THE RELEVANCE OF POLICY, PRACTICES AND OTHER DYNAMICS IN THE LIVES OF PEOPLE FACING MENTAL HEALTH AND ADDICTIONS CHALLENGES AND HOMELESSNESS IN RURAL ONTARIO

JACQUELINE HARRIS

THESIS SUBMITTED TO THE FACULTY OF GRADUATE STUDIES IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF THE DEGREE OF MASTER OF SCIENCE IN NURSING

GRADUATE PROGRAM IN THE SCHOOL OF NURSING,
YORK UNIVERSITY, TORONTO,
ONTARIO, CANADA
DECEMBER 20, 2023

Abstract

Limited research explicitly addresses the diverse experiences of people who face mental health and addictions challenges and homelessness (MHACH) in rural Canada, although it is well documented that they face significant health inequities. This critical ethnography, exploring how policies and dynamics affect the lived experience of adults facing MHACH in rural Southwestern Ontario, aimed to enhance responsive policy and supports. Using purposive convenience sampling, semi-structured interviews were completed with four people with lived experience (PWLE) and three key informants. Using conventional content analysis and critical social theory, themes emerging from the narratives illustrated the complexity of PWLE's lives, survival strategies and resourcefulness. PWLE were contradictorily visible and invisible, encountering profound barriers to care such as stigma and discrimination that resulted in their feeling "less than human". Nursing implications include the importance of giving voice to PWLE, so we can understand how policy and practice decisions impact their everyday lives.

Dedication

To a misunderstood soul, who was both contradictorily visible and invisible in his own community. May he rest in peace.

Acknowledgements

Writing a thesis was harder than I thought. My inspiration to complete this thesis came from many people with lived experience that I have met over my 30 years of nursing. My mission to give them voice kept me on track.

Thank you to Dr. Judith MacDonnell, my supervisor, for her expertise and patience. She took the time to share her wisdom and knowledge to help me gain a deeper understanding of critical social theory and its importance in nursing. Thank you also to Dr. Claire Mallette for her guidance and humour throughout this journey. Inspiration always came after meeting with her.

I would also like to thank the Registered Nurses' Foundation of Ontario for supporting me as a recipient of the Joyce Shack Memorial Bursary in 2021 and the Faculty of Graduate Studies for awarding me the Academic Excellence Fund in 2022.

On this journey, I was fortunate enough to meet Jennifer Hodder, whose enthusiastic and unwavering support kept me focused. A true friend.

I am beyond grateful to my family for their understanding over the past few years. Special thanks to my Mom who was my editor for my earlier drafts and my Dad for his words of encouragement. I could not have undertaken this journey without the love and understanding of Zahrain, Elisha, James, Kevin and Hallie. Lastly, I'd like to mention Cooper and Sophie (my fur family). They were always at my side.

Table of Contents

List of Figures

List of Tables

Chapter 1: Introduction and Background

One of the fundamental prerequisites for health identified by the Ottawa Charter for Health Promotion (1986), is shelter (WHO, 1986). Unfortunately, not all Canadians have access to shelter-for many it is a luxury. We are currently in a housing crisis, and homelessness has become a national disaster and public health crisis (Karabonow et al., 2022)! People facing mental health and addictions challenges are disproportionately affected by homelessness, and it is estimated that 25-50% of people who are homeless live with a mental health condition (Mental Health Commission of Canada [MHCC] & The Centre for Addiction and Mental Health [CAMH], 2012). Mental health policy in Ontario has changed over the past 30 years and shifted from a system of institutionalization of people facing mental health and addictions challenges, to a system that delivers services within the community (Canadian Mental Health Association [CMHA], n.d.). Multiple national and provincial strategies involving mental health services, criminal justice systems, and drug policies have attempted to integrate services to improve timely and equitable access to mental health and addictions care. However, people facing mental health and addictions challenges and homelessness (MHACH), including those living in rural communities, continue to fall through the gaps (Buck-McFadyen, 2021a, 2021b; Evans et al., 202; Kauppi et al., 2017; MacDonald & Gaulin, 2020; Waegemakers Schiff et al., 2015).

The stigma and discrimination that people facing MHACH experience day-to-day contributes to these gaps and health inequities (National Academies of Sciences, Engineering, and Medicine [NASEM], 2016; Raphael, 2020; Tam, 2019). This stigma is often perpetuated through negative media portrayals of people experiencing homelessness and creates a sense of an ‘us’ versus ‘them’ mentality, which makes them feel like outsiders (Blanchet-Garneau et al., 2019; Raphael, 2020; Tam, 2019). Issues related to mental health, substance use, and homelessness are front and centre in the media, which invokes fear and intensifies the perceived dangers of people facing MHACH (Dej et al., 2021; NASEM, 2016). Locally, communities are inundated with stories of violence on the streets, in emergency shelters and homeless encampments which fuel the stigma associated with people experiencing homelessness (Butler, 2023; Mitchell & LeBel, 2023; Olson & Pauly, 2023).

Situating Myself in the Study

I am uniquely positioned as a registered nurse with 30 years of experience working with people facing MHACH in multiple service settings in Canada and the United States. I am aware of the barriers and strengths of this population and have seen firsthand the downstream effects of homelessness, while working in emergency departments in urban and rural communities. The ability to work upstream as a public health nurse in harm reduction and community health showed me the importance of removing barriers to help individuals achieve their optimal health. I am aware that the language used to describe mental health and mental illness has evolved over time; I have chosen to use the term “facing mental health and addictions challenges”, as I believe this term is more person-centred and less stigmatizing than “living with mental illness and addictions” (NASEM, 2016).

The current COVID-19 pandemic has brought to light the complex interplay of MHACH in peoples’ lives. Homelessness is a public health crisis, as well as a social justice issue (Borras et al., 2023; Karabonow et al., 2022). There is an increasing sense of urgency to find equitable solutions to end homelessness. At the beginning of the pandemic, I was able to engage with an informal coalition in my community through my work as a manager in a community health centre. This coalition consisted of a group of resilient people with lived experience (PWLE) of MHACH in a rural county in Southwestern Ontario. This coalition wanted to provide input on the local pandemic response to homelessness, as well as future policies that may impact them. In the spring of 2020, due to provincial and local public health COVID-19 lock down measures, access to public restrooms, soup kitchens, harm reduction services, and primary care became non-existent. One temporary solution in some of these rural communities was placing porta-potties in high traffic areas; however, they were swiftly removed once they became shelters for people who were experiencing homelessness. Decisions were made by municipal leaders that had unintended consequences for people experiencing homelessness. People were stripped of their human dignity and had to resort to urinating and defecating in public areas. These scenarios are not limited to a local context and can be seen widespread across Canada.

The informal coalition that I engaged with consists of a group of people that have experienced or are experiencing homelessness and who meet on the street to support one another and to talk about policies that exclude them. Their grit and determination to advocate for change and equity mirrors my values and beliefs. The personal and professional relationships I have established with them and others over the past three decades are driving my desire to study the relevance of policies and practices on this complex population, and to advocate for giving voice and meaningful inclusion of PWLE of MHACH in policy and service development. Since the start of this study, three members of this coalition have died on the streets.

My public health work, related to engaging youth and populations who are marginalized, reminds me to consider Arnstein's (1969) Ladder of Citizen Participation, which is a typology that contrasts the seemingly powerless citizens to powerful decision-makers. The varying levels of participation on each rung of the ladder begin with little to no participation on the bottom rung, to full participation at the top rungs (Arnstein, 1969). Each rung or step up the ladder represents an individual's power in determining the end result and their ability to participate in decision-making (Arnstein, 1969). The levels of nonparticipation, tokenism, and citizen control are relevant when considering policy and practice development in rural communities in relation to people facing MHACH (Arnstein, 1969). In my experience, I have often witnessed tokenism with this population when a few PWLE are included in community coalition meetings–but with restricted input (Arnstein, 1969). Without the voices of people impacted by homelessness in policy and practice initiatives, there is a risk of further marginalizing this population (Mullins et al., 2021; Norman & Pauly, 2013; Silva et al., 2013). Because of this, meaningful inclusion of PWLE of MHACH and giving them a voice to influence policy and practice development in rural communities in Ontario are my priorities (Dej et al., 2021); I have chosen to explore the lived experiences of people who simultaneously face MHACH in rural communities, with a goal of giving them voice. In this study, a critical social theory lens with a focus on complex dynamics of power is explored. Power is conceptualized as both oppressive (e.g., determinants of health (DOH), such as racism); and as positive, such as taking action in the face of adversity–which is aligned with a strength-based approach (White, 1995; McGibbon & Lukeman, 2019).

Background

To understand this unique population, I explored nursing, health and social services literature that addressed health equity with a focus on structural and social DOH, oppression, intersectionality, and neoliberalism. Literature on the policy context, rural homelessness and access to services in rural communities, as well as meaningful inclusion of PWLE and strategies to enhance their voice in policy processes was also examined. In this next section, I provide an overview of some key concepts from the review of the literature to provide context for this study.

Understanding Homelessness

According to Gaetz et al. (2016), homelessness "is the result of systemic barriers, lack of affordable and appropriate housing, the individual/household's financial, mental, cognitive behavioural or physical challenges, and/or racism and discrimination" (p.1). Cuts in government funding for social housing in 1990s and income supports in the 1980s have contributed to the increasing rates of homelessness in Canada (Doberstein & Smith, 2019; MacLeod et al., 2016). Policies and other programs that are implemented at the organizational and local levels contribute to organizational and systemic barriers for services and supports for people experiencing homelessness (Borras et al., 2023; Doberstein & Smith, 2019; MacLeod et al., 2016).

The homeless population across Canada is diverse and represents individuals across a range of social difference, including age, gender, and ethno-racial background (Gaetz et al., 2016). When an individual or family is without appropriate, permanent, or stable housing, they are considered to be experiencing homelessness (Gaetz et al., 2016). There are many different ways of measuring homelessness, which makes it difficult to determine an exact number (Segaert, 2016). In rural Canada, homelessness is a concept that has only been recently acknowledged, as it is often far less visible than urban homelessness (MacDonald & Gaulin, 2020; Waegemakers Schiff et al., 2015).

Health Equity

According to National Collaborating Centre for Determinants of Health (NCCDH) (2013), "health equity means that all people can reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance" (p. 1). Health inequities arise from systemic factors such as socioeconomic, demographic, and geographic conditions that are unfair, with avoidable health differences between population groups (NCCDH, 2023). Health, healthcare, and housing are all intricately linked (Liu & Hwang, 2021). Health issues that are experienced by people who face MHACH are shaped by structural and social DOH (Addorisio et al., 2021; Liu & Hwang, 2021; Stafford & Wood, 2017). As stated in Blanchet-Garneau et al. (2019), "health inequities are produced and sustained by the inequitable distribution of social DOH and structural inequities such as discrimination and institutional racism" (p. 1).

It is important to understand that people facing MHACH contend with mental, physical and social burdens that increase their risk of morbidity and mortality relative to the general population, and that homelessness has a direct adverse effect on health (Addorisio et al., 2021; Fazel et al., 2014; Liu & Hwang, 2021). Using a structural and social DOH lens with an equity focus instead of with a limited biomedical focus (e.g., pharmaceutical treatments) helps to yield understanding of the complex dynamics that influence health and homelessness and is critical to finding solutions (Borras et al., 2023; Etowa & Hyman, 2022; Morrow & Malcoe, 2017; Stafford & Wood, 2017).

Mental Health and Addictions Challenges

According to the MHCC (2012), approximately 25-50% of the homeless population suffers from mental health challenges, and almost half have substance use disorders (Gaetz et al., 2016; Hickert & Taylor, 2011; Liu & Hwang, 2021). According to Magnus and Advincula (2021), "mental health struggles and formal conditions are a serious concern in rural areas, with 18.4% of American rural adults, or approximately 6.6 million people, living with some form of mental health condition" (p. 39). Some serious mental health challenges that have been identified include: chronic depression, bipolar disorder, schizophrenia, schizoaffective disorders, and severe personality disorders (Hickert & Taylor, 2011). Alcohol misuse disorders as well as problematic opioid use disorders (OUD) are widespread (Addorisio et al., 2021; Fazel et al., 2014; Government of Canada, 2019; Grywacheski et al., 2019).

In addition to housing needs, people facing MHACH have unique health service needs, and rural communities struggle to integrate appropriate services (Forchuk et al., 2010; Kauppi et al., 2017; Magnus & Advincula, 2021). Some people must leave rural communities to access addiction and mental health services in urban centres, which in some cases are hours away (Buck-McFadyen, 2021a; Forchuk et al., 2010; Magnus & Advincula, 2021).

The Rural Context

The definition of rural in Canada is complex and sometimes contradictory. Generally, a rural community is considered the population living in towns and municipalities outside of urban centres. It is described as small towns, villages and other populated places with less than a population of 1,000 and a population density of less than 400 people per square kilometer (Statistics Canada, 2018). Most research on homelessness has focused on large urban centres and smaller communities may struggle with tailoring these policies and programs to a rural context (Dej et al., 2021; MacDonald & Gaulin, 2020).

Small communities are known for their lack of privacy, and it is common for residents to negatively label people experiencing homelessness and those facing mental health and addictions challenges; these prejudices and other dynamics contribute to the invisibility of rural homelessness (Waegemakers Schiff et al., 2015). PWLE may be too ashamed to ask for help and avoid accessing health and social service agencies, thus reinforcing their invisibility in the community (MacDonald & Gaulin, 2020). The public may recognize that someone is experiencing homelessness because they see they do not have a roof over their head; however, what may not be visible are experiences of hidden homelessness that include couch-surfing. Less visible to the public eye are the lived experiences of social exclusion and marginalization that are often faced by PWLE of MHACH in rural communities (MacDonald & Gaulin, 2020; Magnus & Advincula, 2021).

People who are experiencing homelessness and live in rural communities have limited access to health and social services, which contributes to adverse health effects; the high prevalence of mental health and addictions challenges further exacerbates these risks (Addorisio et al., 2021; CMHA, 2017; Magnus & Advincula, 2021; Waegemakers Schiff et al., 2015). Rural homelessness is not caused by lack of housing alone. Multiple factors, including the lack of affordable housing, economic downturns, poverty, isolation, deinstitutionalization, and limited community resources to deal with mental health and addictions challenges, all contribute (MacDonald & Gaulin, 2020). Due to pressures from the public and the stigma of homelessness, the demand for smaller municipalities to act quickly to develop immediate and long-term solutions is becoming common.

Nursing Role in Addressing MHACH

According to the Canadian Nurses Association (CNA) (2022), it is critical for nurses to understand the structural and social DOH and the impact they have on individuals and communities that they work with. Homelessness, when viewed through a structural and social DOH lens, is considered a key driver of poor health, and results from cumulative adverse social and economic conditions (Stafford & Wood, 2017; NCCDH, 2013; NCCDH, 2023). A bi-directional relationship exists between social DOH and mental health (Stafford & Wood, 2017; NCCDH, 2023). Poor mental health can aggravate poor personal choices, which may affect a person’s living conditions and health, while long term stressors related to lower socioeconomic status and dynamics such as racialization may affect a person's mental health negatively (Alegria et al., 2018; Deferio et al., 2019; Patterson et al., 2012).

Through my work, I have become familiar with policies and practices such as Housing First policies, harm reduction strategies including needle syringe programs, and the banning of people facing MHACH from local business establishments and health and social services. These policies and practices that are implemented are influenced by politics and power (Belle-Isle et al., 2014; Clarke, 2010; White, 1995). Sociopolitical knowing can help nurses to understand the social and political context of policies and practices that impact people experiencing MHACH, while allowing us/them to question and expose the power over this already marginalized population (White, 1995). These economic, cultural and sociopolitical inequities are at the root of oppression and require a careful, methodical approach by nurses to help address these inequities. Simultaneously nurses can support the participation of PWLE of MHACH in policy and practice development in a meaningful and respectful way (Belle-Isle et al., 2014; Borras et al., 2023; Norman et al., 2015; Restall & Kaufert, 2011; White, 1995).

All nurses are uniquely positioned to contribute to these solutions; we have an ethical imperative to uphold the principles of justice (Borras et al., 2023; CNA, 2017). However, we struggle sometimes as a profession with understanding what social justice means in our discipline and why it is important. Social justice requires us to critically think and expose, clarify, and eliminate societal differences that oppress some groups of people while privileging others (Banks, 2014). Critical nursing researchers caution us to consider that "despite the fact that nurses cannot rectify global structural inequities, we can practice in a way that take inequities into account, mitigate the impact of inequities on people's quality of life, and avoid participating in further entrenching inequities" (Varcoe et al., 2014, p. 270). Nurses can advance progressive policies through nursing research that address the structural and social DOH (CNA, 2022).

Rationale for Undertaking This Study

It is clear that people living with MHACH face discrimination and health inequities in their everyday lives, even more so in a rural context. This topic is timely, considering the vast media coverage of homeless encampments in both urban and rural communities and proposed bylaws that make it illegal for charitable groups to distribute food and temporary shelter on public property. There is an urgency to find effective solutions that tackle health and homelessness concerns to meet the needs of diverse groups of PWLE who face MHACH (Butler, 2023; Draaisma, 2023; Healey, 2023). Rather than the almost exclusive focus on problematizing PWLE of MHAHC that is reflected in the media, it is important to also share the strengths and resiliency of this population. My review of the literature suggests that there is limited nursing research that addresses: a) the lives of adults who simultaneously experience MHACH in rural communities, b) how policies, practices and other dynamics (i.e., stigma, discrimination) affect their everyday lives, and c) studies that take a strength-based approach. I chose a qualitative research design using critical ethnography to address these gaps.

Research Objectives and Questions

The purpose of this critical ethnography was to explore how policies, practices and other dynamics (i.e., stigma, discrimination) shape the lives of adults facing MHACH in rural communities with goals of yielding understanding of the complexity of their lived experience and using the findings to contribute to change aligned with social justice. There were four study objectives:

1. Explore the diverse lived experiences of this population;
2. Explore how policies, practices and other dynamics shape their everyday lives;
3. Give voice to this population who are often not heard; and
4. Use these research findings to influence policy and practices.

The following research questions were explored:

1. What are the lived experiences of diverse people facing MHACH living in rural communities?;
2. How do policies, practices and other dynamics enable them to live with dignity and meet their everyday needs?;
3. How do policies, practices and other dynamics create barriers in their everyday lives?; and
4. How might their diverse voices and lived experiences be amplified through policy, and practice processes or other strategies to improve their everyday lives?

A critical ethnography using a critical social theory lens was undertaken. Interview data was collected with two groups of participants: four adult PWLE of MHACH who were living in rural Southwestern Ontario and three key informants (KIs) who were providing services to these communities. The knowledge gained through this study will be used to give voice to people facing MHACH, and to utilize that voice to influence responsive policy and supports in rural communities in Ontario.

Chapter 2: Literature Review

In this chapter, I provide an overview on the literature related to people facing MHACH while living in rural communities. I first provide a brief overview of homelessness and explore the literature related to: health equity, with a focus on structural and social DOH, oppression, intersectionality, and neoliberalism. I then address the literature on the policy context, with attention to policy and program directions, rural homelessness and access to services in rural communities. The final section addresses meaningful inclusion of PWLE and strategies to enhance their voice in policy processes.

Setting the Context for a Focus on Homelessness

It is estimated that on any given night in Canada, 35,000 individuals experience homelessness, while approximately 235,000 Canadians experience homelessness in a given year (Gaetz et al., 2016). It is estimated that 2-4% of the homeless population in Canada is chronically homeless–meaning that they have been on the streets for over a year (Gaetz et al., 2016). The average age of people staying in shelter is 37 years of age and that includes children, youth, adults and the elderly (Gaetz et al., 2016). Some groups of individuals are disproportionately affected by homelessness–men between the ages of 25-55 comprise 50% of the homeless population in Canada (Gaetz et al., 2016). Other subpopulations within the homeless population that have unique challenges include: youth, Indigenous people, and women and families (Gaetz et al., 2016). These populations are at an increased disadvantage due to multiple intersecting forms of oppression related to sexism, racism, and ableism (Paradis et al., 2011). These kinds of dynamics, along with policies and practices, have key roles in the everyday lives of people facing MHACH.

Health Equity and Social and Structural Determinants of Health (DOH)

Health equity, in a context of critical social theory, is an important concept to explore when undertaking research with marginalized populations (McGibbon & Lukeman, 2019). In this section, I turn to critical health and social science researchers, including nurses, to understand concepts such as health equity and their relevance for nursing research that aligns with social justice goals. When people are free to realize their full potential in terms of health and are not prevented from doing so due to race, gender, or other socially determined circumstances, this is known as health equity (NCCDH, 2013). Examples of well documented health inequities in a Canadian context point to differences in health status that can be linked to the systematic social disadvantage that populations face. For example, Indigenous communities contend with everyday impacts of colonialism compared to settler communities, and this has impacts on their everyday health and wellbeing (Etowa & Hyman, 2022; NCCDH, 2023; Raphael, 2020). People living in rural communities, where there are fewer resources than in urban centres, have limited access to healthcare services, which may contribute to poorer health outcomes and an increase in morbidity and mortality for people experiencing MHACH (Addorisio et al., 2021; Deferio et al., 2019; Etowa & Hyman, 2022; Liu & Hwang, 2021). As NCCDH (2023) explains, "health inequities share core features: they are a result of societal choices that are systematic, avoidable, modifiable and unfair (NCCDM, 2023, p. 3). Thus, action on the structural and social DOH is warranted to shift deeply embedded dynamics that contribute to these health inequities. A large proportion of health inequities in Canada are a result of structural and social DOH (Etowa & Hyman, 2022).

Both structural and social DOH are relevant to consider when attempting to understand the health inequities of PWLE who are members of marginalized communities. When the root causes of structural and social DOH are identified, upstream structural solutions can be considered (Borras et al., 2023; Crear-Perry et al., 2021; NCCDH, 2023; Southwell et al., 2023). Crear-Perry et al. (2021) illustrate how the structural and social DOH relate to one another:

> cultural norms, policies, institutions, and practices that define the distribution (or maldistribution) of social DOH. These structures and systems….shape the distribution of power and resources across the population, engendering health inequities along racial, class, and gender lines and intersections (p. 231).

According to Raphael (2020), the social DOH "are the economic and social conditions that shape the health of individuals, communities, and even entire jurisdictions" (p. 18). Social DOH include housing, income, health services and race (Raphael et al., 2020). When viewed through a social DOH lens, homelessness is identified as a precipitant of poor health and a consequence of adverse socioeconomic factors (CMHA, 2017; NCCDH, 2023; Stafford & Wood, 2017). Mental health outcomes, including addictions challenges, are influenced by the social DOH; socioeconomic status and mental health are often linked and have long-lasting generational health effects (Alegria et al., 2018; Deferio et al., 2019; Morrow & Malcoe, 2017; Stafford & Wood, 2017). Many homelessness studies discuss the social DOH as well as the interrelated concepts of equity and social justice in relation to broader structural factors; these include youth transitioning out of foster care or institutions into the community without adequate supports (Patterson et al., 2012; Piat et al., 2015; Stafford & Wood, 2017). Piat et al. (2015) identified structural factors as most influential to prolonged and continued homelessness in their qualitative study related to pathways into homelessness.

McGibbon and Lukeman (2019) emphasize that strategies for social change must address the root causes of health inequities, that is the structural DOH, with a focus on oppression in its various manifestations. In their view, that would entail:

> structural change that confronts and eliminates oppressive processes and social injustices such as ableism, ageism, colonialism, ethnocentrism, genderism, heterosexism, racism, sexism….They are called structural because they are part of the political, economic, and social structure of society and of the culture that informs them (McGibbon & Lukeman, 2019, p. 4).

These inequities and injustices are shaped and sustained by oppression (Raphael, 2020); which according to Freire (2017) is the dehumanization of individuals by a dominant group that sees anyone outside this group as inferior. Normative social hierarchies privileging some groups over others, for instance those defined by race; these dynamics of oppression are reflected in “common sense” ways of thinking, and these social norms are embedded in all institutions and are often not recognized at the conscious level (Etowa & Hyman, 2022). According to McGibbon and Lukeman (2019), “when we consider oppressions from a structural perspective, we are analyzing the role of systemic processes in the creation and maintenance of micro and macro aggressions associated with all of the isms” (p. 4). Systemic discrimination that is backed by policy-driven oppressive power is considered oppression, for example, heteronormative organization policies (McGibbon et al., 2021).

Intersectionality

Intersectionality highlights the complex health and social outcomes in individuals that result from interactions between systems of oppression that shape their multi-dimensional identities, such as the dynamics that contribute to stigma and related mental health challenges for racialized gay men (Fraser et al., 2019; Morrow et al., 2019). Intersectionality can be used as a method of policy analysis to address the ways policies and practices tackle these inequities. It can help to illuminate how systems of power operate together (e.g., racism and gender dynamics) to contribute to oppression and inequities (Hankivsky & Cormier, 2011; Morrow et al., 2019; Smith-Maddox et al., 2020). Rooted in queer and postcolonial theory, Black, Indigenous and third world feminist writing, intersectionality makes explicit power relations shaping individuals impacted by oppression and inequalities, while at the same time portraying them as multidimensional human beings that are resilient with many strengths and skills (Hankivsky et al., 2014; Morrow & Malcoe, 2017). Instead of focusing on an individual's single circumstance (single characteristics), such as a female person experiencing homelessness, other complex factors (social categories), such as past trauma, racism, colonialism, sexism, and ageism are also considered when exploring their lived experiences (Hankivsky et al., 2014; Morrow & Malcoe, 2017). Single characteristics and social categories are inseparable and are shaped by power and influenced by time and place (Hankivsky et al., 2014). Studies on homelessness that use an intersectional lens are valuable to understand the complexity of dynamics that diverse groups of people who face MHACH contend with, in order to understand the importance of tailoring solutions to these groups. Schwan et al., (2020), for instance, reviewed the literature on the state of housing need and homelessness for women, girls, and gender-diverse people in Canada. They identified that a range of subgroups of women, girls and gender-diverse people included newcomers, youth, and those facing intimate partner violence. They noted that the causes and conditions of homelessness are unique for these various populations and do not fit into the standard definition or typology of homelessness in policy, practice or research but require unique approaches. Similarly, Fraser et al. (2019), in their review of literature on LGBTIQ+[1]

---

[1] The acronym LGBTQ refers to Lesbian, Gay, Bisexual, Transgender, and Queer communities. Other references may use other acronyms including 2S that refers to Two-Spirit communities, Intersex represented by I. The plus (+) represents a range of sexual and gender diversities that may be relevant beyond the ones named.

homelessness, highlighted that despite the fact that this group makes up 20-40% of homeless populations, few studies take intersectionality into account, instead focusing on specific elements (Fraser et al, 2019). They recommend taking a intersectional-systems thinking approach in order to inform the development of responsive and affirming programs and supports for the diversely situated groups within the LGBTIQ+ populations, such as racialized trans people (Fraser et al., 2019).

Neoliberalism

Another important structural dynamic that shapes the social context of health inequities for people facing MHACH is neoliberalism. In Canada, neoliberalism has dominated government practice and policy development for the past 30 years (Morrow & Malcoe, 2017). The definition of neoliberalism is multifaceted and is a dominant ideology in public policies of many governments in the Global North and South, as well as international agencies such as the World Bank and the WHO (Navarro, 2007). Reductions in government spending, permitting labour and financial markets to regulate themselves through free trade are examples of capitalism when these markets are controlled by private owners allowing the rich to get richer and the poor to get poorer (Labonte & Stuckler, 2016; Navarro, 2007). Policy changes and severe cuts in funding to health and social services have occurred globally that negatively impacted housing, income supports, employment programs, and healthcare systems (Morrow & Malcoe, 2017). Large psychiatric hospitals were closed in Canada which resulted in individuals being displaced into ill-equipped communities that lacked the health human resources and funding to provide the much-needed/equitable care/services (Morrow & Malcoe, 2017). In the 1990s, the Canadian federal government also stopped the building of new social housing units and devolved the administrative responsibilities of existing units to the province (Browne, 2010; Doberstein et al., 2019). During the 1970s, so-called “the war on drugs” also occurred that had long lasting negative effects on people who use substances; they became stigmatized and criminalized–which continues to this day (Hardill, 2019). Unfortunately, during this time, homelessness became increasingly visible in communities across Canada (Doberstein et al., 2019; Owadally & Grundy, 2023). Because of this increased visibility, there was growing pressure for municipalities to develop plans of action that have become highly politicized; punitive laws which criminalized homelessness and substance and which targeted encampments and congregating during COVID-19 have now become commonplace (Hardill, 2019; Owadally & Grundy, 2023).

Policy Context

Healthy public policy is a key component of the Ottawa Charter (WHO, 1986). Public policy is defined as plans or rules that are reduced to statements or instructions of expectations that occur or are directed in three types of settings: government (macro), organizations (meso), and the local level (micro) (Marquis & Huston, 2006; Smith el al., 2019). Healthy public polices can improve the physical, social, environmental and economic conditions where we live, work and play (Public Health Ontario [PHO], 2023). Health policies are a component of public policy and can be used to promote health as well as structural and social DOH that may impact health (Clarke, 2010; WHO, n.d.).

Public policies impact the experience of poverty by affecting the living and working conditions to which individuals and communities are exposed, which in turn may endanger one's health and standard of living (Raphael, 2020). As Fraser et al. (2019) stress, “poverty is the main driver of homelessness….A structural factor that is intimately linked to homelessness” (p. 3). In recent decades, structural changes in the economy and in government policy have led to reductions in income support, affordable housing stock, funding for community-based mental and social healthcare for people with severe mental illness (Morrow & Malcoe, 2017; Patterson et al., 2012). The impacts of these reductions and other policies have perpetuated vulnerability to homelessness for an increasing number of diverse Canadians (Patterson et al., 2012, Raphael, 2020). Access to health and social services for people facing MHACH is influenced by policies related to homelessness and mental health and addictions across federal, provincial and local levels (Smith et al., 2021).

The involvement of municipalities in homelessness initiatives varies across Canada. Often housing solutions are urban-centric, and there has been a call to look at approaches better suited for rural communities with the aim of keeping people in their community instead of sending them to larger cities for support (Buchnea et al., 2021). Governments and funders often look for a one-size-fits-all model or solution to end homelessness; however, the lack of engagement of PWLE severely limits a community's ability to create the needed changes (Buchnea et al., 2021). Some municipalities have representation and inclusion of PWLE at decision-making tables, however this is not consistent across communities. Some communities struggle to find meaningful ways to engage PWLE, while others have advisory councils comprised of PWLE (Buchnea et al., 2021).

Grassroots advocates, public systems and sectors, municipal, provincial, and federal governments and the community in general all have their specific agendas and solutions to ending homelessness. Despite the best intentions, policies and programming that focus on homelessness tend to target service provision such as integrated services rather than addressing root causes, which in turn leads to further marginalization for this population (Paradis, 2016; Patterson et al., 2012; Silva et al., 2013). However, the root causes of homelessness are complex involving a number of structural DOH; therefore, the strategies need to be comprehensive.

Directions for policies and programs that would also potentially address health inequities for PWLE who are also facing MHACH should address structural and social DOH; however, many factors shape the policy context in a given time and place (Malcoe & Morrow, 2017, Raphael, 2020; Stafford & Wood, 2017).

Policy and Program Directions

Neoliberal discourses with a priority on efficiencies and an individual focus will often shape actions that lead to downstream solutions. Downstream solutions are often offered by policy-makers to address homelessness issues, sometimes without understanding how equitable structural and social DOH distribution can prevent homelessness (Borras et al., 2023; Raphael, 2020). Some examples of downstream solutions include emergency shelters, soup kitchens and drop-in centres. Downstream solutions, often favoured by politicians, are bandaid solutions; although individuals may be temporarily housed, such strategies do not address the root causes of homelessness (Borras et al., 2023). Equity-focused discourses which attend to these root causes will support comprehensive and upstream solutions (NCCDH, 2023). A variety of policies and processes that address MHACH and which have been initiated in Canada are discussed below.

