval. Any additional institutional approvals must be coordinated through the Office of Research Administration prior to initiation of this research. All drug dispensing must be coordinated through the Research Pharmacy at 416-864-5413.

Dr. Vicky Stergiopoulos (REB# 11-296)
The St. Michael’s Hospital (SMH) Research Ethics Board (REB) operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans, the Ontario Personal Health Information Protection Act, 2004, and ICH Good Clinical Practice Consolidated Guideline E6, Health Canada Part C Division 5 of the Food and Drug Regulations, Part 4 of the Natural Health Product Regulations, and the Medical Devices regulations. Furthermore, all investigational drug trials at SMH are conducted by Qualified Investigators (as defined in the latter document).

With best wishes

☐ Dr. Bob Hyland
Chair, Research Ethics Board

Dr. Brenda McDowell
Vice Chair, Research Ethics Board