Opioids and Harm Reduction

The opioid crisis in Canada is complex and has had devastating consequences for individuals, families and communities (Grywacheski et al. 2019). In Canada, approximately eleven lives are lost each day because of opioid poisonings and many others are hospitalized from opioid misuse (Government of Canada [GC], 2019). It is recognized that opioid poisonings affect people from all walks of life; however, smaller Canadian communities are experiencing opioid poisoning and hospitalization rates that are more than two times higher than urban cities

(Grywacheski et al., 2019). To address the opioid crisis, Canadian authorities have initiated policy recommendations, including standards for opioid prescribing, as well as monitoring systems for narcotic drugs (Fischer et al., 2016). Despite these best efforts, fewer opioids are being prescribed, but the harms associated with their use are on the rise (Grywacheski et al., 2019). This may be due in part to the impact of illicit opioids, which have become very valuable on the street and have disproportionally affected Indigenous and other vulnerable populations (Fischer et al., 2016).

In contrast to abstinence-based approaches to substance use intervention, needle and syringe programs encompass harm reduction interventions that minimize the harms related to substance use by creating a safe, non-judgemental environment for individuals; such strategies are consistent with supporting the social DOH (Switzer et al., 2019).

Deinstitutionalization and Housing First

In response to the impacts of deinstitutionalization and the resultant fragmented mental healthcare and social service systems (Johansson & Holmes, 2023; Morrow & Malcoe, 2017), targeted programs that address homelessness and mental health have been implemented in Canada and across the world. The “Housing First” model, originally developed in the 1990s, has been recognized in Canada and the United States as an important policy direction for ending homelessness (Polvere et al., 2014; Woodhall-Melnik & Dunn, 2016). This is a comprehensive approach to supporting PWLE of MHACH, an evidence-based intervention that takes their social and medical needs into consideration and offering rapid housing, harm reduction, occupational and education programming (Stafford & Wood, 2017).

A ground-breaking Canadian based project emerging from the Housing First model, the At Home/Chez Soi Project, has been studied extensively and helped to inform policy and programming to end homelessness in Canada (Goering et al., 2014; Stergiopoulos et al., 2014). This project provided supportive housing for people with mental health challenges in five cities across the country (MacNaughton et al., 2013). A unique element of the project, particularly at the Toronto site, involved the contribution of PWLE in the advisory groups (Stergiopoulos et al., 2014). People experiencing mental illness and homelessness were consulted and included in the program design (Dej et al., 2021; Stergiopoulos et al., 2014; Voronka et al., 2014). Although this has been a well-cited project, initiatives based on the Housing First models took place in large urban cities with access to multiple health and social services and other resources options (Dej et al., 2021; Paradis, 2016; Stefancic et al., 2013). Housing First programs that provide supportive housing for people facing MHACH are often implemented with the assumption that all communities have access to support services; however, where many rural communities lack these much-needed housing, health and social services, such an approach is unsustainable (Forchuk et al., 2010; Waegemakers Schiff et al., 2015).

Bylaws and Encampments

Most recently, in an attempt to hide homelessness from residents or tourists in Canadian communities, some policies or laws have been implemented by municipalities to regulate public space by prohibiting loitering, encampments and storing of property in public places such as parks and sidewalks (Darrah-Okikie et al., 2018). Enforcement may include removing individuals from public areas or even destroying encampments and confiscating personal belongings. When these laws are enacted, they have the potential to socially exclude people experiencing homelessness, as well as to dehumanize them (Darrah-Okikie et al., 2018). Policies and legislation that are created to manage encampments and other survival strategies for homelessness are often shaped by imbalances in power relations between the housed and unhoused (Borras et al., 2023). Individuals have the human right to adequate housing; however, as a result of decades of failed housing policy at both the provincial and federal levels, Canada continues to fail to provide this basic need. Encampments are often established due to the absence of safe and affordable housing (Olson & Pauly, 2023). Encampments or tent cities become contentious issues in communities citing safety and public health concerns often resulting in the criminalization of homeless (Darrah-Okikie et al., 2018;Olson & Pauly, 2023).

COVID-19 Measures

The provincial policy responses and public health measures at the onset of the COVID-19 pandemic in 2020 magnified the systemic issues that disproportionately affect marginalized populations, including people facing MHACH (Babando et al., 2022; Karabanow et al., 2022; May & Shelley, 2023; Public Health Agency of Canada [PHAC], 2020). The severe acute respiratory syndrome (SARS) outbreak during 2003 had provided great insight into the many challenges in an outbreak management response, particularly for service providers who worked with people experiencing homelessness (Leung et al., 2008). While some recommendations were used, measures such as social distancing had major impacts for PWLE to access services (Oudshoorn et al., 2021).

Pandemic related studies with PWLE of homelessness and their service providers highlighted the consequence of closing soup kitchens, social services, public spaces and a decrease in the number emergency shelter beds, for people experiencing homelessness (Babando et al., 2022; Cumming et al., 2021). People experiencing MHACH face high rates of chronic medical conditions, poor nutrition, isolation and barriers to accessing healthcare which increased their risk of serious illness and death associated with COVID-19 (May & Shelley, 2023; Oudshoorn et al., 2021).

Rural Homelessness

My review of the literature suggests that there is a paucity of research addressing people simultaneously facing MHACH in a rural context. However, the onset of the COVID-19 pandemic spawned a number of policy documents internationally that address mental health, substance use and homelessness in a rural context. The recent MHCC (2021) report on the impact of COVID-19 on rural and remote mental health and substance use synthesized a range of Canadian-based studies and relevant international policies to provide an overview of developing issues and unique challenges that the pandemic poses for rural communities.

In this section, I summarize rural homeless related literature that occurred for the most part pre-COVID-19 and then address the COVID context. Homelessness in Canada has often been associated with urban communities; however, the growth of poverty in rural communities has increased and has turned this misconception on its head (MacDonald & Gaulin, 2020; Schiff et al., 2022). Over the past few decades extensive research on homelessness as well as policy reports mainly representing Canada, the United States, United Kingdom, and Australia have primarily focused on large urban centres (Demaerschalk et al., 2019; Magnus & Advincula, 2021). During the past decade, while rural homelessness research has been increasing, it is generally limited to policy documents on rurality and small qualitative studies addressing local regions; there is agreement that this is an understudied topic for research (e.g., Demaerschalk et al., 2019; Schiff et al., 2022; Snelling, 2017; Waegemakers Schiff et al., 2015). However, Demaerschalk et al.’s (2019) recent reviews of the literature suggest that many of the available studies are now dated. Given the limited body of research, smaller communities struggle to obtain evidence-informed solutions due to the minimal resources that are available to them (Dej et al., 2021; Kauppi et al., 2017; MacDonald & Gaulin, 2020).

The one study that most closely addressed the focus of my own study was an ethnography undertaken by Magnus and Advincula (2021) in a rural region of western United States. The original study aimed to understand the lived experiences and struggles of access to resources for rural people representing a range of vulnerabilities (e.g., homelessness, food insecurity); however, people with severe mental illness were not enrolled in the study. The researchers used arts-based visual ethnography and completed 47 semi-structured interviews with PWLE and stakeholders who were key informants. Magnus and Advincula (2021) reported that analysis uncovered that a leading, but often neglected vulnerability to health and health inequities for people living in rural communities, was PWLE's mental health struggle and the "ailing, virtually non-existent mental healthcare infrastructure" in their rural communities (p. 42). They highlighted the role that community-level and structural conditions such as stigma and discrimination play in individuals' lived experiences. Magnus and Advincula (2021) reported that when PWLE become more visible, they "feel ostracized and socially excluded", creating a divide in the community between the "normal" and the "crazy" (p. 40). The resulting internalization of stigma and shame by PWLE prevents them from seeking mental health services for fear of being seen while accessing these services. When responsive solutions are offered, such as mental health services from neighbouring cities, they are often received with skepticism by the community, because historically the services do not remain for long, and PWLE do not know the service providers. The researchers prioritized voice for PWLE and also included their participants recommendations to take action.

Canadian researchers across multiple disciplines have studied homelessness including: education (Gaetz et al., 2016); social work (Anucha et al., 2007; Kauppi et al., 2017; MacDonald & Gaulin, 2020; Waegemakers Schiff et al., 2015), criminology (Dej et al., 2021), environmental studies (Switzer et al., 2019), and medicine (Frankish et al., 2005; Liu & Hwang 2021; van Draanen et al., 2013), but not always in a rural context. Canadian-specific research on rural issues and homelessness is also limited; however, there are a growing number of Canadian nursing researchers who are using qualitative approaches to studying mental health, homelessness and illicit drug use, as well as barriers to access services for people facing MHACH in rural or urban communities (Belle-Isle et al., 2016; Buck-McFadyen, 2021a, 2021b; Forchuk et al., 2010; Oudshoorn et al., 2021). In this next section, I elaborate on mainly Canadian-based qualitative research focused on the rural context of homelessness and as relevant where mental health and substance use were addressed. The importance of these small qualitative studies that delve deeply into understanding the complexity of lived experiences of communities, PWLE and service providers across rural regions cannot be overlooked. Such studies provide important contextualized evidence, often based on the diverse voices of often invisible PWLE, that can inform responsive supports and policies.

In the United Kingdom, rural homelessness increased 32% between 2010 and 2016; Canada does not have any comparable data (MacDonald & Gaulin, 2020). Most recently, Schiff et al. (2022) collected and analyzed Canadian data from rural homelessness enumerations that challenge the perception of ‘hidden’ or invisible homelessness in rural communities. Enumerations are challenging to complete in rural areas for the following reasons: when it is difficult to locate and count people who are unhoused, if they do not access services, or are geographically isolated living on the outskirts of towns or villages, or if they live in areas that do not offer emergency shelters or food programs (Schiff et al., 2022). The data that has been collected from Canadian rural homelessness enumerations has reinforced that rural homelessness is, without a doubt, a significant issue in Canada (Schiff et al., 2022).

Forchuk et al. (2010) conducted an ethnographic study in Southwestern Ontario that described and compared rural and urban housing and homelessness issues. They conducted a secondary analysis of mental health and housing data that was collected in a 2001-2006 from the Community University Research Alliance (Forchuk et al., 2010). This study highlighted the complex association of social ties, mental health and social services, transportation, and relocation that left participants feeling vulnerable and dependent in their rural communities (Forchuk et al., 2010). Most importantly, Forchuk et al. (2010) identified that individuals living in rural communities have devised many innovative strategies to stay in their communities and are not just passive victims of forces beyond their control.

MacDonald and Gaulin’s (2020) exploratory study on the invisibility of rural homelessness in Quebec, Canada highlights how invisibility hampered PWLEs’ ability to speak up about the challenges they face. Recommended strategies for preventing and reducing rural homelessness included affordable and social housing and drop-in day centres where there was access to phones, computers and food. Despite significant attention to recruitment strategies, the researchers identified that their greatest obstacle was recruiting PWLE to speak about their experiences of homelessness.

According to Buck-McFadyen (2021b), research on rural homelessness has identified several gaps in knowledge around prevalence, risk factors, impacts and potential solutions. Her qualitative study in a small town in Eastern Ontario on factors that lead to rural homelessness revealed competing perspectives in the community on the root causes of homelessness which were variously attributed to individual responsibility or systems failure. Stigma associated with addictions, homelessness, and the rural context shaped individual and community perspectives and the nature of solutions (Buck-McFadyen, 2021b).

MHCC (2021) highlighted the substantial impact that COVID-19 continues to play on the mental health and substance use needs in rural communities, as well as the increasing lack of access to timely service and adequate resources. MHCC (2021) cites evidence that “while the pandemic has led to an increase in the rate of homelessness and precarious housing across Canada, rates in rural and remote communities are equivalent to or potentially higher than those in urban areas” (p. 7). Social DOH and health equity were identified as unique factors that influence how COVID-19 affects rural communities in terms of mental health and substance use (MHCC, 2021). This report from MHCC does consider structural factors such as colonialism and racism as pertinent issues across mental health and substance use systems and the need to recognize the heterogeneity of these communities and their unique needs. The report notes that federal and provincial governments’ responses to address service needs for mental health and substance use was swift; however, the virtual options that were created an additional barrier to people living in rural and remote areas without access to broadband internet coverage. Given the significant and long-lasting effects on mental health and substance use during the pandemic, the MHCC report stresses the importance of focusing on post-pandemic support. MHCC (2021) sees this as an opportunity to transform the system and address unique needs that were identified in rural communities in partnership with the communities themselves to foster resiliency. Although policy recommendations were provided, at times they reflected a downstream solution, for example investing in harm reduction initiatives. With such attention to virtual care options without explicitly calling for comprehensive strategies to address homelessness, the report raises questions about the priority MHCC places on people living with MHACH.

Unfortunately, the needs of PWLE of homelessness are often overlooked in rural communities, since the understanding of rural homelessness is poor compared to urban populations (Kauppi et al., 2017; Waegemakers Schiff et al., 2015). Waegemakers Schiff et al. (2015) examined and described the elements of rural homelessness across Canada. Their literature review identified the complexity of rural homelessness, and lack of consolidated information across Canada which led to the development of a document: Rural Homelessness in Canada: Directions for Planning and Research (Waegemakers Schiff et al., 2015). The authors recommended the development of a research network that focuses solely on rural homelessness, with the intent of implementing tailored responses at the community level.

The pressure for smaller municipalities to act quickly to develop immediate and long-term solutions is becoming common (Buck-McFadyen, 2021b; Kauppi et al., 2017; MacDonald & Gaulin, 2020). However, the consequence of quick or one-size-fits-all solutions for homelessness is often the further marginalization of people affected by severe mental health and addictions challenges (Dej et al., 2021; Mullins et al., 2021; Silva et al., 2013). In this context, I found it helpful to turn to one Canadian qualitative study that was conducted in a mid-size city rather than a rural region that address contentious issues surrounding public safety and homelessness (Dej et al., 2021). The researchers aimed to create a fact-based counter-narrative on the experiences of homelessness and community safety, while thinking of strategies to address these issues while promoting community resilience (Dej et al., 2021). The researchers found that the stigma and rhetoric of demonizing people who are homeless limits the opportunities to discuss ways in which all levels of government, community agencies and the community in general have a role to play in ending homelessness (Dej et al., 2021). It is important for housing and homelessness committees to remember these findings when considering the level of PWLE engagement when creating housing policies and programs in rural communities. Given the limited resources in many rural communities, it may be difficult to directly apply the findings to the rural context. However, the principles of multilevel collaboration and focus on community resilience and voice are relevant.

Access to Services in Rural Communities

Despite Canada's universal healthcare system, many Canadians still have difficulty accessing healthcare (Shah et al., 2020). This barrier is magnified within rural communities, which make up approximately 18% of the Canadian population (Wilson et al., 2020). Canadian research on rural healthcare is limited, but from Canadian sources we do know that rural populations are generally older, sicker and less affluent (Kephart, 2012; Wilson et al., 2020).

Access to healthcare and mental healthcare is not the same for people living in rural and remote communities compared to urban dwellers (Browne, 2010; Kauppi et al., 2017; MacDonald & Gaulin, 2020; Moroz et al., 2020; Snell-Rood et al., 2021). Geographic barriers can limit the ability for people to access healthcare, and travel to urban centres is common; but, without the ability to find transportation or harsh weather conditions causing road closures, this can make accessing services near impossible (Browne, 2010; Buck-McFadyen, 2021a, 2021b; Forchuk et al., 2010). People living in rural areas may be described as disadvantaged when accessing services; however, those that live within an hour of an urban community may have better access to culturally relevant services (Browne, 2010; Cattaneo et al., 2021; Snell-Rood et al., 2021). For people who are also homeless, barriers to service access include: mistrust of healthcare providers, lack of access or availability of services, lack of health coverage due to lost OHIP cards, the inability to afford the cost of medications, and competing priorities such as securing food and housing which take precedence over healthcare (Liu & Hwang, 2021). However, mental healthcare systems lack the resources to provide preventative care and supports in rural community-based agencies (MacDonald & Gaulin, 2020; Morrow & Malcoe, 2017;

Waegemakers Schiff et al., 2015). In addition, as a result of delays in seeking care as well as the adverse effects of homelessness itself, these barriers put PWLE of MHACH at significant risk for acute and chronic physical and mental health conditions (Liu & Hwang, 2021).

Many studies can be found that focus on mental health or substance use, while experiencing homelessness, in combination or separately, with the focus being on the impacts of stigma while accessing healthcare (Biancarelli et al., 2019; Burgess et al., 2021; Clair et al., 2016; Skosireva et al., 2014). A range of barriers have been identified for people who are accessing mental health and addiction services, including: lack of service integration, long wait times, cultural and language barriers, stigma, geographic, cost of services, not knowing where to go, and lack of mental health professionals (Biancarelli et al., 2019; Burgess et al., 2021; Moroz et al., 2020). In 2019, 2.3 million Canadians reported unmet or partially met mental healthcare needs, citing not knowing where to go as one of their top barriers (Moroz et al., 2020).

Mental health and substance use disorders are the most highly stigmatized health conditions in the United States (NASEM, 2016), with people facing mental health and homelessness being the most marginalized groups (Skosireva et al., 2014). Magnus and Advincula (2021), in their American-based ethnographic study, stress the complexity of the rural barriers for those facing mental health and addictions challenges such as "stigmatization [which] often produces feelings of shame and embarrassment...[such that they] feel ostracised and socially excluded from their community….[This contributes to] strong social boundaries between who the community identifies as 'normal' and 'crazy'" (p. 40). The media intensifies the perceived dangers of people with mental health and addictions challenges by often framing their lives almost exclusively in relation to violence and crime (NASEM, 2016). It is far too common in mental health policy and practice for people to be labelled as mentally ill and treated as “non-persons” (Morrow & Malcoe, 2017). Stigma associated with addiction is often common for people experiencing homelessness, even if they are not actively using substances; often they are deemed guilty by association or by common stereotypes (Buck-McFadyen, 2021b).

People facing MHACH are often blamed for their mental and substance use disorders, assuming it is a personal choice or a sign of immorality (Blanchet-Garneau et al., 2019; Buck-McFadyen, 2021b; Clair et al., 2016; Hardill, 2019; McGinty & Barry, 2018; NASEM, 2016). When policy-makers focus on individual choice instead of historical social and structural levels, systemic oppression occurs (Morrow & Malcoe, 2017). Dej et al. (2021) also identified the misconception that drug paraphernalia found in public spaces is often blamed on people experiencing homelessness without considering that housed people who use drugs may be contributing to this.

Stigma was identified as a barrier to developing and accessing addiction services in rural communities; while creating safe, non-judgemental spaces counteracted this as Buck-McFadyen et al. (2021) reported in their evaluation of a rural outpatient opioid treatment program in a small town in Ontario. Having more than one stigmatizing conditions (similar to people facing MHACH) magnifies one’s experiences with stigma and feelings that the community doesn’t care for them, and that can affect the likelihood that they access care or supports (Buck-McFadyen et al., 2021; McGinty & Barry, 2018).

Meaningful Inclusion of PWLE and Voice

In the past decade, community engagement in health policy, practice and research settings has become popular as an approach to designing fair and equitable initiatives globally (Greer et al., 2019; Happell et al., 2019; Islam & Small, 2020; Miller et al., 2017). Although the importance of engagement in research has been established, there is limited literature that focuses on how or whether participants actually feel meaningfully engaged (Goodman et al., 2017). What makes reviewing the literature difficult is the multiple definitions of three words that are used interchangeably: engagement, inclusion, and participation (Brunton et al., 2017; Islam & Small, 2020). When these terms are used in policy or program planning, it becomes confusing if they are not defined or policy-makers assume their meaning is self-evident. (Brunton et al., 2017; Islam & Small, 2020; WHO, n.d.). With this growing interest, the number of terms that are used to describe meaningful inclusion of PWLE in policy or decision making tables has also increased (Brunton et al., 2017; Islam & Small, 2020).

Members of the public have often become active participants in health service delivery and research instead of passive recipients (Islam & Small, 2020). In recent decades, involvement of PWLE in mental health service systems has become best practice and a plethora of literature about their consultation and integration as advisors, workers, and trainers has been written (Greer et al., 2017; Lived Experience Advisory Council, 2016; Norman & Pauly, 2013; Norman et al., 2015; Paradis et al., 2011; Switzer et al., 2019; Ti et al., 2012; Voronka et al., 2014).

In my review of the literature that focuses on homelessness, the studies have predominantly focused on the use and accessibility of health and mental health services for those experiencing homelessness, pathways into homelessness, the experience of being homeless, as well as the effectiveness of the Housing First model, geared to urban contexts as a solution to ending homelessness (Buck-McFadyen, 2021a, 2021b; Forchuk et al., 2010; Oudshoorn et al., 2013; Patterson et al., 2012; Piat et al., 2015; Voronka et al., 2014). Some qualitative mental health and addiction studies share recommendations or lessons learned from the inclusion of PWLE in program and policy planning; however, few research studies have discussed how inclusion was implemented and what the outcome evaluations looked like from a PWLE's perspective (Dej et al., 2021; Happell et al., 2019). Unfortunately, I found few research studies that discuss meaningful engagement of PWLE in areas of policy and program development related to mental health, addictions challenges and homelessness.

The following four studies used various methodologies to examine meaningful engagement of PWLE. van Draanen et al.’s (2013) grounded theory study examined lessons learned from PWLE from the Toronto site of the At Home/Chez Soi research project to better plan for meaningful inclusion of consumers in housing solutions. Process related themes were identified related to the complexities of including PWLE in a large research project. PWLE described their level of participation as advising or consulting. However, the level of participation was not described in great detail, nor were the various levels of participation or engagement compared or explored further by the researchers. An important finding highlighted the need of study participants to be representative of the service or policy recipient, a problem that continues to be identified in other research projects (Dej et al., 2021; Happell et al., 2019; Paradis, 2016; van Draanen et al., 2013).

A qualitative study conducted by Fleury et al. (2014) looked at the planning and development of the At Home/Chez Soi project in Montreal and, in particular, user participation, governance structure and the interactions between the stakeholders. An Advocacy Coalition Framework was utilized to help analyze the implementation process of the pilot project that provided housing to people with mental health and addictions (Fleury et al., 2014). Three separate advocacy coalitions were asked to participate in the At Home/Chez Soi project and the researchers noted that conflicts did arise between the coalitions (Fleury et al., 2014). Conflict was not seen as a failure of the project, instead, it provided and opportunity for dialogue and resulted in a broader understanding of the complexities of homelessness and the best means to address this complex issue (Fleury et al., 2014).

Norman and Pauly (2013) conducted a scoping review of the literature focusing on recommendations for the development and implementation of policies and practices that promote meaningful inclusion of people experiencing homelessness in a mid-size Canadian city. Norman and Pauly (2013) argue that PWLE of homelessness which make them uniquely qualified to inform solutions to ending homelessness while policy and program planners do not have access to this expert knowledge. They noted that some people experience social exclusion due to structural processes that marginalize and exclude them from participating as social and political equals in their community. Although this was a preliminary review of the literature, this scoping review identified key themes that help to understand the impact of social exclusion, the development of inclusionary policies, and identifying strategies of inclusion at the community level for people who are homeless (Norman & Pauly, 2013).

A rather unique Australian mental health study included researchers with lived experience of mental illness, exploring their own perspectives partnering with consumers of mental health services. One barrier identified was the concern about hierarchies and how PWLE are positioned by professionals in subordinate ways; this in turn may impact the experience of PWLE when engaging in social justice policy processes or initiatives that impact them (Belle-Isle et al., 2014; Happell et al., 2019; Switzer et al., 2019; van Draanen et al., 2013).

Belle-Isle et al. (2016) conducted an emancipatory study to explore power relations for PWLE who participated in four advisory committees in Canada related to substance use. Findings focused on power relations at decision-making tables and what factors led to the transformation of the power relations (Belle-Isle et al., 2016). They identified the following factors that influence power at these tables: organizational context, socioeconomic inequities, influence of the political context, stigma, creating a safe space, practicing democracy, and representation (Belle-Isle et al., 2016). They also identified how to select PWLE from harm reduction services or peer run organizations but also cautioned about that potential for tokenistic participation (Arnstein, 1969; Belle-Isle et al., 2016). Happell et al.'s (2019) study also pointed to inequalities such as power and tokenism, and researchers indicated that PWLE were often pre-selected who were anticipated not to disrupt preferred directions in the policy work.

Researchers such as Dej et al. (2016), Smith et al. (2021) and Ti et al. (2012) and others stress that meaningful inclusion of diverse PWLE in decision-making processes for housing solutions and policy development is imperative to end homelessness in Canada. However, literature that includes PWLE in policy and program development in rural communities is few and far between (Dej et al., 2021). Best practice recommendations and methodologies to implement inclusion are often found in existing literature about the inclusion of people with mental health and addictions in program and policy planning (Belle-Isle et al., 2014; MacDonald & Gaulin, 2020; Miller et al., 2017; Norman & Pauly, 2013; van Draanen et al., 2013).

Peer engagement is an approach to decision making that can be used in program planning, and policy work that helps to improve marginalized groups' influence over decisions that affect them (Addorisio et al., 2021; Greer et al., 2019; Happell et al., 2019; Mullins et al., 2021; Ti et al., 2012; Voronka et al., 2014). Greer et al. (2019) used a community-based participatory study to conduct focus groups to examine the perspectives of people who use or have used illicit drugs (PWUD) on peer engagement in health and harm reduction settings across British Columbia, Canada. The focus group question guide and data analysis were completed in collaboration with PWLE, and although this study did not focus on engaging people who were homeless, important barriers and facilitators to peer engagement were identified that can be applied to housing and homelessness initiatives (Greer et al., 2019). This qualitative study identified PWUD as important stakeholders in decisions that impact them and several factors that influenced participation were identified. How they experienced peer engagement, the barriers they face, as well as what could improve their engagement were all identified (Greer et al., 2019).

Summary of the Literature Review

Despite a solid body of research that addresses homelessness, most of the literature focuses on urban centres. The literature on homelessness which explicitly focuses on the rural context has increased to some extent, especially with the onset of the COVID-19 pandemic, but is still limited in scope. My review of the literature suggests that there are well documented health inequities for people who are facing MHACH in a rural context. However, no studies, to my knowledge, aimed to simultaneously examine the lived experience of people living with all three challenges of mental health, addictions and rural homelessness. A variety of studies offered insight into a range of factors that impact their lived experience and recommended solutions to address them. As this review suggests, research with a focus on health equity and social and structural DOH can illuminate the complex factors from policy to stigma that are relevant to MHACH in a rural context. Consistent with a critical social theory lens, research focused on MHACH in a rural context points to both oppressive dynamics of power such as the historical, economic and political contexts as well as power conceptualized as positive that contribute to a strengths-based approach (e.g., resilience and voice).

Policy and program directions which have been created to address homelessness, mental health and addictions challenges reflect both neoliberal and oppressive dynamics of power, as well as those aligned with social justice aims. In this vein, a body of literature emphasizes the importance of addressing meaningful inclusion of PWLE in policy and practice development in order to develop: a) rural-specific solutions that meet their needs to access to care and b) responsive services that are tailored to the diversity of PWLE who are facing MHACH.

Critical nursing researchers in this literature review offered insight into a small but increasing body of Canadian qualitative nursing research on the rural context of people facing MHACH. In addition, I found the contributions of other critical nursing researchers valuable to better understand health equity and related concepts. This review of the literature provides a solid rationale for undertaking a qualitative exploratory study on the lived experiences of people with MHACH in a rural context, noting that this is an important but understudied area of research. There is a very limited understanding of the complex lived experiences of diverse people facing MHACH in rural Canada. Given the need for nursing research that can offer insight into strategies that support PWLE, further qualitative nursing research which fosters understanding and social justice goals is required.

Chapter 3: Methodology

This qualitative, exploratory, critical ethnographic study focuses on the relevance of policy, practice other dynamics in the lives of adults living in rural Ontario facing MHACH. It was informed from critical reflection on my nursing practice and my belief that people with lived experience need to give voice and meaningfully participate in all levels of decision-making when policies and practices are being developed that impact them.

As discussed in the literature review, most research on MHACH in a rural context originates from the United States, United Kingdom and Australia and Canada. There are a growing number of Canadian nursing researchers who are studying homelessness and illicit drug use in rural communities, as well as barriers to access services; however, little is known about the lives of people experiencing MHACH in rural communities, as well as how policies, practices and other dynamics such as stigma and discrimination affect their everyday lives. An exploratory, qualitative critical ethnographic design in which participants are encouraged to share their and others' stories through semi-structured interviews was used to provide rich data and to give voice to this population who are often not heard.

Theoretical Frameworks

Critical Ethnography

A critical ethnographic approach was used with a goal of yielding understanding of the complexity of their lived experience and to use the findings to contribute to change aligned with social justice, giving voice to PWLE of MHACH. Critical ethnography allows the researcher to bring to light underlying assumptions of power and control, which can lead to actions that can disrupt the status quo (Madison, 2020), by invoking a call to action through the use of knowledge as a catalyst for change (Thomas, 1993). It requires that common sense or taken for granted assumptions are questioned.

Critical ethnography has been used in nursing research for: advancing refugee women's health (Al-Hamad et al., 2022), hypertension self-management among Haitian immigrants (Sanon et al., 2016), perceptions of clinical issues of outreach nurses (Paradis-Gagne & Pariseau-Leguault, 2020), people experiencing homelessness (Oudshoorn et al., 2013), and rural food insecurity (Buck-McFadyen, 2015). Critical ethnography is well suited for health research, as it examines larger social, political, and economic issues that focus on power and oppression (Cook, 2005). A critical approach to health promotion and ethnography share a common goal of emancipation (Cook, 2005) and recognize that individual health related behaviours are influenced by social DOH and not by choice (Alegria et al., 2018).

Critical Social Theory

This study is grounded in a naturalistic critical paradigm. Critical social theory is an analytical lens often used in social justice research and is increasingly used in nursing research to unpack hegemonies, interrogate historical and social contexts, encourage upstream thinking, and frame transformative action (Kagan et al., 2009). Paulo Freire's (2017) critical social theory framework and his interpretation of social justice, change, and critical knowledge was used to guide my study and inform the way I developed the research design and methods. Freire (2017) challenges us to question or reflect on our existing knowledge and to transform change; Freire and Kagan et al. (2009) define this as praxis. According to Kagan et al. (2009) the premise of critical theory is that knowledge must be practical, related to action, and its purpose emancipatory. Freire (2017) coined the term *conscientização*, to refer to the process of learning to perceive social, political and economic dynamics, and to act against the oppressive elements of this reality (Kagan et al., 2009, p. 104).

Emancipatory knowing in nursing is the ability to be aware of and to critically reflect on the political and social status quo and question why it is that way; it hinges on acting to reduce or eradicate injustices and inequality (Peart & MacKinnon, 2018). Nurses need to be critically aware that policies may be influenced by personal and professional self-interest and therefore, participate in social criticism and social change that have a goal of social justice (Fawcett, 2019). I used a focus on health equity, with attention to the structural and social DOH, in my approach to applying a critical social theory lens (McGibbon & Lukeman, 2019; Etowa & Hyman, 2022). The focus is an analysis and critique of social structures, policies, laws, and power and privilege that disadvantage or harm marginalized groups (Fawcett, 2019). Throughout this study, power dynamics that define the reality, values, and ideas that have become normalized over time for people facing MHACH are brought to light and challenged (Kagan et al., 2009; Denzin & Lincoln, 2018). As a nurse, I deal with human rights issues daily, and I have an ethical commitment to give voice to the voiceless and provide an equal opportunity for people facing MHACH to experience social justice.

Philosophical Assumptions

In this section, I describe the key philosophical assumptions that underpin my critical methodology. By critically reflecting on my diverse nursing practice and my power and privilege personally and professionally, I was able to examine and begin to understand the implications of my authority to represent diverse voices for people experiencing MHACH in rural communities in a particular context (MacDonnell, 2011).

Ontology

Ontology refers to the nature of reality and being (Ponterotto, 2005; Saldana & Omasta, 2018; Strega & Brown, 2015). In a critical paradigm, relativist ontology is reality constructed in the human mind and is relative to each individual who experiences it in a given time and place (Moon & Blackman, 2014). Reality is never static or fixed, because there are multiple realities or worldviews of any event or situation within a community that can change over time or can be affected within a certain context (Yilmaz, 2013). In my worldview, I share the belief that reality is shaped by cultural, social, and political values, which are mediated by power relations that are historically and socially constructed that may be used unconsciously to oppress others (Kagan et al., 2009; Ponterotto, 2005; Scotland, 2012). Over time, these values become normalized and are socially accepted as stereotypes that are widely believed to be true. For instance, prevailing norms such as heteronormativity are embedded in all social institutions (e.g., family). Examples of stereotypes include the belief that people choose to be homeless, or that all people experiencing homelessness are addicted to drugs.

Epistemology

Epistemology is a term used to describe how we come to know something and is concerned with the nature and forms of knowledge (Scotland, 2012). In a critical paradigm, the nature of knowledge is both socially constructed and influenced by deeply embedded power relations from within society (Denzin & Lincoln, 2018; Scotland, 2012). The relationship between myself (the would-be knower) and the research participant (the knower) is instrumental in understanding the phenomenon under investigation (Denzin & Lincoln, 2018), with the perspective of the participant being essential (Yilmaz, 2013). Subjectivist epistemology assumes that knowledge is acquired by how people perceive and understand reality, they impose meaning and value on a world and interpret it in a way that makes sense to them (Moon & Blackman, 2014). I recognize that knowledge is linked to power and therefore, it is important for critical self-reflection on deeply held convictions or values. It can provide increased awareness of knowledge that can be relevant that can inform nurses actions for emancipation. Hegemonic knowledges based on normative hierarchies (e.g., racism based in White superiority) contribute processes that privilege and marginalize groups defined by race, class, gender, for instance and as well as the authority ascribed to their knowledges (Etowa & Hyman, 2022). Action at the structural level can address the root causes of health inequity such as those focused on the "isms" (Kagan et al., 2009; McGibbon & Lukeman, 2021; Strega & Brown, 2015). The ultimate goal is emancipation towards equity and justice for all.

Axiology

Axiology refers to the role of values in research with the understanding that biases are present in relation to their role in the study context; however, different paradigms consider biases in different ways as either valuable or problematic (Creswell & Poth, 2018). In a critical paradigm, critical reflexivity focuses on the politics and ideologies that are embedded within the research processes as well as within the researcher (Strega & Brown, 2015). It requires that I intentionally bring my awareness to what influences the participants, as well as my perceptions and responses throughout the research process (Strega & Brown, 2015). As the researcher, I critically reflected on how my own assumptions and values shaped the dialogue with the study participants. I bring significant social privilege to this study as a middle-aged, middle class White woman with a university degree who has worked in many healthcare settings throughout Canada and the United States including acute care, public health and primary care. In the latter two roles, I worked primarily in harm reduction programs and with people living in poverty. The professional and personal relationships that I have established over my thirty years of nursing have opened my eyes to the stigma and oppression experienced by people who use substances and are experiencing homelessness. I have witnessed first-hand the discomfort some of my nursing colleagues have when working with people who use substances. When I first worked as a nurse in acute care, I too felt uncomfortable working with people who use substances and judged them negatively before becoming more aware of their life experiences. Critical self-reflection allowed me to change my epistemological and ontological views over the past few decades; but, I am mindful of the need for ongoing reflection, given the deeply embedded power dynamics that can contribute to my unconscious bias. The evident oppression that I see now in this community drives my reasoning for conducting this research. I do recognize that my position of power, values and preconceived ideas about this population and how they are included in communities may impact my relationship with the data. My worldview is centered with a critical social theory lens, and this shaped my research design, including the methodology, the questions I asked and how I interpreted them.

Research Purpose and Design

Statement of Purpose

The purpose of this study was to explore how policies, practices and other dynamics (i.e., stigma, discrimination) shape the everyday lives of adults facing MHACH in rural communities with a goal of yielding understanding of the complexity of their lived experience and use the findings to contribute to change aligned with social justice. There are four study objectives:

1. Explore the diverse lived experiences of this population;
2. Explore how policies, practices and other dynamics shape their everyday lives;
3. Give voice to this population who are often not heard; and

4. Use these research findings to influence policy and practice processes.

Research Design

I used a qualitative, exploratory, critical ethnographic design to understand the diverse lived experiences of people facing MHACH in rural Ontario, as well as how policies, practices and other dynamics shape their everyday lives. This approach, using a critical social theory lens, offered an opportunity to critically reflect on and question the political and social status quo and to create a call to action to reduce or eradicate injustices and inequality in this population (Peart & MacKinnon, 2018). Semi-structured interviews were conducted via Zoom or in-person with two groups of participants: PWLE of MHACH and KI participants. In this study, I asked the following research questions:

1. What are the lived experiences of diverse people facing MHACH living in rural communities?;
2. How do policies, practices and other dynamics enable them to live with dignity and meet their everyday needs?;
3. How do policies, practices and other dynamics create barriers in their everyday lives?; and
4. How might their diverse voices and lived experiences be amplified through policy, and practice processes or other strategies to improve their everyday lives?

Ethical Considerations

Ethics approval was received by the Review Ethics Board (REB) at York University in August 2022. Due to the vulnerability of the research participants, people facing MHACH, this research was conducted in the manner outlined by York University ethics guidelines for undertaking research on homelessness. Because of the mitigation strategies described below that

I put in place to protect my study participants, the level or potential for risk for both PWLE and KIs was no more than faced in everyday life. I have worked with this population for decades and my nursing expertise helped me to mitigate any potential risks that may have been experienced.

I addressed ethical considerations such as maintaining confidentiality and conflict of interest; but, I was also mindful that ethical considerations included the need to be thoughtful regarding the use of respectful language and the shifting nature of the language used in the findings chapter in relation to people facing MHACH. In the interviews, participants representing PWLE used a variety of words and phrases to describe their substance use and living situations. In order to stay close to the data, their exact phrasing was presented in the findings chapter. Some examples include: “hardcore junkie drug addict”, “addict”, “outcasts”, and “scumbags.” To decrease stigma and negative bias, I used first-person language (e.g., person with opioid use disorder) when discussing substance use.

Informed Consent Process

Informed consent is a continuous, transactional process that allows participants to play a collaborative role in making decisions about their ongoing participation across the whole research process (Polit & Beck, 2017). Informed consent and confidentiality were addressed in multiple ways throughout this study. Participants were provided the opportunity to ask questions and challenge the purpose of the study and specific research questions. Consent was not coercive and participation was voluntary, which required informed consent before proceeding with the study. Written and verbal information related to the study purpose, research design, possible risks and benefits, and dissemination of study results was thoroughly reviewed with each potential participant prior to their participation in the study on Zoom or in-person depending on the nature of the interview (See Appendix A & B). Written consent (See Appendix A & B) was obtained from most participants; however, verbal consent (See Appendix C & D) was obtained from some of the PWLE and KI participants when they did not want me to collect any personal identifiers. I kept a record of the consent process within my reflexive journal using their assigned pseudonyms, including the reason for obtaining consent verbally. Participants were made aware that they could withdraw consent at any time throughout the study without consequence up to the data analysis stage. A copy of the informed consent was given to all participants. As data collection and data analysis occurred concurrently, a date was provided on the informed consent form to identify when data analysis was expected to occur. This provided the participant the opportunity to contact me after the interview if they decided to withdraw consent up to the date listed. All data from the PWLE and KIs was de-identified and they were assigned pseudonyms, to minimize the possibility that situations and locations that they discussed could be identified in the study findings.

Given my commitment to advocating for the voice of lived experience in service and policy processes, and the evident distrust of healthcare providers by people facing MHACH, I aimed to collect data through individual face to face interviews from these diverse individuals if at all possible. I noted that conducting interviews via Zoom or other online platforms would be difficult for this population due to barriers accessing WIFI, as well as difficulty obtaining electronic devices to participate in the study. However, in the event a participant requested to meet virtually (and they had the technology) due to the desire to physical distance during COVID-19, or due to geographical barriers for people living in rural areas without transportation, Zoom was offered (Polit & Beck, 2017). I conducted three interviews in-person and four interviews using Zoom technology. As it turned out, only two of the PWLE interviews were conducted in-person.

Due to my expertise working closely with this population who have lived experience of MHACH, I was tuned to signs that someone was experiencing emotional distress. I checked in with them at the beginning of the interview process and as the dialogue proceeded to monitor and mitigate any stress responses. Mental health crisis numbers were provided to all participants, as some of the dialogue created an emotional response. Transportation to mental health crisis locations was offered (at my expense) via public transportation or a cab if required. None of the participants required a mental health crisis intervention. The risk for KIs to participate was minimal. Emotional distress was also a potential risk for KI participants given the challenging nature of clinical and social support for PWLE. To mitigate this risk, I checked in frequently with the participants to determine if the interview should be stopped or if they needed a break and also provided them a mental health resource number.

Given my extensive clinical experience with PWLE in this rural region, I anticipated that I might encounter potential and actual conflicts of interest if they participated in this study. Potential conflicts of interest were identified with one member of my local community, a PWLE experiencing mental health and addictions challenges, who was a friend and fellow advocate for our community; to maintain the integrity of my research, they were not engaged in the recruitment, data collection and data analysis stages of this study. Due to my commitment to this population professionally and personally, and my respect for their expertise and desire to have a voice, I asked instead if they would like to participate in dissemination of the research findings, as well as with the engagement of the community in possible next steps of this study. I did not anticipate conflict of interest in recruitment of KIs, because I have not worked in the health and social organizations that would be sites of KI recruitment in the past three years.

Demographic data was stored separately from other data that was collected. Participants were informed that all paper data has been locked in a filing cabinet and that my electronic data is password encrypted. I also discussed the duty to warn, and that confidentiality would only be broken if a participant disclosed the potential to harm themselves or others, or if there was suspected child abuse discussed (CNO, 2019). I also explained that in some situations, a third party might subpoena the information that was collected. This was explained to all participants prior to obtaining consent to participate. To date, this has not occurred. If this does occur, I will consult my research committee and the REB for direction.

Geographic Location of Study

I conducted this research in Southwestern, Ontario in the catchment area known as the Southwest Local Health Integration (SWLHIN). This area extends from Lake Erie in the south, to the Bruce Peninsula in the north, Oxford-Norfolk county in the east, and Chatham Kent- Elgin county in the West. The SWLHIN catchment area is comprised of seven counties: Grey, Bruce, Huron, Perth, Middlesex, Elgin, and Oxford. This area is 36,798 km^2 and is home to less than 1 million people, with over 30% of the population living in rural areas, and approximately 30% living in small to medium communities (SWLHIN, 2021). Approximately 2% of the population identify as Indigenous and 14% of the population identify as immigrants, with fewer than 2% as recent immigrants (SWLHIN, 2021). London is the largest urban centre, with a population of approximately 405,000, and five First Nations communities are found within the SWLHIN catchment area.

After receiving a request to participate from a PWLE outside of my catchment area, I submitted an amendment to the Office of Research Ethics in November 2022 to expand the study setting to include the Erie St. Clair LHIN. The Erie St. Clair LHIN borders the SWLHIN to the west and is comprised of three counties: Sarnia-Lambton, Chatham-Kent, and Windsor Essex (Erie St. Clair Annual Report, 2018). This area is 7,323.66 km^2 and has a population of approximately 627,633, with approximately over 30% of its population living in rural areas and small communities (Statistics Canada, 2016). Unfortunately, after receiving approval to expand my catchment area in November 2022, the PWLE was no longer available to participate and no other participants were recruited from this area.

As noted in the literature, people experiencing homelessness and/or living with mental health and addictions challenges are diverse. Although there is not a lot of specific demographic data on rural homelessness for the SWLHIN or for Ontario, various homelessness enumeration reports can be found for some municipalities that identify the breakdown of gender, sexual orientation, and race; however, collectively, these important diverse characteristics are under reported (Schiff et al., 2022; Waegemakers Schiff et al., 2015). Age and gender seem to be the most common demographic information that is reported and according to Strobel et al. (2021), from 2010 to 2017, there has been an increase in the number of people younger than 40 years experiencing homelessness in Ontario. Across Canada, the number of people experiencing homelessness is diverse: 27.3% are women, 18.7% are youth, 28-34% are Indigenous, and 2,950 are veterans (Gaetz et al., 2016). It is estimated that 20-40% of the homeless population is comprised of LGBTIQ+ people (Fraser et al., 2019). In this study, my aim was to understand diverse perspectives within this community and my sampling strategy was developed accordingly (Creswell & Poth, 2018).

Recruitment and Participant Sampling

Existing literature identifies that recruiting people facing MHACH may be difficult, as there is often mistrust in healthcare providers, fears of being identified in small communities, and a fear of being judged because of their mental health diagnosis and lifestyle (Hough et al., 1996). It is reported that approximately 25-50% of people experiencing homelessness suffer from mental health challenges and almost half have substance use disorders (Hickert & Taylor, 2011; Liu & Hwang, 2021). For reasons of feasibility, I aimed to recruit 5-7 adult participants that reflected a combination of PWLE of MHACH and KI perspectives. I understood that the combination of rural homelessness, mental health challenges and addictions as my inclusion criteria would severely limit my ability to recruit participants. My intent was to maximize the recruitment of PWLE with a maximum of two KIs represented in the study sample; however, six PWLE of MHACH and three KIs were recruited from across the SWLHIN and Erie St Clair LHIN. Of these, four PWLE and three KIs from the SWLHIN participated in the study. To better understand the diverse perspectives that PWLE could bring, purposive sampling with a focus on maximum variation sampling (Polit & Beck, 2017) was used to recruit a diverse sample of:

1. Adult participants with lived experience of MHACH who were diverse with respect to:
    a. social location (e.g., gender, age, race, family status, sexual orientation); and
    b. geographic location (e.g., at minimum, three rural communities within the catchment area)
2. Key Informants (KIs) (e.g., health or social service providers who can provide insight into the above diversity of PWLE)

Recruitment Strategies

Recruitment occurred over a four-month period from August 2022 to December 2022 after I received REB approval. Rural homelessness is often considered invisible, so I connected virtually and in-person with KIs across the SWLHIN and Erie St Clair LHIN catchment area to publicize the study, and to recruit a combination of PWLE of MHACH and KIs. KIs serve as gatekeepers who regulate access to people and information (McKenna & Main, 2013). The professional relationships and networks that I have established over the years were key in my recruitment process, as this allowed me to gain access to this population. With the support of KIs, recruitment posters were distributed in harm reduction settings, foodbanks and shelters across the catchment areas once permission from the various organizations was obtained (See Appendix E). To minimize the influx of participants from my own community, I began recruitment in areas outside of my local community before advertising the study locally. I started recruitment in my local community six weeks after initial recruitment began. Information from initial participants helped to guide the selection of subsequent diverse participants (Polit & Beck, 2017). One KI participant was able to refer me to a group of mothers experiencing homelessness, which was a population I did not identify initially, and a PWLE introduced me to another PWLE participant that was living precariously and had limited supports in the community. Recruitment was more challenging than anticipated but, given the enormous challenges on top of the rurality challenge too, I had a very good response.

Participant Selection-People facing MHACH

I developed a screening tool to determine eligibility with all potential participants facing MHACH (See Appendix F). In this study, the inclusion criteria for people facing MHACH included: 19 years or older, currently experiencing homelessness, have a history of mental health and addictions challenges, currently located in a rural community in the SWLHIN or Erie St. Clair LHIN catchment area, and English speaking. If a participant was under the age of 19, they were excluded. Adults were my focus for this study and I considered anyone under the age of 19 a youth. I recognized that the inclusion criteria of “currently experiencing homelessness” was subjective for most of the PWLE participants and therefore, used my demographic questionnaire to further explore their living situations and determine eligibility (See Appendix G). For the purpose of this study, I accepted participants' self-report of their housing status. Some PWLE participants identified themselves as provisionally accommodated (temporarily housed or lacks security of tenure) and therefore, considered themselves as experiencing homelessness (Gaetz et al., 2012).

In the event an individual requested to participate and did not meet the outlined inclusion criteria, I asked them if they would like to participate with the dissemination of the study findings. For example, they were asked if they would like to assist with presenting findings at a local Housing and Homelessness committee meeting. This was important to establish my credibility with this population, as well as showing trust and respect. Only one person that requested to participate did not meet the inclusion criteria and expressed a desire to assist with the dissemination of the findings.

Data collection occurred between September 2022 and December 2022. Six individuals with lived experience expressed an interest in the study and four agreed to participate. These PWLE participants contacted me by phone or email to set up an interview and all indicated that they wished to meet in-person (n=4) or via Zoom (n=2). I conducted one interview with each eligible MHACH participant either in-person or via Zoom, as retention of participants facing MHACH varies due to their transient nature and potential instability due to substance use (Hough et al., 1996). I was flexible with the length of my interviews and took approximately 60-90 minutes to complete them, as it is sometimes difficult to engage with people facing MHACH for a longer period of time (Calsyn et al., 2004). Occasionally, the interviews needed to be stopped and restarted multiple times to allow a participant facing MHACH to have a break or to regroup, but all participants seemed enthusiastic about having the opportunity to participate. One PWLE participant thanked me throughout the interview for "taking the time to talk to me."

Participant Selection- KIs

My previous professional experience provided the opportunity to identify potential KIs from community health centres and public health agencies across various settings throughout the SWLHIN and Erie St. Clair LHIN catchment area. KI recruitment posters were distributed via email to various email listservs that included harm reduction, community and public health agencies (See Appendix H). Over one hundred emails were sent to community agencies throughout the SWLHIN and Erie St. Clair LHIN requesting help with advertising my study. The study was also advertised on the Evidence Exchange Network for Mental Health and Addictions website and at times I was invited by KIs to attend in-person program meetings for clients to promote the study.

KIs included service providers that offer services or supports to people facing MHACH in rural communities and may have insights into their experiences (McKenna & Main, 2013). Inclusion criteria for KI participants included: health or social service provider with the knowledge and experience of working with people facing MHACH in rural communities. KIs under the age of 19 were excluded.

The demographic information of KIs that was collected reflected their experience working with people facing MHACH and also determined their eligibility to participate (See Appendix I). 60-90 minute, semi-structured, 1:1 in-person or Zoom interviews occurred in private and were recorded with permission and transcribed verbatim into a word document. I did ask the KIs to assist with the recruitment of diverse participants facing MHACH verbally through their programming and by advertising the recruitment poster. To my knowledge, only one MHACH participant was recruited with the assistance of a KI.

Sampling and Sample Size

Using purposive convenience sampling and maximum variation sampling (Polit & Beck, 2017), I had aimed for a sample of adult PWLE of MHACH who were diverse with respect to social location (gender, age, family status) and geographic location (representing at minimum three communities). I had advertised the study extensively throughout the SWLHIN and Erie-St. Clair LHIN and despite the enormous challenges that I had identified in recruiting people facing MHACH, nine individuals in total expressed interest in the study, I exceeded the number of participants (5-7) that I had expected to recruit. Six PWLE of MHACH expressed an interest in participating in the study, but two of the PWLE participants opted not to participate. I interviewed four PWLE and three KI participants. Approximately fourteen hours of audiotaped in-depth interviews yielded rich narrative data. PWLE participants all identified various stages of substance use, mental health challenges and recovery and housing, which reflected the diversity of their everyday experiences. I also aimed for a geographically diverse study sample and was able to achieve this. The participants were from multiple locations across the SWLHIN. I met with my supervisory committee in December, 2022. We discussed the characteristics of the seven diverse participants who had been recruited to date, which we noted was a strong response to the invitation to participate in the study given the COVID context and anticipated challenges to recruitment. I had achieved the diversity of the sample I was seeking (e.g., geographic, social location). We discussed the nature of the rich narrative data that had been collected through in-depth interviews with four PWLE and three KIs. Given challenges to recruitment, and achievement of diversity and the richness of the data, for reasons of feasibility they agreed that I could stop recruitment.

Data Collection

Data collection and analysis occurred concurrently to allow flexibility and the potential to identify and pursue follow-up questions based on emerging thoughts or concepts (Hsieh & Shannon, 2005; Thomas, 1993). Multiple forms of data were collected from the KI and PWLE of MHACH participants: demographic data, interview transcripts, interview notes, field notes, and a reflexive journal. Demographic information was voluntarily collected after I determined eligibility and obtained informed consent. Demographic data was collected from all participants using close-ended questions to capture the diverse social locations and/or experiences of the participants (See Appendix G & I). While remaining sensitive to the number and types of questions I asked, I asked each PWLE of MHACH about their age, gender, marital status, number of dependents, financial means, housing situation, mental health diagnosis and characteristics of their past or present substance use. Some of the demographic data was collected during eligibility screening, as well as at the end of the interview once the participants felt more engaged and more comfortable sharing their personal information.

A reflexive journal was used in this study to record my observations, as well as a reflexive note taking strategy to monitor my own thoughts and feelings during the interviews, and how it may have impacted the data (Evans-Agnew et al., 2014). The field notes also captured the non-verbal behaviour that was observed, as well as to capture the settings where the interviews took place. These notes provided context to the narrative that one PWLE shared. From my field notes I recall that they appeared nervous and looked their ankle bracelet continuously. This participant was on house arrest and had special permission to meet with me for the interview. During the interview, they continually looked at their ankle bracelet while they were speaking and they initially seemed guarded when conversing with me. I made every attempt to be non-judgemental, and subsequently they told me that they had shared information with me that they had never told anyone before.

Interviews

With consent, data was collected through in-person and virtual semi-structured interviews (Creswell & Poth, 2018) which were audio and video recorded and transcribed verbatim into a Word document. These interviews took place over a four-month period to allow time to recruit diverse participants. To mitigate risks related to COVID-19 for myself and for research participants, non-invasive data collection procedures were followed and physical distancing, masking and other precautions were implemented if warranted, or if requested by participants. In-person interviews followed physical distancing guidelines as recommended by public health, because I work in an acute healthcare setting and needed to protect myself against any potential exposures. People facing MHACH and those living in shelters were considered a vulnerable high-risk group for exposure to COVID-19 and at the time of the interviews masking was still mandatory in shelters and healthcare settings.

Interviews occurred in mutually agreed upon locations that provided privacy and a safe environment for the participant, as well as myself. I booked spaces in a public libraries, as well as community agencies to create this safe space. It was understood by myself and the participant that this may not provide anonymity if signing in and out of locations was required. The chosen locations were comfortable and accessible by public transportation or foot (Polit & Beck, 2017). Because of the size of the catchment area, I had to travel to meet some of the participants in the communities they resided. When a virtual option was requested, the participant and I determined a safe and private location to conduct the interview and permission was obtained to record the interview. Because the Zoom platform has the option of a camera, the participants determined whether they wanted the session recorded with the camera on or off.

All interviews were confidential, because of the risk of identifying participants. They were also asked if they wanted to provide their own pseudonyms or if I could assign one to them. All pseudonyms were assigned by me and were carefully chosen to represent their strengths. All of the data collected was de-identified; however, some demographic data was collected to reflect the diversity of the participants. Interviews were audio recorded with permission and data was transcribed verbatim into a Word document. Zoom interviews were audio and video recorded with permission and were also transcribed verbatim into a word document. Field notes were captured that described the setting and the participants, and reflexive notes were recorded after each interview and captured nonverbal communication that was observed, as well as my personal observations or interpretations. I found myself wondering whether certain questions worked better than others and found a few of them to be too broad. These elicited further questions from the participants; however, it allowed them to interpret them orally with some probing from myself, but was mostly based on their own worldviews and interpretation.

Transportation costs to the interview location, as well as child care costs for the PWLE participants' children were offered as required. Child care costs included compensation for travel time to and from the interview location. MHACH participants were reimbursed for their time and were given $30 in cash for each interview-whether or not they completed a full interview. All of the interviews were completed in full. Cash was given instead of gift cards, so participants had the autonomy to use it for their own needs.

Interview Questions

The interview questions for the PWLE participants and the KIs centered around understanding mental health, addiction challenges, and homelessness as social problems with a goal of bringing about change in society (Madison, 2020). MHACH participants were invited to participate in semi-structured, conversational interviews that were guided by a topic guide. Questions were open-ended to encourage participants to respond in their own words in a narrative way (Polit & Beck, 2017). Topics within the interview guide included: understanding the lived experiences of MHACH from diverse individuals, the impacts of policies and other dynamics in their everyday lives, and how their diverse voices and lived experiences may be used to influence policy processes and other dynamics in their everyday lives (Creswell & Poth, 2018; Polit & Beck, 2017; See Appendix J). Questions for the KIs included an exploration of their shared understanding of an experience they may have witnessed or heard about for people facing MHACH, as well as their own perspectives or point of views as they relate to policies, practices and other dynamics associated with homelessness, substance use and mental health challenges in rural communities (Madison, 2020; See Appendix K).

Data Analysis

Data collection and analysis occurred concurrently using Hsieh and Shannon’s (2005) application of conventional content analysis and was an iterative process. Content analysis is defined “as a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns” (Hsieh & Shannon, 2005, p. 1278). Content analysis is appropriate when there is limited research on the phenomenon of interest (Hsieh & Shannan, 2005). Using critical social theory, I applied a critical approach to the analysis, examining policy, practices and other dynamics such as power, that may positively or negatively impact the lives of people facing MHACH; recognizing that each experience is unique to each diverse individual. Conventional content analysis has been used in a number of nursing studies that are situated in naturalistic and critical paradigms (Buck-McFadyen, 2013; Choiniere et al., 2010; Paradis-Gagnes et al., 2020; Sanon et al., 2016).

The application of conventional content analysis with a critical lens assumes the experiences of PWLE of MHACH are influenced by deeply embedded power relations from within society that are socially constructed (Scotland, 2012). I applied a critical social theory lens with attention to health equity and the structural and social DOH in my analysis, taking into account that I was focusing on power as both oppressive in a positive sense, aligned with a strengths-based approach (McGibbon & Lukeman, 2019; Etowa & Hyman, 2022).

Constant comparison allowed me to compare newly collected data from participants with data obtained earlier, in order to refine the categories and subcategories (Polit & Beck, 2017). Given this is a qualitative study, I followed an inductive process of data analysis, meaning it starts with the detail about participant experiences and moves to a more general picture of the phenomenon of interest (Creswell & Poth, 2018; Streubert & Carpenter, 2011). The following steps were used following conventional content analysis: a) I immersed myself in the data to obtain a sense of the whole; b) data was read word by word to derive codes; c) I highlighted exact words that captured key thoughts or concepts; d) I made notes of my first impressions, thoughts, and initial analysis in the margins; e) labels for codes emerged directly from the text that were reflective of more than one key thought; f) codes were sorted into eighteen categories based on how they were related or linked; and g) these categories were further analyzed and grouped into six main thematic categories with related subcategories (Hsieh & Shannan, 2005).

Emergent codes, subcategories and thematic categories were created from key thoughts or concepts that the participants shared in the interviews. Stories were shared about their everyday lives and common views and experiences related to healthcare, trust, discrimination and giving voice emerged. I considered how an understanding of critical social theory concepts such as the structural and social DOH as well as power and oppression contextualized their lives, their actions and their ability to give voice (McGibbon & Lukeman, 2019). The initial stages of data analysis resulted in codes that were close to my initial readings of the transcripts. For example I identified: coping, workload, stigma, and authority for PWLE. The interview transcripts and data coding schemes were reviewed multiple times and discussed at several points with my thesis committee. The initial codes were combined and recombined to create categories and subcategories. The ten categories that initially emerged were further refined after reviewing the interview transcripts, field notes and reflexive journal again which resulted in a further reduction yielding the final six thematic categories. In the final analysis, access and barrier categories were included as two subcategories of one of the six final overarching thematic categories, Why Rurality Matters. The four subcategories included under this thematic category were named as: a) Access to Health & Social Services; b) Barriers to Health & Social Services, c) Specific Examples of Resources Issues; and d) Unique Perspectives.

When finalized, there were six thematic categories:

1. The Voice of Lived Experience;
2. The Impact of Rules and Policy: Power Over the Marginalized;
3. What it Takes to Survive;
4. Why Rurality Matters;
5. The Consequence of Discrimination and Stigma; and
6. What it Takes to Support PWLE: (In)formal Policies/Practices and Resources.

Role of Researcher

As a researcher using critical ethnography I was an active participant in co-constructing the interaction and data in the study process, with my ultimate goal of giving voice to PWLE of MHACH's everyday experiences. Using emancipatory knowing, I critically reflected on the political and social status quo and questioned what insights about dynamics of power were emerging through the research process (Kagan et al., 2009; McGibbon & Lukeman, 2019; Polit & Beck, 2017). I initially entered the interview process assuming that the voices of lived experience of MHACH would be the only voice that would help me to understand these diverse individuals. However, I quickly realized the KIs offered important insights through the stories that they shared about the unique and diverse individuals they worked with. One KI shared the complex factors at play for one PWLE who struggled with communicating with their Parole Officer that ultimately resulted in their breach of probation. This situation provided an example of "power over" a marginalized individual and the unjust treatment they received.

It was important for me to establish trust with the participants and my positionality as an advocate facilitated this. I have worked and volunteered with people facing MHACH in many communities. I have a good rapport with people facing MHACH and respect their diversity. I also work as a nurse in a rural community and in my various nursing roles over several decades have advocated for change at micro, meso and macro levels. I recognize that I am also an outsider based on my power, privilege and positionality, but at times I also shared experiences such as motherhood with PWLE participants and as a healthcare provider with KIs; which provoked various reflections on our shared and diverse experiences.

My rapport with the participants varied, but one PWLE was able to validate her trust in me when she shared that she was currently using crystal meth. She sighed and said "If feels so good to be able to say that out loud…because you're not gonna hold it against me, you know? I like that." The importance of creating a safe space for participants to share their experiences in the interviews cannot be discounted.

Measures to Ensure Rigor

Strategies for ensuring rigor were built into the study design in order to establish trust and confidence in the findings of my research study (Cypress, 2017). Reflexivity and Lincoln and Guba's (1985) four criteria to assess rigor and establish trustworthiness in a qualitative study were used: credibility, dependability, confirmability, and transferability.

Reflexivity

Thomas (1993), considers reflexivity one of the most important criterions in critical ethnography. Reflexivity is the process of critically reflecting and making note of my personal values that could impact the collection and interpretation of the data over the course of the study (Polit & Beck, 2017). Throughout the study, reflexive note taking was used to monitor my power relations with this population and to capture my experiences, views and judgements (Rashid et al., 2015). Field notes also captured documented behaviours that I observed in the field, as well as my reflections on them. I was able to refer to these notes during the data analysis stage to contextualize the narratives that were shared (Phillippi & Lauderdale, 2018). For example, one KI appeared very angry during the interview and I wasn't able to ascertain at the beginning of the interview if he was angry with me for taking up his time, or if he was passionate about the topic we were discussing. As the interview progressed and after review of the interview transcripts and field notes, I realized that I was able to provide a platform in order for him to give voice. I was also able to reflect on my initial codes that I created and realized that I needed to review the context of some of the subcategories while reviewing my notes. This allowed me to combine some of the categories in the rurality category such as access and barriers to health and social services and waitlists for services. I also identified other subcategories that needed further exploration.

Reflecting on my positionality within this study was vital, because it forced me to acknowledge my own power, privileges, and biases, while simultaneously calling out the power structures that surrounded the research participants (Madison, 2020). My relationship with the data, the participants, the nature of the study, and even myself as the researcher was also important (Streubert & Carpenter, 2011). Knowledge was co-created between myself and the participants, as influenced by their sociocultural contexts (Evans-Agnew et al., 2014). As a researcher and principal instrument of data collection, my interpretations and what I decided to include in the study findings is acknowledged–therefore, reflexivity is critical.

Credibility and Dependability

Credibility and dependability go hand in hand, meaning you can’t have one without the other (Streubert & Carpenter, 2011). Credibility is the truth of the data and the interpretations of them, and includes activities that increase the probability that credible findings will be produced (Polit & Beck, 2017; Streubert & Carpenter, 2011). Prolonged engagement and member checking with participants is seen as one of the best ways to establish credibility; but, due to time constraints and the transient nature of people facing MHACH, this was not always possible (Streubert & Carpenter, 2011). Common themes did come to light during the interviews which confirmed the credibility of the findings. To establish credibility, I reported verbatim quotes in my study findings from the participants. This reflected the context of the dialogue and showed how they expressed themselves. As a healthcare professional, some of the quotes are difficult to hear but, integrity is important to me, and it was imperative for me to share them. Through this study, I am able to speak on behalf of participants to ensure that their voices are heard (Thomas, 1993); while being mindful that as researcher as instrument, I may influence how they are shared. The study findings will be posted where the participants will have access to them and will also be shared with agencies and individuals who have influence over policies and practices.

Dependability refers to the stability or reliability of the data over time and is met once the credibility of the findings have been met (Streubert & Carpenter, 2011). Triangulation in a critical paradigm, reflects my epistemological and ontological stance as well as my goals of research (MacDonnell, 2011). Triangulation of multiple sources of data contributed to the dependability of the findings, as this is a process of validating data through multiple sources, strategies and time periods. (MacDonnell, 2011). Data triangulation of data sources, the interviews with PWLE and KIs for instance, provided a broader understanding of how policies, practices and other dynamics shape the lives of diverse individuals experiencing MHACH in rural communities (Carter et al., 2014). Data was collected from multiple sources including: PWLE of MHACH, KIs, as well as a reflexive journal, and field notes.

Confirmability

Confirmability is displayed by my recorded activities over time that another individual can follow (Streubert & Carpenter, 2011). An audit trail was created to document my research design and strategy, as well as my thought processes to help clarify understandings throughout data collection and analysis (Creswell & Poth, 2018; Denzin & Lincoln, 2018). I aimed to provide sufficient information about data collection and study findings for the reader to understand my decisions, and to assess the selection of my methods, and the analytical processes used in my research. This allows the reader to make a judgement regarding the consistency of the findings and to evaluate their truthfulness (Slevin & Sines, 2013). In critical qualitative research, researcher bias is important. It is understood that the shared narratives of the participants are not fixed or an objective reality, instead, they are mediated by complex social dynamics that may change over time (MacDonnell, 2011). Data was collected from PWLE of MHACH across varied settings, as well as from KIs. Reflexivity as mentioned above is one of the key elements used to achieve confirmability, and the use of a reflexive journal kept my perspective and position transparent (Lincoln & Guba, 1985). Multiple check-ins with my nursing faculty advisors allowed me to share the common themes that were identified during the data collection and analysis stages which allowed me refine the rich data.

Transferability

Transferability refers to the extent that the findings can be transferred or have applicability in other similar settings (Creswell & Poth, 2018; Polit & Beck, 2017). To enhance the transferability of this study, rich and thick descriptions were provided; multiple geographically diverse communities were explored, and the findings were contextualized for the seven participants who are situated in different ways (Lincoln & Guba, 1985; Slevin & Sines, 2013). The multiple forms of data that were collected, provide an understanding of my research design and analysis.

Knowledge Translation

Knowledge translation is an iterative process that involves the synthesis and dissemination of research findings (Grimshaw et al., 2012). Because action is crucial in critical ethnography, a summary report of key messages that is both an electronic version and a hard copy will be shared with multiple audiences including study participants, politicians and the communities. Study participants, key informants, and members of the community will also be asked if they would like to be involved in the sharing of the findings at the community level.

My study findings can be presented at public health, mental health and addictions, harm reduction, or homelessness conferences through poster boards or seminars. The study findings can also be shared in nursing and social science journals.

Limitations

There are several limitations with this study. The findings represent a small rural geographic area in Southwestern Ontario and may not represent findings from other rural areas of Ontario, Canada or other locations at one point of time during the COVID-19 pandemic. Insights into the diverse experiences of PWLE who simultaneously face MHACH in this region or across other larger regions may have been quite different if the data had been collected prior to the pandemic.

Although this was a small sample size of four PWLE, my goal was to yield a deep understanding of the lived experience of a particular group of people facing MHACH. Given recruitment challenges, I also opted to recruit KIs who could also offer insights into the rural context of the lived experiences of people facing MHACH. With the sample size of three KIs in addition to the four PWLE, this was still a small sample size, but triangulating by different data sources enriched findings and understanding of PWLE through the perspectives of the KIs.

While I was aiming for a diverse sample of participants with PWLE who face rural homelessness, I was aware from the literature that many groups such as Indigenous and LGBTQ are over-represented in homeless populations. Two of those groups are those facing mental health and addictions challenges. I used purposive convenience sampling and maximum variation sampling in order to gather data from diverse PWLE (Streubert & Carpenter, 2011). While I was successful in recruiting PWLE that meet the three conditions of mental health, addictions challenges and homelessness, diversity related to race and ethnic background was limited, as all of the PWLE identified as White. Nevertheless, there were both male and female, older and younger participants, as well as variation related to the nature of their family and housing status. However, there was also significant diversity with respect to their mental health and addictions challenges. For instance, some PWLE used opioids and others used crystal meth, while their serious and enduring mental health conditions ranged from anxiety to personality disorder. The nature of the diversity of this sample yielded rich insights into the diversity and complexity of the lived experiences of adults who live simultaneously live with mental health, addictions and homelessness in a rural context.

I was also seeking diversity in KIs related to: geographic location; the nature of the program and services that they provide; and the nature of their work experiences with PWLE in order to understand the lived experiences of diverse PWLE beyond those that I interviewed. I also sought their perspectives of systems level issues. Even with three participants, there was significant diversity on the above criteria which further enriched the findings. Potential recruitment challenges for the KIs may have been due to their already high workloads especially during the pandemic. However, I did exceed my expectations for KI diversity.

Recruitment of people facing MHACH was challenging due to the strict inclusion criteria that I developed, as well as due to the transient nature of this population and the nature of their mental health and addictions challenges. There was a need to have all three conditions of mental health and addiction challenges and homelessness, as well as living in a rural community in order to participate in the study. The participants that chose to participate in this study may not represent others who experience MHACH and who remain hidden in their rural communities. However, participants' experiences of substance use, mental health challenges and homelessness were diverse. This may in part be related to the complex challenges of recruiting participants in rural communities that are hidden (Buck-McFadyen, 2021a). PWLE participants who were recruited with the help of KIs or through my own networks may not have had similar experiences compared to those who did not participate because of existing relationships between the KI and PWLE, as well as myself and PWLE. Those who did not participate may have had less access to services and supports than those who did.

Summary

The critical ethnographic research design and theoretical underpinnings of critical social theory and emancipatory knowing provided very rich data that offered insight into the lived experience of diverse people facing MHACH living in rural communities. Despite some limitations, the rich data reflected the voices of people who are rarely heard. Those who face MHACH and live in rural Southwestern Ontario shared their stories of policies, practices and other dynamics that shape their everyday lives. The following chapter will describe common thematic categories that were identified from the interviews with the PWLE of MHACH and KI participants.

Chapter 4: Findings

The purpose of this qualitative study was to explore how policies and other dynamics (i.e., stigma, discrimination) shape the lives of adults who simultaneously face MHACH in rural communities in Southwestern Ontario, with a goal of yielding understanding of the complexity of their lived experience. As well, I aimed to use the findings to contribute to change aligned with social justice giving voice to this population who are often not heard.

In order to offer insight into the complex factors such as policy and stigma which influence PWLE and the support available to them in a rural context, I collected individual interviews with two sets of participants living and/or working in the SWLHIN:

1. Four adults living with MHACH, and
2. Three KIs, service providers who support people living with MHACH.

Verbatim quotes are used within each category to enhance participant voices. To protect the confidentiality of the participants, I occasionally use the pronouns “they” and “them”. First, the demographics and descriptions of the seven participants are shared and then the results from the participant interviews are presented and explored in each identified category.

As a healthcare professional and advocate of people experiencing MHACH, I would suggest that some of the findings in this chapter may be difficult for the reader to hear. In staying true to critical social theory’s aim to challenge the status quo, I examine the narratives of PWLE and the KIs to identify the everyday impact of oppressive structures in society and in our health and social services for PWLE. Consistent with a strengths-based approach, I also conceptualize power as positive offering insight into ways that PWLE take action in the face of adversity.

Demographics

PWLE of MHACH demographic information is summarized in Table 1, using pseudonyms that were carefully selected for each participant. KIs were asked questions related to their work settings and work experience and pseudonyms were also carefully selected for them. Their extensive experience is discussed below.

Table 1

Demographics of PWLE

Name	Gender	Race	Marital Status	Dependents	Housing Situation	Income Assistance	Current Substance Use
Sophia	Female	White	Single	0	Temporarily housed (rehab)	No	No
Dalia	Female	White	Married	>1	Emergency Sheltered	Yes- ODSP*[1]	No
Allie	Female	White	Single	>1	Precariously housed	Yes- OW*[2]	Yes
Phoenix	Male	White	Single	1	Couch surfing	Yes- OW*[2]	Yes

Note. *[1] – Ontario Disability Supports Program, *[2] – Ontario Works

Description of the Participants

PWLE of MHACH

The four PWLE participants, Phoenix, Allie, Sophia and Dalia reside in the SWLHIN. Although I collected geographical information to determine eligibility to participate in the study, to maintain confidentiality, I have not shared specific information about individual locations.

This PWLE sample ranged in age from over 25 to their early 50s. All PWLE self-identified as White, three as female and one as male. They were financially vulnerable; all but one received financial assistance. Their housing accommodations were diverse and included: emergency sheltered; temporarily housed (rehabilitation); and provisionally accommodated (temporary unstable housing, couch surfing). Substance use varied. Two of the participants reported that they were a person in recovery, while the other two reported they were a person with a substance use disorder. The types of substances they used (past and present) included: alcohol, marijuana, cocaine, crack, crystal meth, gamma-hydroxybutyrate (GHB), mushrooms and opiates. All the participants disclosed that their length of substance use disorder was greater than ten years. Their mental health diagnoses included a varied combination of the following: depression, anxiety, borderline personality disorder, antisocial personality disorder, post-traumatic stress disorder (PTSD) and attention-deficit hyperactivity disorder (ADHD).

Key Informants (KIs)

The three KIs, Dana, Liam and Mona, were service providers who worked with diverse populations that included people with MHACH. Their current work experience ranged from 2 - 24 years; however, their lifetime experience working with people with MHACH ranged from 5-25 years. Their practice settings comprised of: emergency shelters, community hubs, social services, parenting programs, food banks, and counselling services and reflected diverse rural geographic locations across the SWLHIN. With significant work experience and representing diverse practice settings, they shared quite different perspectives about PWLE through storytelling.

Overview of Thematic Categories

Six main thematic categories emerged from the interview data and are displayed in Figure 1. These categories and subcategories will be discussed in greater detail below.

Figure 1

Six Thematic Categories

Thematic Category 1: The Voice of Lived Experience

I begin with the voice of lived experience, a focus that was woven throughout all of the categories. All seven participants discussed the importance of having a voice, or giving voice for themselves and others that are living with MHACH. Having voice or giving voice in these narratives was related to participants' ability to tell theirs or others' stories, so people could understand their everyday experiences. However, as their stories highlight, the nature of having voice or giving voice varied. At times, voice was related to being able to disclose their medical and/or living conditions when accessing services; at other times, it was tied to a participant's ability or inability to take action, such as participating in advocacy activities to foster social change to improve theirs and others lives. As these findings show, voice and participation for PWLE is tied to their relative power and privilege in a given community or in society, factors that are crucial to their ability to be heard and participate in meaningful ways to challenge the status quo. Phoenix summarized the importance of voice for all of the PWLE participants, remarking that "having their voice heard is key….I think that's where your answers are gonna be is from the people for the people."

Some KIs recognized that having a voice was not always possible for PWLE of MHACH and therefore, stressed the importance of their role in giving voice on behalf of PWLE. They also recognized that some PWLE may also exercise silence as a form of self-protection. Mona recognized the authority and privilege she has as a service provider sharing, "a lot of our families feel like they don't have a voice in the same equal way as you and I might have a voice in our community." Through this research, the KIs shared stories about the unique and diverse PWLE they worked with, expanding insights into the diversity of PWLE and their experiences. It is important to note that the stories shared by the KI participants are based on their own interpretations of PWLE experiences.

The study findings highlight the complex factors and dynamics that create barriers for PWLE to give voice and participate in processes aligned with policy development. These complex factors impact a person's ability to claim certain identities and take action on issues that impact them, their physical and mental wellbeing, and ultimately a sense of belonging to a community. This key category of the voice of lived experience includes three subcategories of: A Day in The Life; Pride in Self and Feelings of Regret; and The Importance of Listening. I will explore how each of these subcategories shape the lived experience of people with MHACH.

A Day in The Life

The PWLE participants provided unique perspectives related to gender, marital status, family dynamics, socioeconomic status, substance use, mental health concerns and housing situations; therefore, each of their stories will be shared to gain a deeper understanding of their everyday lives.

Dalia. Dalia was sincere when she shared her struggles with her mental health, as well as her experience being housed in an emergency shelter. At the time of the interview, she had been living in a motel for approximately two months with her partner and children. She didn't focus on her addiction during the interview, since she has been "sober" for many years. Her primary focus was access to food, shelter and providing for her children, along with wanting to share details of her voice of lived experience. She described her living situation as "very stressful." Food storage in the motel is limited and she described her meals as "unhealthy", since she has "to live off of cans and boxes." Access to meals and soup kitchens are scarce in her community and grocery stores are "pretty costly" in small towns. Dalia also shared that her options are limited to keep her children entertained and therefore, she spends her days walking into town to access free resources such as parks and libraries. Her current living situation puts her at risk with Family & Children's Services, and the sustainability of motels as emergency shelters is uncertain. Dana worries about her future and spends her time searching for housing, but stated, "There's just not much options."

Sophia. Sophia has tried to access addiction treatment multiple times without success, but was recently able to enter treatment and rehabilitation with support from her mother. Sophia was very open about having substance use challenges while completing her post-secondary education and described a feeling of superiority over her classmates. She shared "I kind of thought I was better than everybody and I had control over my using, but I really didn't." She offered detailed insight into her substance use and mental health challenges, describing herself as "very impulsive…very aggressive. I would literally do anything to get alcohol or drugs." Sophia's inability to regulate her emotions, particularly with anger, resulted in many precarious situations for her. She was quick to share that "the tiniest thing would just set me off and there I am again…destroying anything in my path." She described this time of her life as "really hard", since being at shelters she was always surrounded by drugs and alcohol. As she remarked, "the more I drank and used, the more my mental health was deteriorated." Although Sophia is temporarily housed in a rehabilitation centre, she will soon be discharged to no fixed address. She is currently exploring housing and employment options.

Phoenix. Phoenix, a fierce advocate for PWLE in his community, was very straightforward when he talked about how he lives day-to-day. He described himself, "I'm a drug addict….I'm in control. I don't have the hardcore mental health problems. I may have some of the regular ones." Phoenix's housing situations have varied over the years and he compared what it was like to live in a group home versus living on the street. He is currently couch surfing and remarked that living on the street was easier than living in a group home. When he lived in a group home, he received Ontario Works (OW) and only had one hundred dollars to live off of after paying rent. He shared, "That's why people would rather live on the street, cause at least on the street you get 300 and some dollars." When living on the street, Phoenix said, "If you slept the night before, you're gonna wake up and you're sick, physically sick." As he noted, "Every minute of the day is eaten up by finding ways and means of getting more." Phoenix described how he feels when he uses substances and said that he "feels nothing….You don't have to deal with pain. You don't have to deal with life on life's terms. You just, you're not even existing." He appeared to struggle with his desire to be sober over his desire to not be in complete withdrawal. Although his desire to quit is real, the physical pain of stopping pushes him to use again. He openly said, "It's only when you're in full blown withdrawal, is probably the key time when you start thinking about–fuck, I don't want to do this." He is "teetering on the edge of a very slippery slope" between advocacy and substance use. Phoenix's priority becomes doing everything in his power not to be sick; for him, shelter only becomes a priority "as a means of finding a place to do your dope."

Allie. Allie's role in the community could be described as a street mother or an informal resource. She feels that it is her responsibility to help others, but described this work as "draining" and notes that she "gets taken advantage of a lot." She provides shelter and food to PWLE who are banned from services in her community, such as food bands and shelters. Allie is precariously housed and recognizes her own vulnerability in offering this service. She worries about her neighbours and their perception about what she is doing and shared that "they hate me because they don't like, you know, people coming and going all night." Allie described her typical day as a “cycle. You get high, you sit around all day, hang out and you need to get high again.”

Pride in Self and Feelings of Regret

Pride in self and feelings of regret became an important subcategory to consider. Although some of the participants were living precariously, their eagerness to share how resilient they were, and their need to help others quickly became apparent. Each participant shared moments they were proud of, as well as experiences that they described as shameful or regretful. The vulnerability they showed when they shared their stories was poignant.

Phoenix is a strong advocate in his community and participates as a PWLE on multiple community coalitions. Although he is active in his community, he shared, “I don’t find real joy in a lot of things anymore.” In sharp contrast, his pride in self became evident when he shared a time that he was invited to speak at a community forum. Phoenix said that a community member gave him the opportunity to share his story which “gave me boosted confidence.” Phoenix also takes pride in his social standing in his community and his ability to create a safe environment for people to use substances around him. He has saved many lives and has been able to refer multiple people to an outreach treatment program. Phoenix proudly pronounced, “I can pat myself on the back for that.”

Allie shared some remorse in her drive to acquire drugs, saying, “You’re always thinking of a scam to run and that’s not healthy….That’s hard on your fucking spirit.” She appeared to struggle with the shame in finding what she needed to survive, but was also proud of her resourcefulness. She disclosed that her priority for each day was finding drugs and figuring out how she would get her next hit, saying, “You’re gonna rob somebody, you’re gonna steal some from somebody…you’re gonna get it somehow.” She joked that “the smartest people I know are addicts, right? Like, the things they do to come up with using every day." At the same time, Allie takes pride in the work she does for people experiencing homelessness and described her work as "God's calling." Although she takes on the role of a caring person, she also shared that she feels guilt and shame when she listens to other people's stories, as she becomes 'bored" with these stories, since they are so "redundant." She understands the importance of others sharing their stories, but has developed a coping mechanism of "not listening", which I surmised may be to quite possibly protect herself from vicarious trauma.

The KIs described their current successes with programming in their communities, as well as some of their struggles. One of the KIs described their program as a "pretty good little secret here" and mentioned that other rural communities from across Canada are calling for advice. Their passion for working with PWLE was evident in their verbal and nonverbal communication. One KI beamed when they described their program participants, saying, "it's neat to see the little changes that happen." Shame and regret were evident in the KI interviews when discussing the lack of action in their communities when they or others advocate for change in mental health, addictions and housing solutions and policies in their rural communities.

The Importance of Listening

It became apparent throughout the interviews that providing the opportunity for people to give voice in a public forum or to have a voice is not enough to invoke change if we don't listen. Many of the participants expressed the desire to be heard and for decision-makers to understand and believe their lived experiences. Although some of the PWLE were given the opportunity to give voice in stakeholder meetings, they expressed their frustrations that they weren't being heard. This was reflected in their stories about the lack of change and action in their communities. Often people may be invited to decision-making tables to share their stories and provide recommendations; however, some PWLE feel that they are not often heard. Phoenix brilliantly summed up the importance of listening to PWLE, stressing, “Listen to what they have to say….We can work together and you can come up with solutions, find ways and means to live together. It’s really not that complicated.”

KIs stressed the importance of decision-makers such as managers of community agencies and mayors connecting with frontline staff or PWLE when making changes to programs or policies that impact them. Dana shared that “they have to actually connect with those rural communities and the frontline people…and the people who are maybe having more of the experiences….Those are always the voices that need to be heard.” As these KIs emphasize, to make change, more PWLE need to be purposefully invited to decision-making tables and other avenues to give voice, where they could potentially contribute to the power to invoke change.

The findings in this category share a glimpse into the everyday lives of people experiencing MHACH in rural communities. Although some examples were shared of how the PWLE participants experienced shame and regret, they were also eager to share how resilient they are, providing examples of MHACH advocates and other informal resources in their community. All of the study participants stressed the importance of listening to the voice of lived experience when making decisions that impact them, noting that they are the experts.

Thematic Category 2: The Impact of Rules and Policy: Power Over the Marginalized

Many examples of rules and policies that people with MHACH face day-to-day were discussed by all of the participants. Policies and rules in organizations and community settings are often developed and implemented with the intent to improve the physical, social, environmental and economic conditions for the larger community (PHO, 2023). In these narratives, rules and policies were seen in both a positive and negative light. Following rules can often be difficult for some PWLE. Phoenix shared, “You don’t mean to be disrespectful to anybody, but you just can’t. If we could abide by the rules, we probably wouldn’t be in much of the situations we’re in.” An interesting phenomenon emerged from the study that highlighted the impact of organizations and communities enforcing some meso, and micro level policies that can result in some people being banned from the essential services that they need. The impact of these meso and micro level policies and practices will be explored further in the following subcategories.

Law enforcement

Without law enforcement, we are not able to enforce the laws that govern society. Although laws are put in place to protect a community, the perception of how laws are enforced varied among both PWLE and KIs. Many examples related to law enforcement were shared and three subcategories emerged: Parole Officers; Police Services; and Jail.

Parole Officers. One of the KIs discussed a negative experience working with a Parole Officer (PO) and one of their program participants. Communication was poor between the program participant and the Parole Officer, and the PWLE felt that they were being discriminated against. The KI related that they declared to the PO, “You are taking grown men and women and talking to them like they are dogs or children. You know you are not listening to what that person has to say…and we fuck him right around.” The KI believes that the justice system is so overwhelmed, that people are being released without any follow up or support in the community. As they observed, “I’m looking at a system that is so inundated…nobody gives a shit about who that man really is or who is counting on him.” Several other participants shared similar stories and described their interactions with POs as “seeking permission” and “abiding” by rules. Although the role of a PO is to monitor the conduct and behaviour of criminal offenders in the community, the participants reported that their authority is not always aligned with restorative justice principles. The stories that were shared contradict the purpose of restorative justice–to provide an opportunity for victims, offenders and communities that are affected by a crime to communicate and address their needs, while remaining accessible, compassionate and fair (Government of Canada, 2021).

Police Services. The PWLE participants discussed their interactions with police as both positive and negative. One believed that they are "hurting people" and "destroying their homes." Another felt "many cops aren't very nice…they're not compassionate" and described what an interaction with police in their community looks like, saying, "You're gonna abide by the law. I'm the boss….You're going to jail. I don't care if you have mental health." One KI described an encounter with police when they accompanied one of their clients to the police station for their arrest due to breach of probation. When they tried to explain to the arresting officer what happened with the PO, the KI said they laughed at them and said, "We actually don't give a shit…turn around." The KI went on to explain that "the way that our police deal with this town on a whole has a negative impact on the mental health of everybody here….I don't know what became of policing, so to speak….If policing is a program, their program is shit." This KI questioned the motive behind police trying to gain trust with PWLE and said, "I don't know why you are trying to gather that information if you are not actively using it." The KI believed that the information that was being collected was not directly related to that specific PWLE and instead focused on other PWLE snitching on one another.

On the other hand, some PWLE also described a few police officers as "open-minded" and "understanding." They all discussed the endless cycle of arrest and release that happens in their communities and shared that "they must feel pretty stupid, um, you know, arresting somebody for shoplifting…when you know what they're shoplifting for….They're not getting any better and it's just a cycle." The endless cycle of arrest and release highlights a broken justice and social services system.

Jail. Two of the PWLE participants talked about their time in jail and the belief that people in charge determine whether you can be referred to addiction treatment or not. One PWLE confessed, "My goal when I got arrested was to quit doing drugs and to get into a treatment program to help me when I got out to survive." Due to an altercation with another inmate "they denied me the opportunity to go to treatment." Their disappointment was evident when they shared "I wasn't able to take advantage of the system that could have probably helped me out." For PWLE, jail can be a key turning point in managing or deepening one's substance use challenges, yet in their view, actions by authorities in jail are more often focused on domination, control and fear.

Banning From Services

Personal experiences of being banned or having restricted access to stores, buildings and services varied across PWLE, but all agreed that access to shelter during the day was considered important to survival for PWLE. Banning and restricted access occurred in some communities because of reported destructive behaviour of some people experiencing homelessness and this stigma fueled communities' fear. Some communities have restaurants with drive-thru options only, which can severely limit daytime shelter access for a number of people living in rural communities. Some other options for day shelter that were shared included city halls and libraries. Mona, a KI, remarked that, in her community, some families are only allowed to be in the local coffee shop for no more than twenty minutes. She shared that "they are trying to access internet and be able to keep warm…and they are being asked to set limits on how long they can stay in there."

When I asked the KI, Liam, about banning people from his program, he shared that he felt his "tolerance is pretty high. I don't care if someone swears at me." Liam shared that he would only ban someone if "they're actively trying to sell dope table to table…physically violent with somebody…and stealing." Liam does not believe in an indefinite ban from services and explained, "as soon as you can walk in the door and answer for what you did…you are good." However, in my experience, indefinite or lifetime bans are not uncommon in some communities.

The PWLE talked about people not being able to access the emergency shelter in their communities and the injustice of this, particularly if someone is struggling with their mental health. They shared a story about an individual who was struggling, saying, "They won't let him in…the bureaucracy over there is crazy, the politics suck….Like, how dare you turn someone away?" They also described a 16-year-old who was not allowed to stay in the shelter and said "they can't make these people change into normal rules normal society has, because they don't live like that." One PWLE challenged the purpose of rules and declared, "When you try to conform them into something that they don't wanna be…it's not gonna work." They were quick to add, "I'm not saying let them run wild or anything like that. Like there has to be rules in life, right? But you have to be a little bit lenient."

Eviction

Remaining housed without supports is often difficult for people experiencing MHACH. Rules are often rigid in group homes, and it is easier to evict a person from a group home versus an apartment or house. Phoenix mentioned that residents must sign a contract to live in a group home "and it's to the T you follow it or you're done." He described a time when he was evicted from a group home during COVID-19 for providing shelter to some of his friends in the winter, as well as a time he was accused of selling drugs. He disclosed, “I never had an opportunity to prove otherwise or state my case.” He shared that once he was on the “list” for breaking some rules, “they find ways and means to getting you out….Their whole mission is to make sure that you’re evicted from the group home.”

In these narratives, PWLE recognized the need for rules, but highlighted their struggle with following them. Often rules or policies were implemented at the organizational level, but interpreted by the local provider–sometimes incorrectly. Inconsistencies in enforcing some rules can further marginalize PWLE of MHACH. Some of the MHACH participants were banned from essential services such as primary care, food banks and shelters, while others missed opportunities to access mental health and/or opioid treatment.

Thematic Category 3: What it Takes to Survive

Survival emerged as another important category to consider with all of the participants and is threaded through all of the categories. The vulnerability of the PWLE participants was evident when they discussed survival on the street and their ingenuity to live day-to-day. Often times, the focus is on individual risk factors (i.e., choice) that may increase someone’s risk of experiencing homelessness, instead of how structural and social factors and system failures may be at play. These factors may include lack of adequate income, access to affordable housing and discrimination; they all influence an individual’s ability to live day-to-day. These barriers create challenges for people trying to access basic needs. Some of the stories that were shared by the PWLE highlighted the importance of focusing on the structural and social factors and system failures to help combat the belief that some behaviours exhibited by PWLE are based on choice rather than the need to survive. The need to survive far outweighs the risks associated with breaking the law. In this category, the subcategories: “Relive It and Relive It and Relive It”: Managing Everyday Challenges; Bending the Truth; Spirituality; The Vulnerability of Trust; Feeling Secure; and Finding Employment emerged as ways to survive.

“Relive It and Relive It and Relive It”: Managing Everyday Challenges

The day-to-day experiences shared by all the participants illustrated different ways in which they adapt to stress and how they manage everyday challenges, that for these PWLE are strategies or responses for surviving in highly difficult circumstances. An example of a survival response was described by Phoenix, who shared that in order to survive, some people have to “boost” or steal and “resort to doing things that they normally wouldn’t do.” He described “boosting” as an activity where a group of people go into a large store and fill up shopping carts and leave, saying, “One guy gets caught, takes the blame, but he gets taken care of when he gets outta jail.” He shared that people also make money by taking their entire OW cheque before paying rent and will spend it all on fentanyl “and then they try to sell it.” Phoenix postulated that is why the crime rate is so high in his community.

Although one of the KIs says their desire is to make a difference, and that is what motivates them in their work with PWLE, they find it “draining.” They disclosed that they are not able to “stop work” because of their drive to make a difference. To manage stress, they shared that they ride a motorcycle and have “very supportive” partner. Alcohol was a common substance that is used by most of the PWLE and KI participants. One KI joked that after work some days they go home and have a glass of wine. What I found interesting is that only one study participant identified alcohol as a substance that can be misused and could potentially have devastating effects for some people–this was a PWLE participant. Another PWLE often finds themselves in risky situations when they are on the street. They revealed that they carry

Naloxone and have saved many people from dying. Although these actions seem heroic, the consequence is dire, since they have no one to talk to about these stressful experiences and use substances to help them cope. The PWLE participant said, “I had no one to talk to…. to work myself through it to realize, okay, this is what happened.” Instead, they disclosed, “I just have to go home and be by myself, smoke crystal meth and dwell on what just happened.” These scenarios are relived over and over along with the guilt they experience when they hear someone has died and they weren’t there, “I know if I could have been, they would be probably alive.”

Bending the Truth

PWLE participants used the term “lying” in a number of their narratives. I chose to use the term “bending the truth” since most of the examples that they shared involved things that they did to survive. “Lying” was commonly used to cope with everyday life experiences, to manipulate others to meet their basic needs (food, shelter, drugs), connect with people, and to access services. One of the PWLE participants summarized their experience with lying, saying, “My first language was lying for the last 10 years….I’ve manipulated, I’ve stolen and I’ve hurt people for things I wanted….We all just want, want, want, and we want to take.” Some of the participants described lying when they explained what their current relationship was like with Family & Children’s Services. For them, the need to keep their children in their custody outweighed the consequence of lying. Another PWLE shared, “My whole life is a lie….I have to protect my child.” PWLE noted that they often have to lie to access housing because references are often needed. Allie disclosed, “I had to make up phone numbers, make up people to say who they were, just to get into the house.”

For the most part, the KIs conveyed an understanding of why PWLE may need to bend the truth. At various points in the KI narratives, they provided valuable insight and understanding of their challenges and the lengths to which people would go to access basic needs. They also recognized how difficult it would be to be completely open regarding their substance use and mental health challenges when accessing services. Mona shared that “it is common ground for them to share their story over and over because they had to repeat it every time they meet someone new”. She went on to share that sometimes “they don’t have emotions associated with it”. This could be associated with managing everyday stress.

Spirituality

Spirituality was a perspective that I was not expecting to hear about. One of the MHACH PWLE talked about God a lot throughout the interview and identified themselves as a Christian. They described their work with their peers as “God’s calling”; however, they also discussed their struggle with “feeding their addiction”, stealing from a church and then lying about it. They described a situation that happened years ago where they stole some money from a church and they have not been able to forgive themselves. They confessed, “I’ve paid for it since….If you can lie to God in God’s house and then go lie to your pastors and your parents, that’s pretty shitty.”

A sense of belonging through church and family appeared to be important to another PWLE participant and keeps them from leaving their community to find permanent housing. They recognize that resources are limited in their small community, but when they talked about leaving to move to a larger community, they hesitated because “my family’s here, my church is here, like my kids are rooted here.” Another PWLE mentioned thanking God when they are in “full blown withdrawal” and when they start to think about their sobriety. They disclosed, “Fuck, I don’t want to do this…and you tell yourself that until you take that first toke and then it’s like, oh yeah , okay. Thank God." They also thanked God multiple times when they talked about being there "to save people's lives."

The Vulnerability of Trust

One of the KIs was very vocal about the current climate with policing in their small community and in particular how police give a false sense of trust and security to people with MHACH. Often in small communities, police patrol the streets on foot and interact with people experiencing homelessness. They visit soup kitchens or shelters, have coffee and talk to patrons or talk to them on the streets. Although most communities view this as a positive interaction with police, since it reportedly contributes to community safety, one KI believed that the police cause harm and mistrust, explaining that the police "come around here and talk shit behind their backs and make them want to kill each other." This KI reports that police befriend some PWLE which allows them to let their guard down, but results in mistruths being shared about other PWLEs. This helps to take the focus off of themselves and causes others to be unfairly targeted by the police.

A sense of belonging in a community is difficult when trust is lacking. It impacts one's wellbeing and ability to engage socially and to participate within a community. Trust and survival were closely related for Sophia. She discussed what trust meant to her and possible ulterior motives when someone was being kind to her. She remarked that "I'm not used to genuine people just being nice…nothing's just given on the street to be nice."

Trust and mistrust were identified as important factors to consider when people are accessing services. Allie talked about the reluctance for some people to access services and the need to trust service providers, saying, "They [PWLE] don't know who you are…it's all about trust. I think like once they maybe get to know whoever’s there [service provider]….[PWLE] would be more willing to ask for support.”

Feeling Secure

Based on my nursing expertise, I believe in order to feel safe and secure, you need to have a sense of control of yourself and the environment in which you live. Therefore, safety and security becomes unpredictable for these PWLE who face unpredictability related to their MHACH. This vulnerability was reflected in their narratives. A “net code” or unspoken promise between people on the streets who use drugs was described by a few of the participants. Phoenix noted that previously, people looked out for each other, but “unfortunately, nowadays with opiate, uh, fentanyl addiction…people are stealing from each other.” This phenomenon was described as a “crisis” by Phoenix.

Some of the PWLE participants talked about the risk of facing violence from their peers related to gender and finding shelter, while on the other hand they also discussed ways in which they support one another. Unfortunately, PWLE, like larger society often internalize widespread stereotypes that people who use substances are violent. Allie talked about people with severe mental health and addictions who are in active psychosis and the fear associated with encountering these individuals on the street, saying, “Normal society gets scared, I’d get scared too if I didn’t know them.” This fear may limit PWLE access to much-needed services.

Safety and feeling safe were discussed by all of the PWLE participants. Sophia shared that she hasn’t had “the feeling of safety for a long time.” Her sense of safety was in part, tied to gender, and she described the vulnerability of being a woman with substance use disorder and living on the streets. She noted that “they didn’t really see me as human” and described her fear of being vulnerable to assault in a shelter as something that still affects her. Sophia said, “I would still be woken up in the middle of the night by guys trying to get into my room." To keep herself safe, Sophia kept to herself and "avoided big groups of people." Another PWLE discussed safety and being afraid when they talked about their children living in a shelter. They mentioned that the police were always there because "it was a very rough spot to be….It was very dangerous."

Some PWLE discussed strategies to stay safe or to protect others. Sophia discussed the need to protect a female teenager at one of her shelters. She was candid when she shared, "I found myself very protective over her…I absolutely put myself in danger to make sure she was okay." Allie considered jail as a "saving grace for a lot people", saying that "if I know you're in jail, I know you're safe, you're okay."

Finding Employment

The desire to find employment was discussed by three of the PWLE participants, noting that obtaining a job with a criminal record is almost impossible to achieve. One described the stigma associated with having a criminal record, "I feel like it's just a cycle….You can't get a job and then it's, you're just back on your ass." Sophia discussed the importance of employment in her recovery journey, sharing, "I feel like it would be so much easier for the people who are trying to make their lives better and move forward in their lives."

Gender, risk of violence, lack of trust and stigma were factors that influenced participants' ability to achieve a sense of belonging or to feel safe. As these findings show, the strategies that PWLE used to survive are extensive and demonstrate their resilience. Bending the truth, substance use and spirituality were common strategies that were discussed during the interviews to manage everyday challenges.

Thematic Category 4: Why Rurality Matters

Rurality influences the lived experience of people with MHACH. It can enable individuals to live with dignity, but can also create barriers in their everyday lives. Rurality can build a sense of community, while on the other hand create challenges for food security, and can stigmatize vulnerable populations. All seven of the study participants identified potential benefits of experiencing MHACH in a rural community, as well as barriers. The KIs and PWLE all lived or worked in rural communities throughout the SWLHIN. These communities varied in size, demographics, and geographical location, which impacted PWLE access and utilization of mental health, addiction and housing services. They identified barriers to accessing services that included housing policies, transportation, and gaps in services. Complex factors such as stigma, discrimination and the discretionary authority of providers at various organizations contributed to some of those barriers. Occasionally, some decisions were being made about living arrangements for PWLE without their input. Phoenix was evicted from a group home when he was charged with trafficking drugs. The authority that the group home owner had over Phoenix allowed them to convict him and declare him guilty before he even had his day in court. In contrast, “knowing one another” provided a sense of community for some of the PWLE participants. In this instance, they talk about a community in terms of people like them who for the most part are homeless and who are often facing mental health, addictions challenges. This community provided a sense of belonging that was lacking in the larger geographic community and for some, created a sense of safety and security–albeit, a somewhat fragile sense of security, given gendered issues that were mentioned by some of the PWLE.

The interviews brought to light the development of informal resources to fill some of the identified gaps to meet PWLE needs. Although geographically the rural communities differed, common themes emerged that impacted one's ability to access services. The diversity of the PWLE participants and communities provided an opportunity to share perspectives that were unique to each individual and community. To further explore their experiences, this category is divided into four subcategories: Access to Health and Social Services; Barriers to Health and Social Services; Specific Examples of Resource Issues in Rural Communities; and Unique Perspectives.

Access to Health & Social Services

The availability of resources for MHACH varied across the SWLHIN. The need to identify or disclose personal health information with an agency is an important first step in the intake process to access health and social services. Client intake forms require general contact information such as name, address and phone number. This fear of identifying can create a barrier to access, since people are no longer anonymous and may be stigmatized, which can be humiliating. Dana, a KI shared "so much of service delivery relies on people identifying…but a lot of times that also gets in the way."

Some of the KIs discussed ways to make it easier to access services including, telling their story and having a formal mental health diagnosis. Dana discussed the possibility that sometimes it is a bit easier for individuals with a formal mental health diagnosis to access resources, since rigid eligibility criteria for services can limit one's options. She provided an example of an individual that tried to access services without success and remarked that "he doesn't really have a concrete diagnosis….I think it would be more straightforward if he had it." Mona explained that people need to "tell their story" when accessing services so they are able to express their thoughts and feelings and to identify their needs. A PWLE also stressed that is important for people to tell their story; however, suggested that service providers and other PWLE become apathetic over time, since these stories are "redundant".

Barriers to Health & Social Services

The demand for MHACH resources and services in rural Ontario far exceeds their availability. The KIs shared their concerns. Mona explained that "the number of people becoming homeless or struggling with addictions…and the resources that are available are just not at par anymore." Dana described how "in a rural community, you don't have the population density to take advantage of a lot of programs, services" which limits their availability. She compared accessing services in a rural community versus an urban centre and felt individuals in an urban centre are at a greater advantage. She said, "They would be able to access food security or housing services or things more easily, whereas here people are um, that much more vulnerable." The participants suggested that PWLE could move to larger communities to access services; however, they would have to leave their community and family behind. Dalia, a PWLE, shared that "people that I've known have moved into the city because that's the only option." Sophia was the only PWLE that left her community to access services elsewhere; however, ironically, she left an urban centre to access services in a smaller community. This contradicts the belief that services are easier for everyone to access in urban communities.

The PWLE also felt there were not enough resources available in their community and some were not even aware of them. Hours of operation was cited as a barrier by most of the participants, and Phoenix shared "all resources are shut down at five o'clock." Allie believed that services needed to be advertised better, saying, "Why is it such a secret? Why is it so hard to access that information?" She pointed out that people with severe mental health and addictions challenges are at an even greater disadvantage to accessing services, and said, "I just think there’s not enough resources for them.” Navigating the healthcare system becomes more complex for individuals with severe mental health and addictions, since it is difficult for them to find an advocate that they can trust to share their story. Sometimes with crystal meth use, psychosis can occur, and violent behaviours become evident. These behaviours severely limit their ability to engage with service providers and unfortunately, some people receive lifetime bans from essential services such as shelters, soup kitchens, primary care, banks, and pharmacies. Although the safety of staff is paramount, as some KIs note, alternative solutions are rarely offered and these PWLE who already contend with significant challenges to surviving day-to-day can be denied access to healthcare, food and shelter.

Several KIs described the geographical isolation in their communities and the impact that had on their current program participants, as well as individuals that were on waitlists for services or were not aware of services in their community. Mona shared that “there is not the same access to certain services or opportunities for some of our families that are isolated….So there are some inequalities for sure around here.” Often mental health and addictions services are housed in larger communities which are sometimes several hours away. The KIs shared that limited services may be offered occasionally in these rural communities; however, often one outreach worker is assigned to one county, one day per week. The demand for services is higher than what is offered; therefore, collaboration with other service agencies and providers is essential. KIs described some of the benefits when collaborating with other service providers in small communities. Often service providers know one another making it easier to connect. Mona remarked, “everybody kind of knows everybody…you are able to kinda speed things up a little bit.”

However, knowing one another in rural communities, was also identified as a barrier to service access. Often people are embarrassed to access services due to the stigma and will wait until they are in crisis before they ask for help. This dynamic can impact an individual's dignity. The KI Liam disclosed, "I can think of a family right now that waited a year too long. Just because the neighbours….Rurally it's a killer." Another KI remarked that they are working with an elderly individual who is too scared to identify or share their information because they would not be anonymous. This individual is known in the community and is currently living out of a storage locker, which have increasingly become options for shelter in some urban and rural communities. PWLE's fear of asking for help outweighs their need to identify. The KI shared that "he doesn't want to lose whatever civility he has."

Specific Examples of Resource Issues in Rural Communities

To better understand how the PWLE participants experience access and barriers to services in rural areas, I will explore the resources that emerged as relevant in these narratives: housing and shelter, counselling, food, treatment options, transportation, and waitlists for services.

Housing and Shelter. The availability of emergency shelters varied in each community. Even when some communities had shelter beds available, there were barriers that were described when individuals tried to access them. If someone needs to access a bed in a shelter, they have to put their name on the list. Most beds are available on a first-come-first-serve basis and often, there are more people requesting shelter than there are available beds. Phoenix described the process when he tried to secure a bed, saying, "We wouldn't get a bed because the people that were there last night get first priority for the beds." Such a shelter policy means that current guests receive priority over others needing shelter, and given the severely limited housing options, this creates barriers for people experiencing MHACH.

The availability and lack of options to rent an apartment or house was raised by several participants. Dalia described her community as “touristy” which limits the number of affordable housing options. She said, “People need to know that rent at 2 grand, at 3 grand for a 3 bedroom is unaffordable for a family.” Phoenix also shared his challenges trying to find housing when people know you have a history of mental health and addictions. He mentioned several times that “a lot of doors closed on my face.”

Counseling. Barriers to accessing mental health counselling was mentioned by all participants. Agencies often limit the number of free counselling services in family health teams and social service agencies, which makes access cost prohibitive. Dalia shared that she was only allowed six sessions and now has to “pay out of pocket…because I’ve used all the resources that are free… I have no more sessions available to me.” Counseling sessions can cost approximately $130 per session, and some agencies offer a sliding pay scale to accommodate. However, basic needs (e.g., food or shelter) become a priority over one’s mental health. In many communities, there are mental health crisis lines that people can connect 24/7, and Mona the KI described this service as “a pretty good initiative.”

Food. Experiences related to access to food varied for these PWLE. Some of the PWLE and KI participants described that food resources were limited in their communities. Some communities lacked soup kitchens and food banks and therefore, travel by car was required to access these services in larger communities. Sophia was the only PWLE participant that shared she “never really struggled with food”, adding that she had “pretty privilege”, so people often bought her coffee and food.

One KI believed that offering food in their agency allowed people to access other services such as housing and counseling, saying, “If you feed them they will come.” This KI was able to use their food program to collect homelessness data instead of using point-in-time counts. They capture the number of people accessing their food program instead of point-in-time counts, which is difficult to do in rural communities. This initiative captures the importance of variation when providing services in rural communities and collecting homelessness data.

Treatment Options. Treatment options are scarce in rural communities, and PWLE often have to leave their community to access these services. There is also a fear of accessing services for addictions, particularly if you are connected to Family & Children’s Services (FCS). PWLE fear they will lose custody of their children if they admit that they have a substance use disorder. One of the PWLE participants stated, “I don’t have an outreach worker or anybody like that…cause I’m afraid of FCS.” Their fear was tangible when we discussed the impact of losing custody of their older children years ago. Unfortunately, this fear significantly limits an individual’s ability to seek treatment.

Methadone, as a treatment option for opioid use disorder (OUD), is difficult to access because “you have to go every day for a drink”, and strict rules are enforced. Dalia and Dana as a PWLE and KI both described access to methadone as a barrier due to transportation issues, since only larger communities dispense it. Dana shared that “you have to drive to get it…it’s an hour and a half in good weather…and obviously winter the highway closes.” Phoenix described methadone as “a really hard program” and “doesn’t work because of the rules and stipulations.” Other treatment options for OUD are slowly becoming available in larger rural communities. A few of the PWLE participants reported that sublocade (used to treat OUD) is being prescribed and administered in some outreach programs.

Transportation. Transportation was an important barrier to consider. Some participants had access to public transportation in their community, others travelled by foot, and others relied on other people with vehicles. Dalia lives in a geographically isolated area, but does have access to a vehicle, remarking that to access resources, “it’s a lot of driving.” People are sometimes reluctant to leave their own community to access resources. The KI Liam felt people want to access services in their own community and shared, “You think I am getting Bob from down the road…into town to talk to somebody? He doesn’t give a shit. He wants help but he wants it here.” Liam’s statement contradicts the dialogue about the fear of identifying in a rural community. Although there may be fear of identifying in a small community because people might know who you are, trust and feeling safe in a familiar environment may override this fear for some.

Waitlists for Services. Housing policies have impacted the availability of safe and affordable housing locally and provincially. Waitlists for services are very common; however, the length of wait time varied depending on the service and community. Waitlists for housing, emergency shelter, treatment options, counseling services and primary care were all described as ranging from months to years to access their services, while housing waitlists average seven to ten years. Someone may be in a state of readiness to access treatment when they first ask for services, but after waiting a considerable amount of time they may be reluctant to accept help when offered. Sophia shared, “It’s been a month or it’s been two months when they get back to me. Like I don’t, I don’t care anymore.”

Frustration and hopelessness was the common response shared when participants discussed waitlists. Phoenix shared that “if you give an addict anymore time, then a couple of hours, chances are they’re gonna change their mind…it’s not worth the hassle.” Several participants spoke about the availability and cost of treatment facilities in Ontario. Two-tier healthcare is evident in this example, as access to these facilities is faster if you have the ability to pay privately. Sophia was able to jump the queue, saying that "if you wanna pay, you get in faster." Unfortunately, not all people have the ability to pay for healthcare. A two-tiered healthcare system contradicts the Canadian Healthcare Act and does not provide reasonable access to health services without financial or other barriers.

Unique Perspectives

It became apparent that the unique perspectives related to living in rural communities needed to be highlighted. These unique perspectives focused on how policies and other dynamics shaped participants' everyday lives and are shared below.

Motels as Emergency Shelter: Urban Solutions. Three of the study participants described the difficulty in finding emergency shelter and long-term housing once having been evicted, because of the "lack of rental stock" in rural Ontario. Housing policies across all three levels of government contribute to these housing problems. The availability of safe, affordable housing is scarce. Emergency shelters are also nonexistent in some of these communities, so that they are using local motels as their shelters. Motels have been used in cities for years due to overcrowding of emergency shelters, and the use of motels became popular during the pandemic to isolate or recover from COVID-19. Rural communities have quickly adopted this practice during COVID-19 and now use them to offer emergency shelter. They were not expected to be used as long-term housing solutions, and now communities are struggling to find alternative solutions for hundreds of people, since pandemic response funding has ended, and there is nowhere for these individuals to go.

Seasonal Workers and Housing in Tourist Locations. A large portion of the SWLHIN includes multiple tourist destinations. Seasonal workers move from urban communities for the spring and summer, and short-term accommodations are sometimes provided by the employer. Some people move into the area not realizing there is a lack of suitable housing. A KI said, "They'll move here and then realize that there's absolutely no housing." They often tell seasonal workers when they access services, "If you go back to a city, you're way, way more likely to find housing."

The KI Dana described an interesting phenomenon that occurred in her touristy community during the first few years of COVID-19. Due to the strong messaging from the government to get outside and explore Ontario, "this area got that much more popular with tourism….We just experienced like an influx of people…that [we] had never…experienced up here [in this community]." This messaging created an unintended consequence with seasonal workers flooding her community with a sudden need to accommodate this influx of tourists and increasing the demand for housing. Urban dwellers also purchased cottages in these communities that had been previously used for rental properties, and this has impacted their current rental stock.

An Informal Resource. The federal policy decision to create more soup kitchens and food banks in Canada over the past four decades has been one approach to address food security. Provincially, The Ministry of Housing and provincial Service Managers develop and administer housing and homelessness related policies and services in collaboration with local agencies. Although the federal and provincial governments' long-term goal is to end homelessness, the availability and accessibility of these resources vary considerably in rural communities. Due to policy decisions at local agencies about access and eligibility of service, some people with severe

MHACH often find themselves banned from emergency shelters and soup kitchens due to their behaviours. In rural communities, options to find alternate shelter or food is nonexistent. Informal resources become critical to one's survival. One PWLE participant disclosed that they (themselves) offer these resources for people with MHACH, saying, "I open the door and let him in….Like how dare you turn somebody away!" Without the PWLE's support, some of these individuals would go without food, shelter, showers or even a sense of community.

Inheriting a Property When You Have Significant MHACH. A number of adult children with mental health and addiction challenges live with their parents without ever moving out on their own, as their mental health concerns have never been diagnosed or treated. The KI Dana shared that in a rural community it is easier to hide, since people are reluctant to ask for help. When their parents die, they often inherit large properties that they are not able to maintain, which makes them "vulnerable to property takeovers." Dana provided an example where an individual was manipulated and allowed someone to move in as their roommate. The roommate used drugs to control this individual, and used the property to make and sell drugs. This individual was forced out of the home and ended up having to live out of their car. What makes this situation unique was the community response. The police did not get involved. Instead, the local community stepped in to help evict the roommate. This geographically localized community consisted of neighbours and families who advocated for the safety of the vulnerable individual and the neighbourhood.

Transitioning in a Rural Community. Dana shared the struggles of a "complex" individual who identifies as transgender and is currently experiencing homelessness. She cited concerns related to their safety while transitioning in a rural community, which made them more vulnerable. She described the individual as "all over the place, like geographically and mentally" and currently lives out of their van. Unfortunately, the individual had to stop their transition due to safety concerns and difficulty in accessing housing services, because their ID didn't match how they identify. This particular rural community was described as inclusive and accepting of the LGBTIQ+ community; however, apparently this did not apply to LGBTIQ+ individuals with a different socio-economic status. Dana revealed that social status within this community determined someone's ability to transition safely and shared that "you could probably live up here as a trans person fairly easily….But I think if you're also homeless…that's gonna make you even more of a target."

Potential benefits for people with MHACH living in rural communities, as well as some barriers were raised. KIs identified many examples of barriers to services access, and potential benefits to knowing one another were identified by the KIs which enhanced KI collaboration. In contrast, knowing one another was described as a barrier by both the PWLE and KIs when accessing mental health and addiction treatment. The stigma associated with accessing services contributed to this barriers. Some unique perspectives that could occur in urban or rural communities were shared; however, the influence of rurality provided great insight into unusual challenges.

Thematic Category 5: The Consequence of Discrimination and Stigma

Examples of PWLE of MHACH being targets for discrimination and stigma on almost a daily basis were woven through all of the narratives. Not only did they face negative stereotypes, but they also dealt with internalized self-stigma. As will be discussed, stigma and discrimination influence the nature of interactions with health and social services providers and the community and ultimately how or whether they access services. Two subcategories will be discussed: Public

& Self Perception; and When Accessing Health and Social Services: Feeling “Less Than Human”.

Public & Self-Perception

The PWLE and KI participants all agree the that PWLE commonly face stereotypical thinking from the general public. In their narratives, they suggest that stereotypical thinking for PWLE of MHACH is so deeply embedded in society, that at times, they themselves, have to consciously fight stereotypical thinking about both PWLE and MHACH more broadly. The descriptions about PWLE and incidents that they shared were candid and reflected common societal stereotypes.

When Sophia discussed her experiences with addiction and mental health, she expressed her disappointment with the health and social service providers and people in the broader community. She felt their judgement was harsh and sometimes unfair and said, “No one judges harder than ourselves…we feel like we’re already the scum of society….People being scared of us, when really, we’re just, we’re just trying not to be broken.” Self-stigma was common with all the PWLE participants. Sophia felt the need to justify other PWLE’s behaviours and the need for community members to understand her own and others’ struggles, saying, “I see people [PWLE] like how I used to be, they are sick…people are just so pushed down the scale that they don’t think that they can get better.” Allie’s experiences were similar and she felt that “normal” people were afraid of her and others. Bearing the brunt of constant negative stereotyping affected both of their sense of belonging in their communities. Allie also shared, “You don’t feel a part of the community, right? Because we’re outcasts now.” These examples of stigma and discrimination that PWLE experienced, fuel the internalization of negative stereotypes which impact their own self-perception and self-stigma.

One KI emphasized the nature of stigma when accessing rural services, remarking that "stigma is that much worse in rural communities because of the interconnectedness of people ….People know people, and people judge people, and that judgment sticks with people a lot longer cause you're, you're not anonymous at all." The KI shared an example of how community stereotypes affect their ability to openly offer responsive harm reduction programs, given organizational decision-makers' fear of public reaction. As this KI noted, "the board was afraid of donor's reactions." Although the services are much-needed in the community centre that are specifically geared to be responsive to PWLE of MHACH's needs, the importance of positive public perception prevails, but with discriminatory consequences. Therefore, the narratives suggest that there is a need to address the underpinnings of both stigma and discrimination related to mental health and addictions challenges in rural communities.

When Accessing Health and Social Services: Feeling "Less Than Human"

Multiple examples of experiencing discrimination and stigma when accessing healthcare encounters were shared. Sophia and Phoenix both discussed their concerns with the lack of compassion they see in healthcare providers. Phoenix said, "We haven't found too many doctors or nurses that are very compassionate." Participants shared that often they were reluctant to access emergency care due to the degrading experiences they previously endured. Allie contemplated, "I'm pretty sure people have probably died from, you know, endocarditis …because they won't go." Sophia's main message throughout her interview was her "humiliating experience" accessing healthcare. She struggled with the contradiction of what she believed caring for someone meant and the care that she actually received. When Sophia finally asked for help from a psychiatrist, the care she received was disgraceful. The psychiatrist discharged her back onto the streets without treatment. The impact of her interaction with the psychiatrist was described multiple times throughout the interview. She shared, "You treat people like this when they're at their absolute bottom….It was the most humiliating experience I think I've gone through in this whole entire 10 plus years of my addiction….It's basically like he didn't look at me as a human."

Phoenix shared similar experiences when accessing healthcare. He said, "Nobody wants to go to Emerg….Unfortunately, the abuse that drug addicts get when they go to the Emerg is, should be against human rights….They treat people as less than human." If someone does access care at the hospital, they often leave before being seen due to the wait time and the discrimination that they receive.

Health and social services all require an intake process and eligibility criteria to access services. The only exception to this rule would be accessing emergency healthcare in an acute healthcare setting. Although certain criteria may be in place for service providers to use as a guideline, the interpretation of these rules sometimes varies. The discretionary nature of these rules can have significant impacts for PWLE. Dalia shared her struggles accessing emergency shelter when she first experienced homelessness. She tried to access housing support through a local community agency and said she was told "part of our policy is that you have to be homeless before we can help you…so once you become homeless, you can call back." She shared that the experience "made me feel small, made me feel helpless." Unfortunately, the service provider misinterpreted the eligibility criteria and caused an unnecessary delay in support.

Sophia discussed the rules she has to abide by in her rehabilitation (rehab) facility and was able to reflect on the purpose of them. She shared that, "she [counsellor] puts these policies in place because she's seen how when you don't follow these policies, it ruins your life. They're there for a reason." Sophia had to sign a contract when she entered rehab. Although she struggles with rules, she knows it is in her best interest to follow them. Sophia admitted "I've always had a problem with authority figures…you tell me to do something, I'm gonna do the complete opposite. I just like pissing people off."

Three specific social services agencies were discussed by most of the participants: Family & Children's Services; Mental Health & Addictions Services; and Ontario Works. Each of these services will be explored further.

Family & Children's Services (FCS). FCS was described by multiple participants as both a barrier and a positive resource, as they may be able to offer resources or funding that other agencies do not have access to. The KI Mona shared that "sometimes our families have good experiences with them because they may have abilities that we don't." However, she did also share that FCS involvement is "inevitable" for families living in emergency shelters, not because of their parenting, "but [given] the situation" they may be in right now.

In the past, one PWLE had a negative experience with FCS when they lost custody of their older children. They still have a fear of FCS, but shared with me how their current worker is able to work with them in a positive and supportive way. They described their worker as "a wonderful lady", who told them "I know your struggle, but all we want is to keep that baby safe and protected."

Mental Health and Addiction Services. Some programming and housing associated with mental health and addiction agencies require participants to be abstinent to enroll. A PWLE described the difficulty abiding by these rules and the consequences when you don't. They shared "it's almost impossible to benefit or follow their rules that they have in place". They described the repercussions if you do relapse, saying, "You get kicked out and there's no leeway there…and they don't give you another chance after you've broken the rules that many times."

Another PWLE tried to access services with one agency while they were actively using substances and were turned away at that time. They were told that they needed to be “sober” before [the agency] helped them with their mental health. They reported that they were told, “Well, you wanna use, goodbye…there’s the door.” These rigid rules contradict the scientific evidence and understanding that addiction is actually a disease and not a choice.

The KIs shared that some larger mental health agencies are generally housed in larger towns or cities and are also funded to offer services in rural communities. However, the KIs described such agency service as sporadic and expressed their frustrations at the lack of services in their communities. One KI expressed, “You are also accountable to this community ‘cause we’re part of your services area.” Another KI echoed these concerns and felt that funding should be going to local agencies that provide services in the small communities. Funding models created at the macro and meso levels create barriers to access for smaller agencies and individuals in rural communities.

Ontario Works (OW). OW is part of a social services agency that is government funded and offers financial assistance, housing and homelessness services and child welfare support. Although the amount of funding was described as subpar by all of the participants, OW was described as a great resource by the PWLE participants. Allie shared that she felt OW has changed recently and has offered resources and programming that assist people with mental health and addictions that better meet their needs. She mentioned that they have workers that are specially trained in mental health and addictions and described them as “more understanding, more compassionate.” She shared that they understand her lifestyle, saying, “If you’re late for an appointment, she [their service provider] can understand why….Sometimes my lifestyle can’t keep up to the 9-5.”

In this thematic category, the consequences of stigma and discrimination were evident in the narratives that were shared by both the KIs and the PWLE participants. Common stereotypes that are shared publicly are fueled by stigma and misunderstanding of PWLE of MHACH. Unfortunately, these negative stereotypes impact the way PWLE see themselves as well as how their communities see them. This stigma and discrimination cross over into health and social services and influences their experience with accessing care and services. As multiple PWLE shared their feelings of being "less than human" over and over again as they interacted with providers, organizations and the larger community, their anger and emotional upheaval was palpable.

Thematic Category 6: What it Takes to Support PWLE: (In)formal Policies/Practices and Resources

In this section, I address the range of (in)formal policies, practices and resources that it takes to support PWLE of MHACH in rural communities. Subcategories include: a) Funding; b) Workload; c) Accountability; d) Data Collection; and e) Participant Recommendations. Several subcategories relate to sustainability of resources to support both PWLE and KIs. Participant voices inform recommendations for action.

Funding

Mental health and addictions programming and treatment has been poorly funded in rural communities and has been described as a barrier by all of the participants. Some municipalities are recognizing the importance of MHACH programming and provide sustainable funding, while others are struggling to assist. One KI's program has been growing over the past two years. That KI shared that their program is a registered charity and relies on donations from "wealthy retired people." Previously they were only funded to be open six months a year, but over the past two years they’ve had funding to stay open the whole year. One KI has concerns about the future of their shelter and its sustainability since most of their funding is private, and they recently found out that the municipality is giving less money for the year. They described their struggles, saying “funding is an all-day, everyday thing for me as well. I have to be putting out results as far as I am concerned that I hope make it worthwhile or viable for people to invest.” Without volunteers and local churches donating funds, many rural programs may not be sustainable.

One KI was passionate when they shared how larger social service agencies in urban centres receive funding over small rural community programs. They said “we have been giving the great [service agency] all the fucking money….They should be pouring half of that into small things like this that are actually feet on the ground, you know in their hometowns.”

Workload

The stress associated with the current workload for both the PWLE and KI participants, as well as the fear and frustration that the work never seems to end was explored. When the KI Liam described what his average work day looked like, he seemed to be doing the work of several people at the expense of his own mental health. Liam described his work as “draining” and disclosed, “I can’t stop. I work and work and I work till I hit a wall…all day I am just like a panther pacing around here.” He described a sense of urgency in the work that he does and went on to share, “I’m going to save the world today. I am going to save the friggen world today.” Mona compared her workload over the past two years to her work when she first started and described the increase as “substantial and alarming.”

When Allie talked about the work she does in the community as an informal resource, she questioned how long she will be able to continue doing it. She also described her work as “draining”, because she gets taken advantage of a lot and there are always people looking for food and shelter that are not able to access formal resources. She shared her fear of not being able to provide food for people when they need it. She said, “What happens if there’s no food here one day…who’s gonna do it?” As a “life saver”, Phoenix is slowly becoming burnt out and shared, “I’m spent. I’m so disgruntled as far as the lifesaving aspect of it goes when it’s so unrewarding….You can only save so many lives…like, fuck man, how many times are we gonna do this?” The high demands, increased workload, and stress navigating the health and social service systems associated with mental health, addictions and homelessness and the lack of health human resources puts the sustainability of formal and informal programming and resources in jeopardy.

Accountability

Accountability and a responsibility for one’s actions was discussed by all of the participants. Phoenix struggles between his sense of responsibility in the community, as well as the need to care for himself. Liam struggles with what he feels his role is in the community and the need to work collaboratively with all community agencies. He feels he is “in a pretty delicate situation” and shared, “I feel like I’m walking half my life on a tight rope you know, kinda in between what authority thinks it is and what people need to actually start doing for themselves.” Liam expects his clients to be accountable and shared “if you are going to waste my time again you don’t need to come back.”

The accountability of government and municipal action for homelessness was also discussed by many of the study participants. Dalia shared that many people are writing letters and advocating for change related to housing concerns in her community. She feels that the advocacy letters are going unnoticed, as no tangible change has occurred. Mona echoed these concerns with her municipality and said, “They are not listening to the little guys….No one is really doing anything about it.”

Data Collection

Point-in-time counts are common in larger communities and create a snapshot of the number of people experiencing homelessness during a given time. When describing homeless enumeration, the KI Dana discussed her frustrations with applying an “urban-informed” practice such as point-in-time counts. Dana indicated that in her community, “people are geographically isolated, and people also don’t want to identify themselves.” She said people are very difficult to locate, which is “fairly typical in a rural community” and often, she may only encounter someone once a month. Dana also shared that some people don’t consider people who are couch surfing (provisionally accommodated) as homeless in their community “because it is so common.” Dana and Liam both felt that point-in-time counts do not capture the “real picture.” Liam shared the struggles he endures when he tries to collect any statistics in his community, remarking, “How am I supposed to find all the homeless people when they always shack up on somebody’s couch they know….They are couch surfing, they are of no fixed address, some don’t even call it homeless.” As described previously, one KI has been able to capture homelessness data in their community in a unique way.

Participant Recommendations

Both the PWLE and KI study participants were eager to share their recommendations to challenge the status quo, create power with decision-making tables, improve access to health and social services for people experiencing MHACH, and combat stigma and discrimination. They give voice in ways that make recommendations at all levels from micro and meso to macro level. All study participants’ voices are represented in these recommendations, and I have paraphrased or shared verbatim quotes to capture their narratives. Some of the recommendations have already been implemented in a few forward-thinking rural communities in varying degrees; however, we have more work to do. The KI participants recognize what it takes to support PWLE and honour them by speaking on their behalf. The following recommendations are not an exhaustive list; instead they represent solutions that these participants felt would improve the everyday lives of PWLE of MHACH living in rural communities. The recommendations have common themes and have been categorized into four sections: housing suggestions; healthcare suggestions; rural considerations; and advocacy.

Housing Suggestions. Most of the participant recommendations focused on housing options (affordable, geared to income, and supportive), increasing funding for rent and housing assistance programs, dealing with landlords, and providing tax incentives for landlords.

All of the participants discussed the need for more affordable housing options, which included increasing the number of geared to income housing and rental properties. Sophia shared that “nothing’s affordable”, and Mona echoed, “Even the working class can’t afford them.” Access to supportive housing varied across the SWLHIN, and the need for more of this type of housing in rural communities is evident. Supportive housing was cited by all of the participants as options to remain housed. Phoenix described supportive housing as an option “for people who are struggling to cope with life on life’s terms” and felt that “we need more places like that where there’s staff on site for when people are needing to talk or deal with their issues.” The need to closely monitor and maintain geared-to-income housing was recognized, as this type of housing was described as “infested with bedbugs…worse than living on the street” by one PWLE participant. Consistent maintenance was recommended which includes creating a policy to “get sprayed consistently twice a year.”

Allie suggested that more funding should be available to people needing support with hydro, gas and rent if they are in arrears. She shared that “you only access once a year or once every two years….There’s just not enough money, right? There’s not enough funding.”

Dalia felt that she needed support from housing workers in “dealing with landlords” and how to talk to them. Other participants described the need for more support when they are facing evictions or dealing with disputes with the Landlord and Tenant Board. The support would bridge the gap between the power imbalance amongst the landlord and tenant. Phoenix and Dana both expressed a need to compensate landlords through “tax incentives” or “special insurance”, so they would be willing to rent to people with a history of mental health and addictions. Dana also considered “providing funding to landlords to create new rental units”, but cautioned that these incentives needed to come from the government and not just rural communities, since sustainable funding would be difficult in small municipalities.

Healthcare Suggestions. The number of recommendations related to healthcare were limited and focused on treatment access, types of treatment, harm reduction strategies such as supervised consumption sites and the need for healthcare providers to be trained in compassion to combat discrimination and stigma that people facing MHACH experience.

Treatment options and access to services differ across the SWLHIN. The need for immediate access to detox treatment centres was stressed by most of the participants, since most centres are located in urban communities. Participants recommended increasing the number of beds provincially, as well as providing detox beds in rural communities. Sublocade was offered as an alternate solution to methadone and suboxone and was described as “easier” for people to access. A few of the participants access this treatment through an outreach program in their community and one PWLE shared “you can get on the path to recovery through sublocade and you only have to go once a month." Phoenix and Allie both felt there was a need in their community for a "safe injection site." Some communities in the SWLHIN are actively exploring these options.

All participants identified the need for healthcare providers to better understand addictions and mental health. They believed that compassion is lacking and further training is required to combat stigma and discrimination. Sophia shared that she knows there are already courses out there for healthcare providers; however, "I feel like it's just bypassed."

Rural Considerations. Several unique recommendations were shared that highlight the diverse and varied access to health and social services in rural communities. Recommendations centred around the significance of PWLE trusting in service providers, as well as the importance of being able to give voice and participate in decision-making in policies and solutions that impact them. The participants identified the need for: more options for women and families, emergency shelters in geographically isolated communities, employment opportunities, local mental health funding, bringing services to clients, more collaboration between service providers and agencies, small agencies with "real" people, and connecting with rural communities to determine their unique needs.

Resources for women in rural communities are also limited**.** A few communities had emergency shelters for women experiencing abuse; however, substance use was identified as a barrier when trying to accessing this service. Emergency shelters for housing are not equipped for families and Dalia shared "we need better options for people with kids." Only a few of the study participants lived in communities that provide a permanent emergency shelter. Most of the participants expressed the need for a permanent shelter or more shelter beds in their communities.

The PWLE participants discussed difficulty finding employment with a criminal record and the importance of finding employment to get their lives back on track. Sophia stated, “It would be so much easier for people who are trying to make their lives better and move forward in their lives to not get flagged.” In my experience, there are some programs now that receive funding from the provincial government to provide second chances for those with criminal records; however, none of the participants were aware of these programs.

Participants recommended funding smaller, local agencies instead of large conglomerates that funnel money and services to these communities. KIs felt this model was not equitable and creates a disadvantage for rural agencies and residents trying to access services.

Dana shared that if individuals are not able to access services due to being banned or because of transportation barriers, “then the service provider has to bring it to them”. She also said “if it is an absolute safety issue…then there has to be a way of delivering it to them in a safe way.”

Dana lives in a geographically isolated area and identified the disconnect between services when people move from urban centres into rural areas. Communication between these services rarely exist, which may create a duplication in services. Dana stated “I do just wish there was a bit more back and forth between some of the services.” Collaboration between services agencies within a community was also identified as a priority. Mona, a KI, mentioned the use of Situation Tables in her community. Situation Tables are now a common resource in counties across the province that allow service providers to come together once a week to discuss at risk individuals, families and neighbourhoods. These service providers develop an intervention (with consent) with wrap around services and improved access to services.

One KI shared that there needed to be more programming and shelters like their model that serves rural communities. They stressed the importance of having front line staff that have a passion for working with people with MHACH.

The importance of including the voice of lived experience when creating solutions for people experiencing MHACH was stressed. Dana said, “If they want to change how programs and services or policies are created for rural communities, they have to actually, you know, connect with those rural communities and the frontline people.” Creating solutions that are not urban-centric was emphasized. Dana shared, “I don’t think people realize just how different issues are in a rural setting from an urban setting….You can’t just apply the same things, because you’re not dealing with the same situation.”

Advocacy. It became apparent after all of the participant interviews, that advocacy was key for implementing change. Many of the barriers that were identified when accessing services require advocacy to combat the discrimination and stigma PWLE endure. All of the participants felt that people are not listening when recommendations are provided by PWLE or frontline staff, or when policies were identified that need to change. The KIs shared their frustration with advocacy in their communities, with one saying, “We have had lots of people write letters to the mayor and the town council…but I feel like those letters go unheard.” One KI expressed that “somebody has to not be full of shit. Somebody has to honestly say what is going on and be prepared for those consequences.” Although communities may ask for public input or input from PWLE, the lack of follow through with their input smacks of tokenism. The lack of meaningful participation and the need for truth and advocacy comes at an expense for all the participants. There was a shared belief that sometimes people in decision-making roles can’t handle the truth, and sometimes front line workers water down the truth or “are not listening.” Sophia, a PWLE shared that, “Everyone always wants to preach mental health and preach this and that, but…I don’t see the government doing anything.” Frustration was palpable in many of the participant interviews, and many questioned their ability and power to be able to advocate for change. One KI described their position as “supportive” only and didn’t see advocacy as their role. They identified those in power (“a manager or director”) as people who are responsible for advocating for change.

Summary

The study findings highlight the complexity and diversity of lived experience for people who are simultaneously facing MHACH, while living in rural Southwestern Ontario, providing an opportunity to give voice to a population that is not often heard. Complex dynamics of power influenced policies, practices and the development of responsive supports at multiple levels. Stigma and discrimination were perceived as PWLE’s greatest barriers to accessing services and resources, as well as the sustainability of resources, programs and services. Despite everyday challenges PWLE shared examples that illustrated their resourcefulness and that they were able to shine in the face of adversity. A range of participant recommendations at multiple levels including advocacy and supporting meaningful PWLE participation were identified as vital to challenge this status quo.

In the discussion chapter, I situate these findings in the literature and the larger social context and identify implications for nursing. I have organized the chapter to highlight dynamics of visibility and invisibility that are embedded in the findings with attention to the following: a) voice and action in the face of adversity, b) access to housing and health and social services, c) discrimination and stigma, and d) policies and practices. Implications for policy and practice will be addressed by examining selected macro (government), meso (organization) and micro (interpersonal) level policies that influence this population.

Chapter 5: Discussion Chapter

This exploratory study focused on the lived experience of people facing MHACH in rural Ontario. This critical ethnography emerged from critical reflection on my 30-year professional nursing practice with this unique population and the enormous challenges that they face every day. Despite all the recent media attention, to my knowledge, not a lot of studies explicitly focus on the complexity of people who are simultaneously facing these three intersecting challenges: mental health, addictions, and homelessness, while living in rural communities. In this study I aimed to understand their diverse lived experiences with a goal of enacting social change, while at the same time, fostering their voice in that process and making visible their strengths in the face of adversity.

I posed four research questions:

1. What are the lived experiences of diverse people facing MHACH living in rural communities?;
2. How do policies, practices and other dynamics enable them to live with dignity and meet their everyday needs?;
3. How do policies, practices and other dynamics create barriers in their everyday lives?; and
4. How might their diverse voices and lived experiences be amplified through policy, and practice processes or other strategies to improve their everyday lives?

In this chapter, I situate the findings in the literature and the current landscape in which they live. Applying a critical ethnographic lens illustrated how complex dynamics of power which were conceptualized as both repressive (power over), and enabling (power to), offered insight into their everyday lives (Belle-Isle et al., 2014; Norman et al., 2015; White, 1995;

Restall & Kaufert, 2011). The visibility and invisibility of people with lived experience of MHACH, especially in a rural context, is an overarching theme that is threaded throughout this chapter. PWLE of MHACH are portrayed almost exclusively in a negative light in everyday media; rarely is there corresponding attention to other perspectives which shed light on their humanity, the complexity of factors that shape their everyday lives or their positive contributions to their communities (National Academies of Sciences, Engineering, and Medicine [NASEM], 2016; Raphael, 2020). This invisibility has enormous impacts for service providers and decision-makers and also on the communities themselves. I have organized this discussion around the following sections: a) voice and action in the face of adversity; b) discrimination and stigma; c) access to housing and health and social services; and d) policies and practices. I will address implications for policy and practice by examining selected macro (government), meso (organizations) and micro (interpersonal) level policies and practices that influence this population, the impacts on them, and the way they respond to them. I then identify implications for nursing practice, research and education.

Invisibility and Visibility

This study shines a light on the complex lives of people experiencing MHACH in a rural context who are contradictorily visible and invisible. Although some of this population may be visible on the streets of small communities or in contentious encampments due to negative media portrayals, given the nature of the challenges they face they may also be invisible. Because people experiencing MHACH may not access services in small communities due to the lack of available services and other barriers, they may be invisible to both service providers and the general public. Such dynamics contribute to the invisible nature of rural homelessness for people who are also facing mental health and addictions challenges. The social exclusion they experience challenges our understanding of their day-to-day struggles and their lived experiences (Davey & Gordon, 2017; Magnus & Advincula, 2021). This sense of exclusion and invisibility is evident in this study when participants described themselves as feeling “less than human.” Invisibility makes it difficult to ascertain the number of individuals experiencing homelessness; evidence that is often needed by researchers, policy-makers and service providers to make a case that there is urgency in addressing rural homelessness (Buck-McFadyen, 2021b; Demaerschalk et al., 2019; Kauppi et al., 2017; Schiff et al., 2022).

Mental health, addictions and homelessness policy-related discourses impact visibility and invisibility resources and the treatment of people experiencing MHACH (Hardill, 2019). The lack of resources in rural communities and the stigma associated with MHACH are influenced by complex dynamics of power and oppression, including dominant neoliberal policy agendas and beliefs informed by the predominant biomedical discourse (Magnus & Advincula, 2021; Morrow & Malcoe, 2017). A few of the study participants were denied mental health services because they lacked a formal mental illness diagnosis or because they were actively using substances. Their pleas for help were often ignored, because of policies and funding models requiring them to be abstinent or sober before psychiatrists or social service agencies would provide any support. On top of this, mental health infrastructure was often invisible or available in haphazard ways in many rural communities, in part because of a limited focus of rural mental health in funding priorities (Magnus & Advincula, 2021). Critical researchers also point to the almost exclusive predominance of neurobiological explanations of mental illness and the value of pharmaceutical treatments that shape mental health policy and practices, as well as the public’s perception of the nature of mental illness (Johansson & Holmes, 2023; Morrow & Malcoe, 2017). Morrow and Malcoe (2017) say that

> the official story of mental health being told by biomedicine increasingly claims that all forms of emotional suffering are ‘disorders’ and that ‘mental illness’ is a major contributor to the total global burden of disability and disease. Biomedicine claims further that is has developed effective methods of screening, diagnosis, and treatment for these disorders and thus calls for psychiatric and especially pharmaceutical mental health ‘services’ including in institutionalized ‘community’ settings. Absent from this official story are perspectives and forms of evidence that start with an analysis of power and consider the social, political, cultural, and economic production of mental health problems and solutions. Absent too are the diverse voices of experience-psychiatric survivors and others who have lived with various forms of social marginalization and emotional suffering (p. 6).

Understanding how economic and sociopolitical factors (economic status, healthcare system) influence this population is imperative.

Neoliberal influences are closely tied to dynamics of visibility and invisibility for people facing MHACH. In the 1970s, neoliberal policies were implemented globally and in Canada. This resulted in a reduction of social service spending by governments, at that time subsequently increasing rates of poverty and inequity of services (Hardill, 2019; Raphael, 2020). Such neoliberal influences continue to this day; privatization and restructuring in healthcare focus on efficiencies, rather than addressing structural roots of health inequities to meet the needs of the most vulnerable (Blanchet-Garneau et al., 2019; Choiniere, 2010). Systemic oppression has been sustained by biomedicalism and neoliberalism, as they both focus on the individual level instead of the historical social and structural levels (Morrow & Malcoe, 2017). During this same time, a so-called “war on drugs” was also declared in the United States and popularized in Canada which contributed to the development of policies which for the most part criminalized people who use substances, along with decisions to close mental health institutions in Ontario (Hardill, 2019; Morrow & Malcoe, 2017). Policies that are shaped by dominant discourses about mental illness further contribute to discourses about people on the margins who are, or assumed to be living with MHACH, as being dangerous and unpredictable, as well as dehumanizing them (Hardill, 2019; Morrow & Malcoe, 2017). These discourses are evident in rural and urban communities where encampments have increased in their visibility, with the public citing safety concerns and public health issues (May & Shelley, 2023; Olson & Pauly, 2023). However, the structural, systemic and individual factors that contribute to their existence fail to be addressed (Babando et al., 2022; May & Shelley, 2023; Olson & Pauly, 2023). Some of the study participants described encampments as the only other option to emergency shelters if you do not feel safe staying there, you are not allowed to stay there, or there are no open beds. This informal resource of encampments provides a sense of community for some people experiencing MHACH.

People who simultaneously have MHACH are diverse with respect to their gender, race, and socioeconomic status, and many also have complex life experiences of marginalization and trauma including historical trauma that profoundly shape their experiences (Liu & Hwang, 2021; Morrow & Malcoe, 2017; Padgett & Henwood, 2012). Approximately 90% of adult people experiencing homelessness have been exposed to at least one traumatic event or experience as a child (Liu & Hwang, 2021). In people experiencing homelessness, depressive disorder, substance use, victimization and suicidality are associated with this exposure to these adverse childhood experiences (Liu & Hwang, 2021). They also contend with oppression, which as McGibbon (2016) explains, occurs when social, cultural and political structures and processes based on the "isms" (e.g., racism, sexism, ableism) and the social DOH influence discrimination. The predominance of negative stereotypes and discrimination linked to oppression and ultimately social exclusion for PWLE of MHACH in rural communities are often reinforced by neoliberal-influenced policies (Hardill, 2019; Magnus & Advincula, 2021; McGinty & Barry, 2020). This in turn renders invisible, alternative ways of understanding who people experiencing MHACH are and what is needed to address the structures that contribute to deeply embedded health inequities that they face (Blanchet-Garneau et al., 2019; Magnus & Advincula, 2021).

However, at the same time, in a Canadian context there have been decades of advocacy on behalf of people with mental health, substance use and homelessness issues which have contributed to progressive policies, programs and services. Those with a harm reduction philosophy focus on reducing health inequities by improving access to health and social services and meeting people "where they're at" (Belle-Isle et al., 2016; Hardill, 2019; Morrow & Malcoe 2017).

As has been well established, public health measures that were implemented in response to COVID-19 have disproportionately affected already vulnerable populations, the time frame during which this study took place (MHCC, 2021; Public Health Agency of Canada, 2020). Physical distancing requirements were implemented in emergency shelters at the beginning of the pandemic which decreased their bed capacity considerably and access to public spaces including public washrooms ceased (May & Shelley, 2023; Oudshoorn et al., 2021). Mandated lockdowns restricted access to primary care, harm reduction services as well as food services (May & Shelley, 2023). Temporary emergency shelters were opened in motels in some communities to accommodate displaced individuals and to provide wrap-around services.

Although temporary solutions were eventually provided, social relationships and support were disrupted for people experiencing MHACH (May & Shelley, 2023; MHCC, 2021).

Voice in the Face of Adversity

People experiencing MHACH, whether they live in urban or rural areas, are often increasingly visible and as described earlier, at the same time, highly stigmatized and marginalized given the nature of their mental health and addictions challenges (Burgess et al., 2021; Magnus & Advincula, 2021; Morrow & Malcoe, 2017; Paquette et al., 2018; Skosireva et al., 2014). Dramatically increasing numbers of Canadian society are facing homelessness, poverty and food insecurity among other everyday challenges, given a housing crisis with affordable housing out of reach for many that advocates would attribute to years of failed housing (Forchuk et al., 2016; Forchuk et al., 2022; Hardill, 2019; Raphael, 2020). As in urban centres, people experiencing MHACH are also increasingly visible on the streets of small towns, but they are also hidden. Rarely does the media share stories about individuals experiencing MHACH that portray them in any way other than a burden on the system (Greer et al., 2019; Norman et al., 2015; Raphael, 2020; Ti et al., 2012). Sadly, it has been common and socially acceptable for people experiencing mental health challenges to be treated as “non-persons”, especially in a rural context (Magnus & Advincula, 2021; Morrow & Malcoe, 2017). Often invisible are the stories that depict them in ways that show how they are caring, compassionate, and resourceful, such as the multiple ways they take action in the face of adversity. In this section, I will share how the findings illuminate complex dynamics of power. I first address meaningful engagement in the context of research and service delivery, that influence the nature of having voice, giving voice, as well recognizing the possibility that some PWLE shine in the face of adversity.

Meaningful Participation (Giving Voice)

Attention to diversity, equity, inclusion and decolonization is becoming more visible and is prominent in a number of health and social service organizations, increasingly represented by consultations with marginalized groups, as service providers recognize the importance of inclusion (Norman & Pauly, 2013; Public Health Agency of Canada, 2020; Ti et al., 2012). However, historically programs and services have often been created by well-intentioned professionals without understanding and responding to the diversity of the people they serve. The paucity of rural mental health research is a contributing factor. In addition, the limited number of studies especially in a rural context which take into account intersectionality and structural factors for diverse groups that may be impacted by gender, Indigenous ancestry, race, socioeconomic status, for instance, exacerbate the barriers to creating responsive services for these diverse groups (Fraser et al., 2019; Magnus & Advincula, 2021; Raphael, 2020; Schwan et al., 2020). Qualitative studies on rural health that centre the voices of PWLE have been valuable in offering insight into the lived experience of people facing MHACH. These can provide evidence for program and services tailored to the complexities of the particular rural context and the diversity of experience and accounting for intersectionality in response to the various needs within that rural context (Buck-McFadyen, 2021a, 2021b; Forchuk et al., 2010; Magnus & Advincula, 2021).

For several decades critical researchers and advocates, as well as communities themselves, have been stressing the importance of engaging diverse marginalized groups who experience health inequities in meaningful ways in the development of solutions that are responsive to their needs (Al-Hamad et al., 2022; McGibbon et al., 2021; Norman & Pauly, 2013; Oudshoorn et al., 2013; Sanon et al., 2016; Smith et al., 2021). This not only humanizes their experiences through the sharing of stories about the adversities they face, but also points to their strengths and how they negotiate the challenges they face (McGinty et al., 2018; Norman et al., 2015; Norman & Pauly, 2013). The importance of meaningful engagement cannot be overstated. Arnstein (1969) lays out the various ways that those in authoritative positions such as decision-makers and policy-makers actually share power or not when they claim to be fostering "citizen participation" in society. In order to give voice to this population and foster meaningful and respectful involvement and participation of PWLE in decision-making processes, power imbalances at these tables need to be addressed (Arnstein, 1969; Norman & Pauly, 2013).

In a context of advocacy for people experiencing housing, mental health and addictions challenges, critical researchers call for increased visibility and meaningful participation of groups that are marginalized by race, gender (and other social difference), substance use, and mental health challenges (Norman et al., 2015; Norman & Pauly, 2013; McGinty et al., 2018; Silva et al., 2013; Smith et al., 2021). My findings indicate that individuals with these three intersecting challenges (mental health, addictions challenges and rural homelessness) have not been heard in a way that points to or addresses their particular needs. All of the study participants stressed the importance of listening and felt that PWLE "did not have a voice in the same equal way" as "normal people." This was evident in one small community where an emergency shelter was built in a downtown location without input from people that access these services. Currently, this community is struggling with complaints from local residents and business owners, resulting in negative attention on social media.

Alternatively, Canadian harm reduction agencies and homelessness researchers in the past decade have embraced and excel at engaging PWLE to give voice in policy and program development and have developed multiple best practice guidelines and recommendations to help guide this practice (Belle-Isle et al., 2016; Greer et al., 2017; Lived Experience Advisory Council, 2016). These guidelines were developed by Canadian nursing and health equity researchers. Suggestions to foster meaningful and active participation of PWLE at decision-making tables include: equitable representativeness and shared power at the table, clear expectations of peers and staff, fair compensation, adequate and appropriate training in peer engagement best practices (e.g., harm reduction principles, and cultural safety and trauma-informed care principles) (Belle-Isle et al., 2016; Greer et al., 2017). Some communities in Canada are beginning to understand the benefits of engaging PWLE in mental health, addictions and housing initiatives and invite them to a range of activities that influence the development of policies and processes, for instance to advisory groups in outreach initiatives. However, there remains some difficulty in adopting best practice guidelines for engaging PWLE. Deeply entrenched discourses in relation to poverty, mental health, substance use and homelessness are often considered an individual moral shortcoming or a choice without taking into consideration the relevance of the historical context of trauma, racism, violence and structural power and inequity underpinning these assumptions (Blanchet-Garneau et al., 2019; Hardill, 2019; Moore, 2016; Oudshoorn et al. 2013). These negative stereotypes disillusion decision-makers and sometimes PWLE themselves about believing that they do not have the ability to provide insight or awareness (to have or give voice) about their everyday challenges and needs, while some feel they know what is best for the PWLE, without consulting them (Norman & Pauly, 2013; Norman et al., 2015; Silva et al., 2013). Well-meaning policies and practices that are implemented may further disadvantage these already marginalized populations (Borras et al., 2023; Silva et al., 2013). This was evident in this study with the implementation of COVID-19 policies that were required to control infectious disease, but at the same time created barriers to access food banks, soup kitchens, healthcare, and beds in emergency shelters. The stay-at-home orders and policies that were created increased food insecurity, created precarious living conditions for some participants and increased the risk of COVID-19 exposure (May & Shelley, 2023).

Action in the Face of Adversity

As noted in the findings of this study, people experiencing MHACH are not passive recipients of care; instead they are active citizens, exercising agency even under very difficult circumstances using various survival strategies to live day-to-day. For instance, critical social science and nursing literature points to PWLE use of substances as a way to cope with the lack of mental health supports in their communities, as well as the challenges of everyday discrimination and feelings of marginalization and stigma (Buck-McFadyen, 2021b, 2022; Clair et al., 2016; Forchuk et al., 2010). Others cope through strategies that include "boosting" to survive, which is a colloquial term used to describe stealing. Understanding why some individuals have to "boost" or steal to survive is difficult for some people to grasp, as sociopolitical circumstances have placed individuals in situations where the need to survive overrides "personal choice", a theme that resonates strongly with Magnus and Advincula's (2021) research. A few of my study participants shared that the crime rate is very high in their communities attributing this to "opiate addiction….[where people] will do things that they never have done before" in order to survive.

Some PWLE bend the truth to keep their children in their custody, others provide false information to landlords to obtain housing, or to access services. Social interaction theorists offer that some individuals engage in behaviours to present themselves in a way that avoids discomfort to themselves and others; they may withhold information or might lie to cast themselves in a more positive light (Snyder et al., 2022). In a critical ethnographic study, Oudshoorn et al. (2013)

reported that people experiencing homelessness feel forced to bend the truth at times when policies are seen as a barrier to accessing basic needs.

Often invisible in the everyday lives of PWLE of MHACH is attention to their engagement with spirituality a counterpoint to the negative focus and an unexpected finding that emerged from this study. These study findings extend the very limited literature addressing spirituality and people experiencing MHACH. In one study, Hodge et al. (2013) identified spirituality as crucial in helping mothers exit homelessness, as it helped to deal with stress and it improved mental health. Magnus and Advincula's (2021) study findings in rural American communities highlighted the tensions that PWLE of mental health and addictions faced, even with strong connections to their faith. Given the stigma they encountered in their faith community when they sought social support, they contended with social exclusion related to their mental health conditions. The importance of community which included family and church should not be minimized. These findings make visible how the lives of people living with MHACH in a rural context include ways they engage in community advocacy, protecting others in their community (others who also experience MHACH) by looking out for them, giving Narcan and stepping up to provide informal resources to fill the gaps. Two of the PWLE participants in this study provide food and shelter for members of their community, as well as lifesaving services when people use substances around them. Resources such as soup kitchens, pharmacies and primary care services were often scarce or nonexistent in some rural communities necessitating creative approaches to surviving every day. In my experience as a nurse working with these communities extensively in rural contexts, those banned from essential services such as those mentioned previously, are particularly at risk of incarceration or death; behaviours become the focus for service providers instead of how the structures of society may be impacting them (Raphael, 2020). For example, often the public lays blame on people experiencing MHACH for their circumstances or behaviours instead of questioning how they can survive on inadequate social assistance benefits or lack of health and social resource supports (Raphael, 2020). In my experience, the dire consequences of these policies, such as banning them from essential services is often initially invisible to the service provider. However, ironically those who are banned may become highly visible in the public eye which feeds the negative stereotypes attributed to people facing MHACH.

Violence and safety ultimately impact an individual's ability to survive day-to-day as the findings of this study suggest. The unpredictable risk of violence for people experiencing homelessness is high and is estimated that approximately 27-52% of those experiencing homelessness have been sexually or physically assaulted in the past year (Fazel et al., 2014; Kerman et al., 2023a). In relation to child and family homelessness, risk is reportedly higher for women, youth, and 2SLGBTQ+ people (Kerman et al., 2023a), and mental illness and substance use increases this risk considerably (Buck-McFadyen, 2022; Ellsworth, 2019; Kerman et al., 2023a). As NASEM (2016) indicate, the risk of victimization is higher for people experiencing mental health and addictions challenges. Although the risk of violence was discussed by the study participants, a personal sense of belonging in their community was high. Similarly, participants in Forchuk et al. (2010) expressed that living in rural communities provided them with a sense of security and belonging. The use of the term belonging has many meanings: connection to your physical environment (home, community) is described as belonging, while social belonging includes connection your social environment and relationships with others (friends, family, neighbourhood) (Raphael, 2020). Interestingly, Raphael's (2020) description of a sense of belonging in community challenges the statement by the study participants, as it is described as having access to resources such as adequate income, health and social services or programming as well as community events. Often, people facing MHACH frequently experience social exclusion because of structural processes that marginalize and exclude them from housing and other supports that would enable them to participate in their communities as social and political equals (Magnus & Advincula, 2021; Norman et al., 2015; Raphael, 2020; Restall & Kaufert, 2011).

The findings of this study suggest some PWLE may protect one another, and this was often seen in the female participants as being protective over younger people experiencing MHACH; while others provided the basic necessities of life to others when they themselves had little to offer. These seemingly random acts of kindness were actually described as commonplace by all of the PWLE participants. The resourcefulness of PWLE of MHACH in the face of adversity resonates with similar findings in other rural homelessness literature (Buck-McFadyen, 2021a; Forchuk et al., 2010; Kauppi et al., 2017; Magnus & Advincula, 2021).

Discrimination and Stigma

The findings suggest that PWLE experience stigma and discrimination as a barrier to care, as well as a barrier to their mental wellbeing. There were four ways that stigma and discrimination are relevant: a) internalized; b) in 1:1 interactions with providers or authoritative figures in health and social services including law enforcement sectors; c) their interactions with the organizations themselves (the environments, policies and practices); and d) in 1:1 interactions with the public. The PWLE study participants had more than one stigmatizing condition that included MHACH, which according to a number of researchers (Buck-McFadyen, 2021a, 2021b; Magnus & Advincula, 2021; Skosireva et al., 2014) can significantly exacerbate their experiences with stigma and discrimination. Additionally, “poor bashing” in relation to living in poverty further stigmatizes this group as they are blamed for their own problems and believed to be lazy, dishonest and immoral (Raphael, 2020). These negative stereotypes and media portrayals influence the way the public perceives people experiencing MHACH, as well as how they perceive themselves. It should be noted that stigma related to MHACH cannot be understood or treated independently from stigma related to other characteristics such as race, gender, sexual orientation, and socioeconomic status; they all impact mental and physical health, as well as dehumanize others (Magnus & Advincula, 2021; Tam, 2019).

Internalized or Self-Stigma

Often degrading terms were used by the PWLE participants in this study to describe themselves including: “drug addict”, “scum”, and “outcasts”, while using the term “normal” to describe others without MHACH. The study participants used the term “normal” to describe me. Other studies focusing on mental health and addictions reported similar findings related the division between us versus them, which further stigmatizes this already marginalized population (Biancarelli et al., 2019; Burgess et al., 2021; Lancaster et al., 2015; Paquette et al., 2018; Skosireva et al., 2014; Tam, 2019). When these negative stereotypes related to mental health challenges and substance use disorder are internalized, self-stigma occurs (NASEM, 2016). This negative self-perception challenges PWLE’s sense of belonging in their communities and their ability to safely access healthcare when needed. These narratives were consistent with other studies, which found that the stigma people with MHACH experience translates into their perception that members of the community don’t care about them, which causes a sense of rejection, shame, feeling useless, unwanted and isolated (Buck- McFadyen, 2021a; MacDonald & Gaulin 2020; Magnus & Advincula, 2021).

Interactions with Providers or Authoritative Figures: Feeling "Less Than Human"

Healthcare. Anticipated discrimination and stigma associated with accessing healthcare as a person who is simultaneously facing MHACH is a barrier to open disclosure to providers, yet this invisibility limits the possibility of receiving appropriate care. However, for PWLE their concerns are often well founded. The findings of this study suggested that interactions with healthcare providers in acute and primary healthcare settings were often described as lacking "compassion" and "humiliating" (Burgess et al., 2021; Kauppi et al., 2017; Magnus & Advincula, 2021; Oudshoorn et al., 2013). In this study, the care that people experiencing MHACH received in hospitals was described as "less than human." Often wait times were prolonged, their care occurred in hallways, and they were accused of drug seeking behaviours; which made them feel as if the healthcare providers did not care for them or they are not worthy of the care that they do receive, findings that are well reported in the literature (Biancarelli et al., 2019; Burgess et al., 2021; Clair et al., 2016; Magnus & Advincula, 2021; Paquette et al., 2018; Skosireva et al., 2014). Skosireva et al. (2014) reported that discrimination may be an important determinant of access to healthcare among marginalized people. Historically, people experiencing mental health challenges have been feared, criminalized, and brutalized; at the same time their behaviours have been restricted and have been subject to coercive practices such as forced medical and psychiatric treatments, with Indigenous people experiencing this more disproportionately (Magnus & Advincula, 2021;Morrow & Malcoe, 2017). Various qualitative studies related to the lived experience of substance use and mental health reported that participants encountered stigma and discrimination when accessing healthcare (Burgess et al., 2021; Lancaster et al., 2015; Magnus & Advincula, 2021;Paquette et al., 2018; Skosireva et al., 2014). It has been reported that healthcare providers may view people who use drugs negatively, mistrust them or fear being deceived; which may delay individuals seeking treatment and/or ultimately impacts the quality of care that is being provided (Biancarelli et al., 2019; Magnus & Advincula, 2021; Skosireva et al., 2014). Not surprisingly, people experiencing MHACH may resort to “secrecy” to conceal their drug use to avoid stigmatizing experiences (Burgess et al., 2021).

Law Enforcement. Canadian drug policies which criminalize the use of psychoactive substances contribute to the narrative that substance use is considered a deviation from social norms and fuel the stigma associated with substance use (Hardill, 2019; Paquette et al., 2018). Drug policies that are created at all levels from federal to municipal influence how they are enacted at the community level and can contribute to a sociopolitical climate that is hostile to harm reduction programs such as supervised consumption sites (SCS) (Hardill, 2019). Although overdose prevention sites were recognized by the federal government as filling an urgent public health need in 2017, stigmatizing attitudes about substance use and harm reduction within communities have delayed the uptake of this much-needed service (Taha et al., 2019). Political tensions still exist in some communities despite the growing evidence base that SCS are effective in preventing overdose deaths, and mitigate serious health risks associated with injection drug use (Kerman et al., 2020). Local public health agencies continue to explore the need and feasibility of SCS and treatment facilities in their communities despite these challenges (Broadley, 2018; Kerman et al., 2020).

Visible surveillance of SCS sites, as well as soup kitchens and emergency shelters by police officers, suggests to the public that criminal activity occurs here as well, fueling the safety community fears for people who are underhoused and poor (Greer et al., 2022a; Kerman et al., 2023b; Owadally & Grundy, 2023). For PWLE who are accessing these services for non-judgemental support, the presence of law enforcement creates barriers to access and criminalizes them by virtue of their presence (Carroll et al., 2023; Greer et al., 2022a; Owadally & Grundy, 2023; Strike & Watson, 2017). A few participants described the false sense of security that police provide when they visit people experiencing MHACH in such health and social service agencies. These impromptu drop ins and “get to know your officer” was reported to contribute to mistrust and negative interactions with police. Some believed that the police often seek out information about criminal activities from other PWLE of MHACH and use it to their advantage which positions individuals against one another. Some studies show that an increased presence of police in the community causes feelings of alienation, marginalization and mistrust of the police (Carroll et al., 2023; Kerman et al., 2023b, Greer et al., 2022a; Magnus & Advincula, 2021). Some researchers also argue that police should not be involved in addressing homelessness at all (Carroll et al., 2023) and believe partnerships between service agencies and police are often punitive, which reinforces the belief that unsheltered people avoid service agencies because they don’t want help, are beyond help or choose to be homeless (Carroll et al., 2023; James-Townes, 2020; Magnus & Advincula, 2021). Greer et al. (2022a, 2022b) suggest that community-based policing and practices described previously may contribute to disproportionate targeting and contact between police and marginalized populations. The well documented over surveillance by police of Indigenous and racialized populations, for instance, exacerbates the barriers to service access for diverse groups of people facing MHACH (Carroll et al., 2023; Greer et al., 2022a, 2022b).

On the other hand, some social work studies highlight the importance of police involvement as trusted members of the health and social services team when planning interventions for at-risk individuals, a dynamic that was identified by two KIs in this study

(Lamin et al., 2016). The study participants as well as other researchers identified trust in the abilities of the healthcare professional, since lack of trust increased their sense of powerlessness (Ellis et al., 2020; Forchuk et al., 2010). However, Olivet et al. (2010) and Purkey and MacKenzie (2019), for instance, stress that fostering trust in health and social service providers, including police is also crucial to high quality care for PWLE, yet the possibility of trusting the police is complex given the above experiences.

Interactions with Organizations. When accessing organizations, trust is described as vital to the health and wellbeing of individuals, as it allows for a shared decision-making process regarding care, which improves health outcomes (Ellis et al., 2020). In this study, trust and the lack of trust in police and health and social service providers was discussed by all of the participants. However, whether PWLE are trying to access services on their own or with others who are known in rural communities to be experiencing homelessness or using substances, they experience stigma which is a barrier to accessing housing and other supports (Buck-McFadyen 2021a, 2021b; Forchuk et al., 2010). Buck-McFadyen (2021a) and Magnus and Advincula (2021) explain that the lack of privacy in a rural communities is very challenging because people including health and social care providers often know who the MHACH are and who they associate with, which can lead to negative stereotyping; it may be difficult for PWLE to overcome reputations acquired by others who are facing MHACH. Health and social service organizations need to simultaneously consider individual and structural influences that impact the populations they serve in order to create and maintain services that will improve the quality of interactions with marginalized populations within these sectors (Duncan et al., 2000; Magnus & Advincula, 2021).

Interactions with the Public. Public perceptions of people experiencing MHACH are influenced by their beliefs about mental health challenges and substance use disorders, as well as their experience or contact with people experiencing these intersecting challenges including media portrayals (NASEM, 2016). Public perceptions are swayed by mental health and addictions and homelessness discourses that blame these conditions on personal choice and not underlying historical, social and political influences (Borras et al., 2023; NASEM, 2016; Paquette et al., 2018; Raphael, 2020). If members of the public lack empathy and/or do not feel connected to people facing MHACH, they rarely see their challenges as problematic and therefore, are less likely to seek out or support social change (Clair et al., 2016; Magnus & Advincula, 2021). Study participants shared their perception of how they feel their communities see them, describing themselves as “outcasts”. They were aware of the fear the public portrays when they encounter people experiencing homelessness in their communities. One PWLE reported people cross the streets when they see us or “people hide their kids from us.”

Access to Housing and Health and Social Services

The federal government sets standards in the Canadian Health Act for provincial and territorial governments to manage, organize and deliver healthcare to their residents. To receive funding, provincial health insurance plans must meet the standards of: public administration, comprehensiveness, universality, portability and accessibility (Government of Canada, 2023). Although these standards are in place, the way each province manages and delivers healthcare to their residents varies. Until recently, rural homelessness in Canada was often overlooked by federal and provincial levels of government, instead focusing on urban homelessness which was more visible (MacDonald & Gaulin, 2020; Waegemakers Schiff et al., 2015). Most often, research and health and social policies and practices developed at the federal and provincial level are delivered in urban areas, leaving rural communities at a disadvantage (Buck-McFadyen, 2022; Schiff et al., 2015; Waegemakers Schiff et al., 2015). Provincial governments tend to focus on and invest more resources in larger cities without focusing on the large rural populations that live nearby (Cattaneo et al., 2021). The rapid growth of poverty and social problems in rural communities, due to a decrease in government health spending in the 1990s (Wilson & Rosenberg, 2004), has shed light on the previously hidden struggles of rural homelessness. Healthcare reform in Canada resulted in structural changes to increase the effectiveness and efficiency of the healthcare system by shifting from hospital-based care to community-based care (Hardill, 2019), while at the same time community-based and peer-run mental health supports have dwindled (Marrow & Malcoe, 2017). Unintended consequences ensued–service planning and delivery were given to regional health boards without sufficient financial resources or health human resources to support actions on the DOH to address health inequities for these groups (Hardill, 2019).

Multiple challenges were identified in this study by PWLE participants in relation to accessing health and social services in rural communities. They raised concerns about the lack of formal resources, availability of resources (knowing where to find help), lack of collaboration between existing services, the fear of identifying to access services, lack of trusting relationships with healthcare providers, long waitlists, banning from services, and transportation issues related to geographical isolation. Many researchers and scholars have identified similar challenges related to rural homelessness and poverty and accessing healthcare (Addorisio et al., 2021; Buck-McFadyen, 2022; Forchuk et al., 2010; Kauppi et al., 2017; Magnus & Advincula, 2021; McGibbon, 2016).

The rural communities represented in this study vary in population density, community demographics, proximity to urban settings, and availability of services. Individuals who live closer to larger cities may have better access to services; however, they still may encounter challenges to access related to travel time and the range of available services (Cattaneo et al., 2021). In order to survive, many people experiencing MHACH in rural communities rely on informal resources such as food and shelter that churches, volunteers or other PWLE offer (Buck-McFadyen, 2015; MacDonald & Gaulin, 2020). However, by accessing informal resources instead of formal services, MHACH can run the risk of becoming further invisible or marginalized as the formal services will not know they exist or understand their needs. (Buck-McFadyen, 2021b; Kauppi et al., 2017).

Food & Shelter

The scarcity of rental stock, subsidized housing and other housing options in rural communities is widespread, due to the lack of investment of affordable housing by the government and the shortage of incentives for developers to build them (Buck-McFadyen, 2021a; Piat et al., 2015; Waegemakers Schiff et al., 2015). People experiencing MHACH manage their homelessness using a variety of strategies including: accessing emergency shelters if available, couch surfing or staying with friends, sleeping in vehicles, sheds or abandoned buildings (provisionally accommodated) where basic amenities are lacking (Kauppi et al., 2017; Schiff et al., 2022).

Treatment for Mental Health and Addictions Challenges

The scarcity of treatment options for opioid use disorder (OUD) in rural communities and having to leave their community to access these services is common (Browne, 2010; Buck-McFadyen et al., 2021; Forchuk et al., 2010; Kauppi et al., 2017; Magnus & Advincula, 2021; Waegemakers Schiff et al., 2015). There are limited number of practitioners to prescribe, as well as a lack of pharmacies to dispense the medications (Browne, 2010; Kauppi et al., 2017; Magnus & Advincula, 2021; Snell-Rood et al., 2021). The success of OUD treatment hinges on the assessment and treatment of underlying mental health concerns; however, significant system level barriers undermine this integrated approach (Snell-Rood et al., 2021). Most efforts to expand opioid treatment in rural communities have focused on access to medication without integrating mental healthcare, such as counselling options and opportunities to attend programs while using substances (Snell-Rood et al., 2021). This absence of integration related to disparities in rural health infrastructure has an impact because people with MHACH may receive less mental health treatment and may cease seeking care because of negative experiences (Forchuk et al., 2010; Magnus & Advincula, 2021; Snell-Rood et al., 2021).Two PWLE participants were unable to access mental health services while “actively using”, while the other two had difficulty accessing mental health services while they received treatment for OUD. While others didn’t know where to find help or struggled with services that were offered only during 9-5 business hours, another barrier identified was the fear of losing custody of a child if individuals are connected with Family & Children’s Services. (Browne, 2010).

Waitlists for Services

In rural communities, mental health and addiction services are often provided by larger agencies that are housed in urban centres. Outreach services usually are offered a few times a week by one or two outreach workers and the demand for these services far exceeds their availability. The lack of resources available in rural communities and the increase in the number of referrals to an already overloaded system, results in people being put on waitlists. Wait times for services are sometimes described as several months to years. Buck-McFadyen (2022) and Forchuk et al. (2010) describe similar concerns and mentioned waitlists are sometimes 5-6 years and people become ‘hopeless’ and ‘stuck’ and ‘cycle in and out of services’. Similar to my study findings, Snell-Rood et al. (2021) and Magnus and Advincula (2021) argue that waitlists shut people out at the critical moment when they are ready to seek care, resulting in people using drugs in the absence of other resources and creating mistrust in healthcare providers. Krendl and Lorenzo-Luaces (2022), explored the initiation and completion of mental health treatment and found in their study that the longer the waitlist, the less likely the individual will wait for services. Williams (2020) and Forchuk et al. (2010) discussed the risks associated with long waits for housing supports and shared without support, individuals felt their only choice was to return to unhealthy or unsafe environments. Opting to access private treatment and rehabilitation services are also unattainable for people who are already struggling to meet their basic needs day to-day. The rural mental health infrastructure has been described as fragmented and haphazard by Magnus and Advincula (2021) with enormous consequences for the most vulnerable who are contending with MHACH.

Collaboration and Knowing one Another

In this study, rural practitioners shared examples of how they work collaboratively to offer support to people experiencing MHACH and sometimes felt they were at an advantage compared to urban centres. Practitioners in small communities often know one another and are able to collaborate and sometimes expedite wrap around services in the event of an emergency or crisis. However, some communities believe that people facing MHACH were at a greater advantage if they could access services in an urban community because of the multiple options available (Buck-McFadyen, 2022; Forchuk et al., 2010). The KIs’ positive outlook on rurality and working with other agencies could have been potentially influenced by trust and knowing one another professionally, which makes it easier to collaborate and work/think outside the box. I have experienced this professionally and do see the importance of knowing one another when collaborating in my community. Likewise, Forchuk et al. (2010) found that rural communities or agencies came up with creative solutions to address the lack of formal resources.

Policies and Practices

Solutions to end homelessness are most often geared to the most visible and don't capture those living on the margins or the invisible (Buck-McFadyen, 2021a; Magnus & Advincula, 2021). McGinty et al. (2018) reports that when the public holds stigmatizing views of people experiencing MHACH, they are less likely to support policies designed to benefit this population. However, reducing stigma does not necessarily mean that the government will increase support for housing and mental health and addictions policies. Neoliberal beliefs and power dynamics are still prominent at policy decision-making tables and people still believe that the focus of addiction and mental health is on the individual themselves and not associated with sociopolitical structures (McGinty et al., 2018; Morrow & Malcoe, 2017). These neoliberal political and economic beliefs and factors continue to produce health inequities that effects marginalized populations at a local level (Blanchet-Garneau et al., 2019).

There are many factors which affect the nature of policies and practices that govern how health and social service organizations address health inequities. It is important to make visible the competing discourses that influence and challenge current practices at the macro, meso and micro levels and take action to address structural inequities such as racism and colonialism (Banks, 2014; Blanchet-Garneau et al., 2019; Carroll et al., 2023; NASEM, 2017). To understand the impacts of policy decisions on PWLE of MHACH in rural Ontario, specific policy examples will be shared. Policies and practices cross macro meso and micro levels, as decisions made at the macro and meso level ultimately impact those at the micro level.

Macro Level Policies and Practices

The housing crisis in Ontario and across Canada can be tied to government underspending resulting from a global recession and underlying neoliberal ideologies (Borras et al., 2023; Wilson & Rosenberg, 2004). Deinstitutionalization in the 1960s and 70s, and disinvestment in social housing in the 1980s, with the responsibility being moving from federal to provincial and finally to local municipalities has resulted in catastrophic implications for people experiencing MHACH (Borras et al., 2023; Johansson & Holmes, 2023; MacLeod et al., 2016).

In the 1960s and 1970s, deinstitutionalization resulted in many people with serious mental health challenges being discharged from Ontario psychiatric hospitals into ill-equipped communities (Addictions & Mental Health Ontario [AMHO], 2017; Johansson & Holmes, 2023). Although these communities offered a myriad of housing options for these misplaced individuals including custodial housing (group homes), they were and continue to be operated by for profit private landlords (Canadian Support and Research Institute, 2012). Custodial housing offers support with activities of daily living for their residents, but not with registered healthcare professionals with mental health expertise (Canadian Mental Health Association, 2023). In the 1990s, as homelessness increased, Housing First emerged as an important policy approach to address the chronically homelessness through permanent housing with comprehensive supportive services attached (Baker & Evans, 2016). In 2008, Housing First was successfully implemented across Canada, which provided a place to live, as well as recovery-oriented services and supports to meet the needs of each individual (Evans et al., 2016; MacLeod et al., 2016). Adaptations of Housing First have been implemented at the meso level with varying success, as rural communities struggle with providing the essential wrap-around services that make this program so successful (Baker & Evans, 2016). Some mental health advocates argue that this program focuses more on a biomedical or illness model without also prioritizing actions to address related inequities such as employment (Morrow & Malcoe, 2017). Although some critics believe a Housing First approach aligns with neoliberal understandings that homelessness is a result of personal choices and focuses on rental housing from the private sector (Evans et al., 2016; MacLeod et al., 2016); some supportive housing models in the SWLHIN are thriving. All of the participants in this study identified supportive housing as a solution to ending homelessness in their rural communities.

The lack of investment in social housing across Canada continues to have a direct impact on homelessness. When the responsibilities for social housing were downloaded from federal to municipal governments in the 1970s and 80s, municipalities struggled (and continue to) with funding to fill this policy void (McNaughton et al., 2013). Municipal service managers are responsible for establishing policies through the development of a local housing and homelessness plan that promotes affordable housing development, contributes to and coordinates funding, manages social housing and develops and administers housing and homelessness programs (Turner, 2016). At the local level, this shift of responsibility and lack of funding resulted in no social housing being built between 1995 and 2001 with the exception of community-based non-profit housing with some financial support from local municipalities (City of St. Thomas, 2018). Presently, individuals at the local level are being placed on waitlists for social housing that exceed sometimes 5-7 years, with no other options for housing.

Meso Level Policies and Practices

At the meso (organization) level, health and social services require a referral form or intake processes to determine eligibility to access programs and resources. This requires an individual to be visible and identify with an agency, which in a rural community can put an individual at an increased risk for stigma and discrimination (Waegemakers Schiff et al. 2015). Although certain criteria are needed to be in place for service providers to use as a guideline, it was reported that the interpretation of the criteria sometimes varied. Different interpretations related to mental health diagnosis and living situations were evident, for example people who were couch surfing were often overlooked and not considered as experiencing homelessness and therefore, did not receive housing support. Having to identify to access services was also identified as a barrier, as often everybody knows everybody and being labelled as a drug user resulted in significant barriers. Identifying includes sharing a mental health diagnosis, current living arrangements and personal demographics or contact information. The need to identify to access services was described as “rurally it’s a killer”. Buck-McFadyen (2021a) and Forchuk et al. (2010) similarly found having to identify to access services as a barrier. Understanding what homelessness is or how it is defined varied between the participants, resulting in a denial of homelessness in rural communities, as some people do not see provisionally accommodated or couch surfing as experiencing homelessness (Kauppi et al., 2017).

The Need for a Diagnosis. Access to publicly funded mental health services is usually dependent on diagnostic criteria which create barriers for individuals requiring preventative care or do not yet have a formal mental health diagnosis (Morrow & Malcoe, 2017). The need to have a formal mental health diagnosis to access some health and social services was discussed by participants in this study. The failure to provide services to an individual because they did not have a formal diagnosis resulted in additional barriers for some participants. All health and social services require an intake process of some sort and require a disclosure of financial or health status. Often people are reluctant to access these services because of the fear and stigma associated with sharing this information (Forchuk et al., 2010; Magnus & Advincula, 2021; Voronka et al., 2014).

Homeless Encampments. Homeless encampments have increased considerably across Ontario since the pandemic, increasing the visibility of homelessness across urban and rural communities (May & Shelley, 2023; Olson & Pauly, 2023). To prevent the spread of COVID-19, social distancing rules were created by the Ministry of Health and Long-Term Care (2020) (macro) and were enforced by public health agencies and law enforcement at the regional (meso) level. Emergency shelters were mandated to decrease the number of available beds to support the social distancing policies, which forced some people into the streets. Local municipalities received emergency funding from the provincial government to rent motels rooms for people displaced from shelters and those needing to isolate from others if they had COVID-19 or were exposed to the virus. Although the emergency funding was welcomed by municipalities the implementation of programming of services/resources was fragmented and inconsistent across Canada (Babando et al., 2022; May & Shelley, 2023; Oudshoorn et al., 2021). The sustainability of using motel rooms as emergency shelters is grim as emergency pandemic funding is drying up.

It is important to note that homeless encampments existed prior to COVID-19 and are commonly used by people who choose not to access emergency shelters due to safety concerns and strict substance use rules that are enforced at some shelters. Many communities are struggling with the visibility of encampments in their communities and are using a law enforcement-led response instead of a housing-led response to homelessness (Mitchell & LeBel, 2023). Recently, in the SWLHIN an encampment was dismantled by the police after a reported violent assault occurred onsite (Butler, 2023). Although the police and city officials reported that mental health and housing supports workers were present to assist the displaced individuals, outreach workers and some PWLE reported that this did not occur (Butler, 2023; personal conversation May 11, 2023). The rapid response and poor communication by the city and police left individuals displaced, angry, and feeling violated (personal conversation, May 11, 2023).

Micro Level Policies and Practices

The interpretation and enforcement of policies and practices by individuals at the local level is discretionary and can be based on beliefs, values and morals. What may be enforced by one person, may not be by another. The ability to abide by rules was mentioned by all of the study participants. The PWLE of MHACH participants' insight into the need for rules was evident; however, they questioned theirs (and others') ability to follow them based on their mental health and addictions challenges. Unfortunately, the inability to follow rules or conform to communities or organizational polices, rules or expectations created to enhance safety can result in individuals being banned from community agencies and essential services. Banning individuals from stores, primary care, soup kitchens, banks, restaurants, pharmacies and shelters often occur. Although safety reasons are often cited as the reason for banning some individuals experiencing MHACH from essential services, the lack of alternative options in rural communities severely disadvantages this already marginalized group (Cattaneo et al., 2021; Kauppi et al., 2017; Kerman et al., 2023b; Snell-Rood et al., 2021;Wein, 2013; Woodward & Richmond, 2019). The effects are more profound in a rural community because there is nowhere else to go, whereas in an urban centre, there are more choices for services (Cattaneo et al., 2021; MacDonald & Gaulin, 2020; Snell-Rood et al., 2021). Meso and micro level policies and practices determine whether or not an individual is banned from a service or agency due to behaviours or the inability to follow the rules. This power over people experiencing MHACH gives them the power to marginalize or exclude individuals that are considered difficult, while facilitating access to those they regard as normal and deserving (Hardill, 2019). Anger, disbelief and feelings of injustice and discrimination were common responses when banning was discussed and MacDonald and Gaulin (2020), reported similar findings in their study on the invisibility of rural homelessness in Canada. The injustice of banning people from much-needed services violates the Ontario Human Rights Code (the Code) which is one of the most important pieces of legislation in Ontario. According Ontario Human Rights Commission (n.d.) every person has a right to freedom from discrimination from services, goods and facilities that includes: schools, hospitals, shops, restaurants, sports and recreation organizations and facilities. If an individual is banned from essential services, providers need to consider alternative solutions, so they are able to bring the service to them. Unfortunately, providing alternative service options for people experiencing MHACH does not happen very often and has been identified as a significant access barrier in this study. Most of the literature related to banning from services is dated and relates to abortion, smoking in psychiatric facilities, and zero tolerance for violence in schools (Middleby-Clements & Grenyer, 2007; Paniagua et al., 2009; Skiba, 2014; Woodward & Richmond, 2019), and is beyond the scope of this study. Further research on the experiences of MHACH who are banned from essential services without alternative options is recommended.

Nursing Implications

This study provided insight into the everyday lives of people experiencing MHACH in rural Ontario. Concepts from critical social theory were useful to foster an understanding of and challenge the historical, social, political and economic factors that contextualize PWLE’s lived experiences of policies and practices, and to give voice to this population who are often not heard. As a Registered Nurse, I am ideally situated and morally obligated in my practice to influence policies and practices (Falk-Raphael, 2005), as social justice and human rights issues are encountered every day in nursing (Kagan et al., 2009; Ray & Turkel, 2014). While incorporating the study findings, I will now identify implications for nursing that will help better understand this population, and suggest opportunities where PWLE are able to amplify their diverse voices through policy and practice processes to improve their everyday lives.

As discussed previously, emancipatory knowing is the fifth way of knowing that Chinn and Kraemer introduced to supplement Carper's existing four ways of knowing: empirical, personal, aesthetic, and ethical knowing (Peart & MacKinnon, 2018). This way of knowing helps us to recognize unjust social and political policies and practices that are often invisible or hidden behind dominant cultural biases and mental health, addictions and homelessness discourses (Peart & MacKinnon, 2018). When these five ways of knowing are integrated into social justice and nursing practice, emancipatory praxis becomes possible (Peart & MacKinnon, 2018).

The importance of voice and engaging the voice of lived experience in various ways with decision-making processes at macro, meso, and micro levels is essential to invoke change across all nursing practice settings. Policies and practices that include PWLE of MHACH can foster the alignment of goals that enable them to live with dignity. A number of qualitative studies and best practice guidelines related to engaging people experiencing MHACH in Australia, Denmark, and Canada support the importance of having the voice of lived experience heard in the development of recommendations for homelessness in rural communities, which makes policy more inclusive, equitable and accepted (Buck-McFadyen, 2021b; Hansen et al., 2021; Mullins et al., 2021; Smith-Maddox et al., 2020); without the voices of people impacted by MHACH there is a risk that the development of effective solutions may inadvertently disadvantage those who are already marginalized (Borras et al., 2023; Magnus & Advincula, 2021; Morrow & Malcoe, 2017; Raphael, 2020; Silva et al., 2013).

Macro Level

Give Voice. Professional nursing bodies including the Registered Nurses Association of Ontario (RNAO) and Canadian Nurses Association (CNA) are uniquely positioned to advocate for the engagement of people with lived experience at macro and meso level policy and practice decision-making tables. RNAO's (2023) mission and values state that they advocate for healthy public policy and are committed to diversity, inclusivity, equity, social justice and democracy. CNA (2023) boasts that they are a strong nursing organization that is leading the development of health policy across Canada, while contributing to the development of policy recommendations to governments in priority areas that include mental health and addictions. Their combined visibility and ability to influence change is high; however, it is unclear whether they encourage members to engage people with lived experience at decision-making tables, or if they practice engagement of PWLE when advocating themselves. It is recommended to actually have members with lived experience at these decision-making tables, but if PWLE are not able to directly participate at these decision-making tables, indirect opportunities to have their voice heard should be offered through participatory research or other processes. Role modeling the engagement of people with lived experience in their development and advocacy of healthy public policy will motivate and inspire other nursing leaders to do the same.

Enumeration and Funding. Rural communities often receive mental health and addiction services from large community agencies that are housed in urban communities (Canadian Mental Health Association Thames Valley Addiction and Mental Health Services [CMHA-TVAMHS], 2023). These agencies receive funding to service rural communities;

however, these services are often sporadic and do not meet the needs of the community. The size of the catchment areas, the number of people that require services and the lack of health human resources compound this problem (Moroz et al., 2020). Community Health Centres and public health nurses are uniquely positioned to participate in homelessness enumerations and to advocate for funding at the local organizational level as well as broader macro levels. They sometimes have unique access to individuals who may not access other health and social services through harm reduction and outreach programs as well as through partnerships with communities such as Indigenous communities. Enumerating rural homelessness presents some challenges due to its invisible nature (Kauppi et al., 2017; Schiff et al., 2022). Traditionally, Point In Time (PIT) counts are used, however not all people experiencing homeless access food banks or shelters where these counts are completed; therefore, the significance of rural homelessness in Canada has been underestimated in policy and funding contexts (Forchuk et al., 2022; Schiff et al., 2022).

Funding allocations to rural communities are not on par with urban centres based on their needs. Rural communities that do not receive regular annual funding must apply for the Rural and Remote stream of federal homelessness funding programs (Schiff et al., 2022). According to Schiff et al. (2022) 29% of the Canadian population are rural residents, and in 2019, only 8% of funding was assigned to this stream. Multiple enumeration methods should be used in rural communities depending on the population density and propensity for geographic isolation. These may include period-prevalence approaches over several weeks, point in time counts, and out of the box methods such as one community is doing in the SWLHIN (Schiff et al., 2022). They collect the number of people accessing food programs in a community, because they might not disclose that they are displaced or experiencing homelessness due to denial and the stigma associated with identifying (Kauppi et al., 2017). These diverse counting methods will help policy and practice decision-makers understand the scale and scope of homelessness in rural Ontario, which in turn may improve funding (Schiff et al., 2022).

Meso Level

As identified in the macro level, participation of PWLE at decision-making tables directly or indirectly is essential when making policies and programs that impact marginalized populations. Nurses who are in leadership positions or participate in community advocacy coalitions or professional practice committees in organization like hospitals or primary care settings are in a strong position to advocate for their participation. In their workplaces, these nurse leaders can influence change at the local level. Nurses in acute care, primary care, community care, home care and public health are involved in (and sometimes lead) housing and homelessness committees, drug and alcohol strategies, mental health, poverty reduction and food security tables. I know this because in my 30-year career, I have participated in and led many of these committees or advocacy groups. It is not always easy for some people and requires an understanding of engaging PWLE while creating a safe space that enables committees to shift decision-making power from “power over” PWLE to “power with” them (Belle-Isle et al., 2016). This requires a critical reflection of how PWLE of MHACH are affected by historical social, political and economic conditions in society (Greer et al., 2017). It also requires skilled facilitation of meetings through structured meetings, providing opportunities for quieter committee members to speak, and inviting comments and opinions (Belle-Isle et al., 2016).

However, there seems to be a knowledge gap in some nurses that can be attributed to our current Canadian nursing curriculum. Some nurses are graduating from universities without the understanding of how historical, social and political factors impact people experiencing mental health, addictions challenges and homelessness (as well as other marginalized populations). I admit that I was one of these nurses. This disconnect is a key factor that contributes to nurses' focus on biomedical reasons that may contribute to mental health and addictions instead of the complex underlying factors described earlier. This disconnect further marginalizes people experiencing MHACH. Nursing curriculum needs to tie in upstream factors that may contribute to a person's health, not just one course on the social and structural DOH or health promotion in general. Many nursing researchers and educators recognize the need to include diversity, equity, inclusion and decolonization training in the nursing curriculum. Cultural safety has been proposed as one approach to address stigma and health inequities in healthcare (Blanchet-Garneau et al., 2019; Borras et al., 2023; Kagan et al., 2014; Hardill, 2019; Norman & Pauly, 2013; Varcoe et al., 2014). We have the literature and the guidance of critical nursing researchers, if these courses are supplemented with best practices or ideas on how to advocate for marginalized groups or to challenge the status quo, nurses would be better equipped to manage their day-to-day work challenges (Borras et al., 2023; Kagan et al., 2009; Peart & MacKinnon, 2018).

It is important to note that participation at decision-making tables alone does not erase inequities in power. If PWLE are given the opportunity to give voice but not given decision-making power, this is considered tokenism (Belle-Isle et al 2014; Mullins et al., 2021; Norman & Pauly, 2013; Silva et al., 2013). In order to create a safe and respectful forum for PWLE to participate, it is imperative for nurses understand peer engagement principles by reviewing and implementing validated best practice guidelines (Greer et al., 2017). Several recommendations and best practices exist that have been developed by Canadian researchers in collaboration with

PWLE of mental health, addictions and homelessness (Belle-Isle, 2016; Greer et al., 2017; Lived Experience Advisory Council, 2016).

Health and social services agencies need to critically reflect on how they deliver services as well as how their staff are trained and continue to be trained. Unfortunately, compassion and inclusion seems to be lacking in most of the health and social services that were identified in this study by the participants. A focus of embedded diversity, equity, inclusion and decolonization processes into organizations is a welcomed direction, given the diversity of people facing MHACH (Buchnea et al., 2021; McGibbon et al., 2021; Raphael, 2020; Tam, 2019). Additionally, organizations should undertake a critical examination of how people experiencing MHACH experience waitlists and banning from health and social services. Although attrition rates on waitlists are often reported, the psychological and physical impacts of these policies and practices are underreported (Krendl & Lorenzo-Luaces, 2022; Pascoe et al., 2013).

Micro Level

Homelessness has been identified is a public health issue, and by default it is also a nursing issue (Borras et al., 2023). Nurses in all practice settings encounter people experiencing MHACH every day. As nurses, we need to become more comfortable advocating for systemic changes that impact these marginalized populations. Falk-Rafael (2005) challenges nurses to speak the truth about societal power imbalances and engage in political action such as demonstrations, or petitioning unjust policy plans in order to improve people’s health (Borras et al., 2023). As Belle-Isle et al. (2014), Norman & Pauly (2013) and Buchnea et al. (2021) stress, the importance of meaningful participation of PWLE and the importance of changing power relations to create an inclusive environment is based on mutual respect and trust. This requires critical self-reflection on power and privilege as priority for practitioners and the organization, as well as cultural humility (Belle-Isle et al., 2014).

However, in order to advocate for people experiencing MHACH, our professional nursing bodies and educational institutions need to better equip and support us. The College of Nurses of Ontario (2019) identifies nurses as “leaders who influence and inspire others to achieve optimal health outcomes for all”, including supporting “healthy public policy and principles of social justice” (p. 7). However, CNO only describes social justice as “studying and understanding the root causes and consequences of disparities” (p. 12) and does not indicate in their competency framework what this looks like at the local level. This lack of clarity by CNO creates a barrier for nurses who may want to advocate, but are fearful of breaching their code of conduct. During the pandemic, some nurses refused the COVID-19 vaccine and protested publicly, which garnered worldwide attention across social media platforms (Khubchandani et al., 2022). Many nurses lost their jobs. It is difficult to know whether or not to take individual or collective action, as different perspectives and contexts shape the complexity of a nurses decision to participate (Buck-McFadyen & MacDonnell, 2017). RNAO (2015) does provide a toolkit for nurses to become politically involved; however, having more nursing role models like Cathy Crowe and Kathryn Hardill may encourage more nurses to speak up and challenge current policies and practices that impact people experiencing MHACH.

Conclusion

This research shines a light on the lived experience of adults experiencing three intersecting challenges: mental health, addictions challenges and homelessness, while living in rural communities in Southwestern Ontario. Their experiences with being visible and invisible in their communities were shared through stories and highlight the importance of voice and action in the face of adversity, how they access housing and health and social services, their experiences with stigma and discrimination, as well as how policies and practices impact them. Stigma and discrimination profoundly influenced everyday survival for PWLE and their ability to access services and resources in rural communities with fragmented health and social services. The sustainability of resources, programs and services for PWLE of MHACH in rural communities who are highly dependent on them for their very survival emerged as an important dynamic, but requires action at the structural level to address deeply rooted health inequities. Nurses have the ability to make this population more visible and enhance understanding of their resilience, resourcefulness and the diversity of their lived experience in a way that is strength-based; while supporting actions at the micro, meso and macro level to challenge the social and structural dynamics to improve their everyday lives. Aligned with a focus on enhancing voice, PWLE and KI participants articulated their priorities for multi-level actions, with attention to advocacy and meaningful participation of PWLE in policy and practice decisions that impact the health and wellbeing of PWLE facing MHACH in rural communities.

References

Addictions and Mental Health Ontario. (2017). *Supportive Housing: Recommendations for the provision of support services.* https://amho.ca/amho-news/supportive-housing-psychotherapy-and-youth-services-get-new-investments/

Addorisio, S., Kamel, M., Westenberg, J., Heyd, A., Maragha, T., Abusamak, M., Wild, T-C., Jang, K., & Krausz, R-M. (2021). Unmet service needs and barriers to care of individuals experiencing absolute homelessness in Edmonton, Canada: A cross-sectional survey. *Social Psychiatry and Psychiatric Epidemiology*, *57*(2). https://doi.org/10.1007/s00127-021-02080-2

Alegria, M., NeMoyer, A., Falgas, I., Wang, Y., & Alvarez, K. (2011). Social determinants of mental health: Where we are and where we need to go. *Current Psychiatry Reports*, *20*(11). https://doi.org/10.1007/s11920-018-0969-9.

Al-Hamad, A., Forchuk, C., Oudshoorn, A., & McKinley, G. (2022). The potential of merging intersectionality and critical ethnography for advancing refugee women's health research. *Advances in Nursing Science, 45*(2), 1-12.

Anucha, U., Smylie, L., Mitchell, C., & Omorodion, F. (2007). *Exits and returns: An exploratory longitudinal study of homeless people in Windsor-Essex County*. Canada Mortgage and Housing Corporation.

Arnstein, S. (1969). A ladder of citizen participation. *Journal of American Planning Association, 35(*4), 216-224.

Babando, J., Woodmas, K., & Graham, J. (2022). COVID-19 and the homeless support sector: Perspectives on a small community's early response to a public health crisis. *International Journal on Homelessness, 2*(1), 105-120. https://journals.scholarsportal.info/pdf/2564310x/v02i0001/105_cathss.xml_en

Baker, T. & Evans, J. (2016). 'Housing First' and the changing terrains of homelessness governance. *Geography Compass*, *10*(1), 24-41. https://doi-org.ezproxy.library.yorku.ca/10.1111/gec3.12257

Banks, J. (2014). *"And That's Going to Help Black Women How?": Storytelling and Striving to Stay True to the Task of Liberation in the Academy*. In Kagan, P., Smith, M., & Chinn, P. (Eds.), Philosophies and Practices of Emancipatory Nursing: Social Justice as Praxis, (pp.188-204). Taylor & Francis. https://doi-org.ezproxy.library.yorku.ca/10.4324/9780203069097

Belle-Isle, L., & Benoit, C., Pauly, B. (2014). Addressing health inequities through social inclusion: The role of community organizations. *Action Research, 12*(2), 177-193. https://doi-org.ezproxy.library.yorku.ca/10.1177/1476750314527324

Belle-Isle, L., Pauly, B., Benoit, C., Hall, B., Lacroix, K., LeBlanc, S., Sproule, R., Cater, J., Johnson, M., & Dupuis, G. (2016). *From one ally to another: Practice guidelines to better include people who use drugs at your decision-making tables.* CARBC Bulletin #14. https://onlineacademiccommunity.uvic.ca/carbc/2016/05/25/lynne-belle-isle/

Biancarelli, D., Biello, K., Childs, E., Drainoni, M., Salhaney, P., Edeza, A., Mimiaga, M., Saitz, R., & Bazzi, A. (2019). Strategies used by people who inject drugs to avoid stigma in healthcare settings. *Drug and Alcohol Dependence*, *198,* 80-86. https://doi-org.ezproxy.library.yorku.ca/10.1016/j.drugalcdep.2019.01.037

Blanchet-Garneau, A., Browne, A., & Varcoe, C. (2019). Understanding competing discourses as a basis for promoting equity in primary healthcare. *BMC Health Services Research*, *19*(1), 764-764. https://doi.org/10.1186/s12913-019-4602-3

Borras, A., Komakech, M., & Raphael, D. (2023). Policy-related homelessness discourses in Canada: Implications for nursing research, practice and advocacy. *The Canadian Journal of Critical Nursing Discourse, 5*(1), p. 31-54. https://doi-org.ezproxy.library.yorku.ca/10.1016/j.drugalcdep.2019.01.037

Broadley, L. (2018). *Supervised consumption site: Where candidates stand*. St. Thomas Times Journal. https://www.stthomastimesjournal.com/news/local-news/supervised-consumption-sites-where-candidates-stand

Browne, A. (2010). *Issues affecting access to health services in northern, rural and remote regions of Canada*. UNBC: University of Northern British Columbia. https://www2.unbc.ca/sites/default/files/sections/northern-studies/issuesaffectingaccesstohealthservicesinnorthern.pdf

Brunton, G., Thomas, J., O'Mara-Eves, A., Jamal, F., Oliver, S., & Kavanagh, J. (2017). Narratives of community engagement: A systematic review-derived conceptual framework for public health interventions. *BMC Public Health, 17*(1), 944-944. ISSN: 14712458

Buck-McFadyen, E. (2013). *The experience of food insecurity for rural families: Nursing practice and policy implications*. [Master's thesis, York University]. Electronic Theses and Dissertations. https://yorkspace.library.yorku.ca/xmlui/bitstream/handle/10315/31693/Buck-McFadyen_Ellen_2013_Masters.pdf?sequence=1&isAllowed=y

Buck-McFadyen, E. (2015). Rural food insecurity: When cooking skills, homegrown food, and perseverance aren't enough to feed a family. *Canadian Journal of Public Health, 106*(3), 140-146. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6972053/pdf/41997_2015_Article_10603140.pdf

Buck-McFadyen, E. (2021a). Rural homelessness: how the structural and social context of small-town living influences the experience of homelessness. *Canadian Journal of Public, Health, 113*(3), 407-416. https://doi.org/10.17269/s41997-022-00625-9

Buck-McFadyen, E. (2021b). Competing perspectives on rural homelessness: Findings from a qualitative study in Ontario, Canada. *Health and Social Care in the Community*, *30*(5),1-9. https://onlinelibrary.wiley.com/doi/epdf/10.1111/hsc.13633

Buck-McFadyen, E., & MacDonnell, J. (2017). Contested practice: Political activism in nursing and implications for nursing education. *International Journal of Nursing Education Scholarship*, *14*(1), https://doi.org/74310.1515/ijnes-2016-0026 PMID: 28749781

Buck-McFadyen, E., Lee-Popham, S., & White, A. (2021). Pilot Program integrating outpatient opioid treatment within a rural primary care setting. *Rural and Remote Health, 21*(4), 1-6. https://doi.org/10.22605/RRH6413

Buchnea, A., Legate, J., McKitterick, M-J., & Morton, E. (2021). *The Systems Planning Collective: The state of systems approaches to preventing and ending homelessness in Canada.* The Homeless Hub. https://www.homelesshub.ca/resource/state-systems-approaches-preventing-and-ending-homelessness-canada

Burgess, A., Bauer, E., Gallagher, S., Karstens, B., Lavoie, L., Ahrens, K., & O'Connor, A. (2021). Experiences of stigma among individuals in recovery from opioid use disorder in a rural setting: A qualitative analysis. *Journal of Substance Abuse Treatment, 130,* 108488-108488. https://pubmed.ncbi.nlm.nih.gov/34118715/

Butler, C. (2023). *St. Thomas police dismantle homeless camp, frustrating some outreach workers.* Canadian Broadcasting Company. https://www.cbc.ca/news/canada/london/st-thomas-police-dismantle-homeless-camp-frustrating-some-outreach-workers-1.6911598

Calsyn, R., Klinkenberg, W., Morse, G., Miller, J., & Cruthis, R. (2004). Recruitment, engagement, and retention of people living with HIV and co-occurring mental health and substance use disorders. *AIDS Care, 16*(Supplement 1), S56-S70. https://doi-org.ezproxy.library.yorku.ca/10.1080/09540120412331315286

Canadian Centre for Diversity and Inclusion. (2022). *Diversity Defined*. Canadian Centre for Diversity and Inclusion. https://ccdi.ca/our-story/diversity-defined/

Canadian Mental Health Association (CMHA). (n.d.). *History of Mental Health Reform*. CMHA. https://ontario.cmha.ca/provincial-policy/health-systems-transformation/history-of-mental-health-reform/

Canadian Mental Health Association Ontario. (2017). *Advancing equity in mental health: An action framework.* CMHA. https://ontario.cmha.ca/wp-content/uploads/2016/07/PPE-0001-Advancing-Equity-in-Mental-Health-2.pdf

Canadian Mental Health Association (CMHA). (2023). *History of Mental Health Reform*. CMHA. https://ontario.cmha.ca/provincial-policy/health-systems-transformation/history-of-mental-health-reform/

Canadian Mental Health Association Thames Valley Addiction and Mental Health Services (CMHA-TVAMHS). (2023). *About Us*. CMHA-TVAMHS. https://cmhatv.ca/who-we-are/about-cmha-tvamhs/

Canadian Nurse Association (CNA) (2017). *Code Of Ethics for Registered Nurses*. CNA. https://hl-prod-ca-oc-download.s3-ca-central-1.amazonaws.com/CNA/2f975e7e-4a40-45ca-863c-5ebf0a138d5e/UploadedImages/documents/Code_of_Ethics_2017_Edition_Secure_Interactive.pdf

Canadian Nurses Association (CNA). (2022). *Social Determinants of Health.* CNA. https://www.cna-aiic.ca/en/nursing/nursing-tools-and-resources/social-determinants-of-health

Canadian Nurses Association (CNA). (2023). *Who We Are?* CAN. https://www.cna-aiic.ca/en/about-us/who-we-are

Canadian Support and Research Institute (CSRI). (2012). *From this point forward: Ending custodial housing for people with mental illness in Canada*. Centre for Addiction and Mental Health. https://kmb.camh.ca/eenet/sites/default/files/wp-content/uploads/2014/12/Community-Support-and-Research-Unit-2012-From-This-Point-Forward.pdf

Carroll, M., Flanigan, S., & Gutierrez, N. (2023). Black lives experiencing homelessness matter: A critical conceptual framework for understanding how policing drives system avoidance among vulnerable populations. *Public Integrity, 25*(3), 285-300. https://doi-org.ezproxy.library.yorku.ca/10.1080/10999922.2022.2090779

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. (2014). The Use of Triangulation in Qualitative Research. *Oncology Nursing Forum, 41*(5), 545-547. https://doi-org.10.1188/14.ONF.545-547

Cattaneo, A., Nelson, A., & McMenomy, T. (2021). Global mapping of urban-rural catchment areas reveals unequal access to services. *The Proceedings of the National Academy of Sciences (PNAS), 118*(2). https://doi.org/10.1073/pnas.2011990118

Choiniere, J., MacDonnell, J., & Shamonda, H. (2010). Walking the talk: Insights into dynamics of race and gender for nurses. *Policy, Politics, & Nursing Practice, 11*(4), 317-325. https://doi-org.ezproxy.library.yorku.ca/10.1177/1527154410396222

City of St. Thomas. (2018). *A brief history of social housing*. City of St. Thomas. https://www.stthomas.ca/cms/one.aspx?portalId=12189805&pageId=12513137

Clair, M., Daniel, C., & Lamont, M. (2016). Destigmatization and health: Cultural constructions and the long-term reduction of stigma. *Social Science & Medicine, 165*, 223-232. https://doi-org.ezproxy.library.yorku.ca/10.1016/j.socscimed.2016.03.021

Clarke, H.E. (2010). Health and nursing policy: A matter of politics, power, and professionalism. In M. McIntyre & M. McDonald, *Realities of Canadian Nursing, Professional, Practice and Power Issues* (3rd ed., 68-90). Lippincott Williams & Wilkens.

College of Nurses of Ontario (CNO). (2019). *Entry-to-Practice Competencies for Registered Nurses*. CNO. https://www.cno.org/globalassets/docs/reg/41037-entry-to-practice-competencies-2020.pdf

Cook, K. (2005). Using critical ethnography to explore issues in health promotion. *Qualitative Health Research, 15*(1), 129-138. https://doi-org.ezproxy.library.yorku.ca/10.1177/1049732304267751

Crear-Perry, J., Correa-de-Araujo, R., Johnson, T., McLemore, M., Neilson, E., Wallace, M. (2021). Social and structural determinants of health inequities in maternal health. *Journal of Women's Health, 30*(2), 230-235. https://doi-org.10.1089/jwh.2020.8882.

Creswell, J. & Poth, C. (2018). *Qualitative Inquiry & Research Design: Choosing among five approaches* (4th ed.). Sage Publications Inc.

Cumming, C., Wood. L. & Davies, A. (2021). People experiencing homelessness urgently need to be recognized as a high risk group for COVID-19. *Health Promotion Journal of Australia, 32*(2), 359-360. https://doi-org.ezproxy.library.yorku.ca/10.1002/hpja.355

Cypress, B. (2017). Rigor or Reliability and Validity in Qualitative Research: Perspectives, Strategies, Reconceptualization, and Recommendations. *Dimensions of Critical Care Nursing, 36*(4), 253-263. https://doi-org.10.1097/DCC.0000000000000253

Darrah-Okike, J., Soakai, S., Nakaoka, S., Dunson-Strane, T., & Umemoto, K. (2018). "It was like I lost everything": The harmful impacts of homeless-targeted policies. *Housing Policy Debate, 28*(4), 635-651. https://doi-org.ezproxy.library.yorku.ca/10.1080/10511482.2018.1424723

Davey, S., & Gordon, S. (2017). Definitions of social inclusion and social exclusion: The invisibility of mental illness and the social conditions of participation. *International Journal of Culture and Mental Health, 10*(3), 229-237. https://doi-org.ezproxy.library.yorku.ca/10.1080/17542863.2017.1295091

Deferio, J., Breitinger, S., Khullar, D., Sheth, A., & Pathak, J. (2019). Social determinants of health in mental healthcare and research: A case for greater inclusion. *Journal of the American Medical Informatics Association*, *26*(8-9), 895-899. https://doi-org.ezproxy.library.yorku.ca/10.1093/jamia/ocz049

Dej, E., Sanders, C., & Braimoch, J. (2021). *Rewriting the narrative on homelessness in mid-sized Canadian cities.* The Homeless Hub. https://www.homelesshub.ca/FromNIMBYtoNeighbour

Demaerschalk, E., Hermans, K., Steenssens, K., & Van Regenmortel, T. (2019). *Homelessness merely an urban phenomenon? Exploring hidden homelessness in rural Belgium.* The Homeless Hub. https://www.homelesshub.ca/resource/homelessness-merely-urban-phenomenon-exploring-hidden-homelessness-rural-belgium

Denzin, N. & Lincoln, Y. (2018). *The SAGE Handbook of Qualitative Research* (5th ed.). Sage Publications Inc.

Doberstein, C., & Smith, A. (2019). When political values and perceptions of deservingness collide: Evaluating public support for homelessness investments in Canada. *International Journal of Social Welfare, 28*(3), 282-292. https://doi-org.10.1111/ijsw.12353

Draaisma, M. (2023). *City of Barrie backs down on plan to ban giving food to homeless people on its property.* Canadian Broadcasting Company. https://www.cbc.ca/news/canada/toronto/barrie-homelessness-bylaws-ban-meeting-1.6884615

Duncan, K., Clipsham, J., Krieger, C., MacDonnell, J., Roedding, D., Chow, K., Milne, D. (2000). *Improving the access to and quality of public health services for lesbians and gay men. A position paper for the Ontario Public Health Association (OPHA).* OPHA. https://www.opha.on.ca/OPHA/media/Resources/Position-Papers/2000-01_pp.pdf?ext=.pdf

Ellis, K., Walters, S., Friedman, S., Ouellet, L., Ezell, J., Rosentel, K., & Pho, M. (2020). Breaching trust: A qualitative study of healthcare experiences of people who use drugs in a rural setting. *Frontiers in Sociology, 5,* 593525-593525. https://doi.org/10.3389/fsoc.2020.593925.

Ellsworth, J. (2019). Street crime victimization among homeless adults: A review of the literature. *Victims & Offenders, 14*(1), 96-188. https://doi.org/10.1080/15564886.2018.1547997

Erie St. Clair Annual Report (2018). *A New Beginning.* Erie St. Clair Local Health Integration Network. http://hccss-word-wgsbdmkuco6a.eba-kut4b5as.ca-central-1.elasticbeanstalk.com/document-library/

Etowa, J., & Hyman, I. (2022). Leadership and system transformation: Advancing the role of community health nursing. *The Canadian Journal of Critical Nursing Discourse, 4*(2), 5-16. https://doi.org/10.25071/2291-5796.101

Evans, J., Collins, D., & Anderson, J. (2016). Homelessness, bedspace and the case for Housing First in Canada. *Social Science & Medicine, 168,* 249-256. https://doi-org.ezproxy.library.yorku.ca/10.1016/j.socscimed.2016.06.049

Evans, W., Phillips, D., & Ruffini, K. (2021). Policies to reduce and prevent homelessness: What we know and gaps in the research. *Journal of Policy Analysis and Management, 0*(0), p. 1-50. https://doi.org/10. 1002/pam.22283

Evans-Agnew, R., Sanon, M-A., & Boutain, D. (2014).Critical Research Methodologies and Social Justice Issues: A methodological example using Photovoice. In Kagan, P., Smith, M., & Chinn, P. (Eds.), *Philosophies and Practices of Emancipatory Nursing: Social Justice as Praxis* (pp. 136-149). Taylor & Francis. . https://doi-org.ezproxy.library.yorku.ca/10.4324/9780203069097

Falk-Raphael, A. (2005). Speaking truth to power: Nursing's legacy and moral imperative. *Advances in Nursing Science, 28*(3), 212-223.

Fawcett, J. (2019). Thoughts about social justice. *Nursing Science Quarterly, 32*(3), 250-253. https://doi-org.ezproxy.library.yorku.ca/10.1177/0894318419845385

Fazel, S., Geddes, J.R., & Kushel, M. (2014). The health of homeless people in high-income countries: Descriptive epidemiology, health consequences, and clinical and policy recommendations. *Lancet 384*, 1529-1540. https://doi.org/10.1016/s0140-6736(14)61132-6

Fischer, B., Rehm, J., & Tyndall, M. (2016). Effective Canadian policy to reduce harms from prescription opioids: Learning from past failures. *Canadian Medical Association Journal, 188*(17-18), 1240-1244. https://doi.org 10.1503/cmaj.160356

Fleury, M-J., Grenier, G., & Vallee, C. (2014). Evaluation of the implementation of the Montreal at home/chez soi project. BMC *Health Services Research, 14*(1), 557-557. https://doi.org/10.1186/s12913-014-0557-6

Forchuk, C., Montgomery, P., Berman, H., Ward-Griffin, C., Csiernik, R., Gorlick, C., Jensen, E., & Riesterer. (2010). Gaining ground, losing ground: The paradoxes of rural homelessness. *Canadian Journal of Nursing Research, 42*(2), 138-152.

Forchuk, C., Dickens, K., & Corring, D. (2016). Social determinants of health: Housing and income. *Healthcare Quarterly, 18*(Special Issue), 27-31. https://doi.org//10.12927/hcq.2016.24479

Forchuk, C., Russell, G., Richardson, J., Perreault, C., Hassan, H., Lucyk, B., & Gyamfi, S. (2022). Family matters in Canada: understanding and addressing family homelessness in Ontario. *BMC Public Health, 22*(614). https://doi.org/10.1186/s12889-022-13028-9

Frankish, C-J., Hwang, S., & Quantz, D. (2005). Homelessness and health in Canada: Research lessons and priorities. *Canadian Journal of Public Health, 96*, S23-29. https://ezproxy.library.yorku.ca/login?url=https://www.proquest.com/scholarly-journals/homelessness-health-canada-research-lessons/docview/231995267/se-2

Fraser, B., Pierse, N., Chisholm, E., & Cook, H. (2019). LGBTIQ+ homelessness: A review of the literature. *International Journal of Environmental Research and Public Health, 16*(15), 2677. https://doi.org/10.3390/ijerph16152677

Freire, P**.** (2018). *Pedagogy of the Oppressed : 50th Anniversary Edition*, Bloomsbury Publishing USA, 2018. *ProQuest Ebook Central*, https://ebookcentral.proquest.com/lib/york/detail.action?docID=6933970. Pedagogy of the oppressed. Bloomsbury Academic.

Gaetz, S., Barr, C., Friesen, A., Harris, B., Hill, C., Kovacs-Burns, K., Pauly, B., Pearce, B., Turner, A., & Morsolais, A., (2012). *Canadian Definition of Homelessness*. Toronto: The Homeless Hub. https://www.homelesshub.ca/sites/default/files/COHhomelessdefinition.pdf

Gaetz, S., Dej, E., Richter, T., & Redman, M. (2016). *The State of Homelessness in Canada. Toronto:* The Homeless Hub https://www.homelesshub.ca/sites/default/files/attachments/SOHC16_final_20Oct2016.pdf

Goering, P., Veldhuizen, S., Watson, A., Adair, C., Kopp, B., Latimer, E., Nelson, G., Macnaughton, E., Streiner, D., & Aubry, T. (2014). National At Home/Chez Soi Final Report. Calgary, AB: Mental Health Commission of Canada. https://books-scholarsportal-info.ezproxy.library.yorku.ca/uri/ebooks/ebooks0/gibson_cppc-chrc/2014-10-25/1/10901125

Goodman, M., Sanders-Thompson, V., Arroyo-Johnson, C., Gennarelli, R., Drake, B., Bajwa, P., Witherspoon, M., & Bowen, D. (2017). Evaluating community engagement in research: Quantitative measure development. *Journal of Community Psychology, 45*(1), p. 17-32. https://doi.org//10.1002/jcop.21828

Government of Canada (2019). *Problematic Opioid Use*. Government of Canada. https://www.canada.ca/content/dam/hc-sc/documents/services/publications/healthy-living/problematic-opioid-use.pdf

Government of Canada (2021). *Restorative Justice*. Government of Canada. https://www.justice.gc.ca/eng/cj-jp/rj-jr/index.html

Government of Canada. (2023). *Canada Health Act.* Government of Canada. https://www.canada.ca/en/health-canada/services/health-care-system/canada-health-care-system-medicare/canada-health-act.html

Greer, A-M., Amlani, A-A., Buxton, J-A., & the PEEP team. (2017). Peer engagement best practices: A guide for health authorities and other providers. Vancouver, BC: BC Centre for Disease Control. http://www.bccdc.ca/resource-gallery/Documents/PEEP%20Best%20Practice%20Guidelines.pdf

Greer, A., Amlani, A., Burmeister, C., Scott, A., Newman, C., Lampkin, H., Pauly, B., & Buxton, J. (2019). Peer engagement barriers and enablers: Insights from people who use drugs in British Columbia, Canada. *Canadian Journal of Public Health, 110*(2), 227-235. https://doi-org.ezproxy.library.yorku.ca/10.17269/s41997-018-0167-x

Greer, A., Selfridge, M., Card, K., Benoit, C., Jansson, M., Lee, Z., & MacDonald, S. (2022a). Factors contributing to frequent police contact among young people: A multivariate analysis including homelessness, community visibility, and drug use in British Columbia, Canada. *Drugs: Education, Prevention and Policy*, *29*(2), 168-174. https://doi-org.ezproxy.library.yorku.ca/10.1080/09687637.2021.1872500

Greer, A., Zakimi, N., Butler, A., & Ferencz, S. (2022b). Simple possession as a 'tool': Drug law enforcement practices among police officers in the context of depenalization in British Columbia, Canada. *International Journal of Drug Policy, 99*, 103471-103471. https://doi.org/10.1016/j.drugpo.2021.103471

Grimshaw, J., Eccles, M., Lavis, J., Hill, S., & Squires, J. (2012). Knowledge translation of research findings. *Implementation Science, 7*(1), 50-50. https://doi.org/10.1186/1748-5908-7-50

Grywacheski, V., Sabad, A., Kushtova, L., Bender, M., Rennie, N., Cheng, R., & Louie, K. (2019). Opioids in Canada. *Healthcare Quarterly, 22*(1), 11- 13. https://doi.org/10.12927/hcq.2019.25842

Hankivsky, O., & Cormier, R. (2011). Intersectionality and public policy: Some lessons for existing models. *Political Research Quarterly*, *64*(1), 217-229. https://doi-org.ezproxy.library.yorku.ca/10.1177/1065912910376385

Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., Ferlatte, O., & Clark, N. (2014). An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity. *International Journal for Equity in Health, 13*(1), 119-119. http://www.equityhealthj.com/content/13/1/119

Hansen, A., Telleus, G., Mohr-Jensen, C., & Lauritsen, M. (2021). Parent-perceived barriers to accessing services for their child's mental health problems. *Child Adolescent Psychiatry Mental Health, 15*(4), 1-11. https://doi.org/10.1186/s13034-021-00357-7

Happell, B., Platania-Phung, C., Scholz, B., Bocking, J., Horgan, A., Manning, F., Doody, R., Hais, E., Granerud, A., Lahti, M., Pullo, J., Vatula, A., Koski, J., van der Vaart, K., Allon, J., Griffin, M., Russell, S., MacGabhann, Liam., Bjornsson, E., & Biering, P. (2019). Changing attitudes: The impact of expert by experience involvement in mental health nursing education: An international survey study. *International Journal of Mental Health Nursing, 28*(2), 480-491. https://doi-org.ezproxy.library.yorku.ca/10.1111/inm.12551

Hardill, K. (2019). That look that makes you not really want to be there: How neoliberalism and the war on drugs compromise nursing care of people who use substances. *The Canadian Journal of Critical Nursing Discourse, 1*(1), 13-27. https://doi.org/10.25071/229-5796.15

Healey, M. (2023). City of London looking for resident feedback on health and homelessness plan. Global News. https://globalnews.ca/news/9905936/city-london-ont-health-homeless-hubs-resident-feedback/

Hickert, A., Taylor, M-J., (2011). Supportive housing for addicted, incarcerated homeless adults. *Journal of Social Service Research, 37*(2), 136-151. https://doi-org.ezproxy.library.yorku.ca/10.1080/01488376.2011.547449

Hodge, D., Moser, S., & Shafer, M. (2013). Spirituality and mental health among homeless mothers. *Social Work Research, 36*(4), 245-255. https://doi-org.ezproxy.library.yorku.ca/10.1080/01488376.2011.547449

Hough, R., Renker, V., Tarke, H., Shields, P., & Glatstein, J. (1996). Recruitment and retention of homeless mentally ill participants in research. *Journal of Consulting and Clinical Psychology. 64*(5), 881-891. https://doi-org.ezproxy.library.yorku.ca/10.1093/swr/svs034

Hsieh, H-F., & Shannon, S. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277-1288. https://doi-org.ezproxy.library.yorku.ca/10.1177/1049732305276687

Islam, S., & Small, N. (2020). An annotated and critical glossary of the terminology of inclusion in healthcare and health research. *Research Involvement and Engagement, 6*(1), 14-14. https://doi.org/10.1186/s40900-020-00186-6

James-Townes, L. (2020). *Why social workers cannot work with police*. Slate News. https://slate.com/news-and-politics/2020/08/social-workers-police-collaborate.html

Johansson, J., & Holmes, D. (2023). "Recovery" in mental health services, now and then: A poststructuralist examination of the despotic state machine's effects. *Nursing Inquiry, 30*(3), https://doi-org.ezproxy.library.yorku.ca/10.1111/nin.12558

Kagan, P. (2009). A nursing manifesto: An emancipatory call for knowledge development, conscience, and praxis. *Nursing Philosophy, 11*(1), 67-84. https://doi-org.ezproxy.library.yorku.ca/10.1111/j.1466-769X.2009.00422.x

Karabanow, J., Doll, K., Leviten-Reid, C., Hughes, J., & Wu, H. (2022). Homelessness during a pandemic: Learning lessons for disaster preparedness in Nova Scotia. Canadian Centre for Policy Alternatives Nova Scotia Office. https://policyalternatives.ca/publications/reports/homelessness-during-pandemic

Kauppi, C., O'Grady, B., Schiff, R., Martin, F. and Ontario Municipal Social Services Association. (2017). *Homelessness and hidden homelessness in rural and northern Ontario.* Guelph, ON: Rural Ontario Institute. https://www.ruralontarioinstitute.ca/file.aspx?id=ae34c456-6c9f-4c95-9888-1d9e1a81ae9a

Kerman, N., Manani-Miller, S., Cormier, L., Cahill, T., & Sylvestre, J. (2020). "It's not just injecting drugs": Supervised consumption sites and the social determinants of health. *Drug and Alcohol Dependence, 213,* 108078-108078. https://doi.org/10.1016/j.drugalcdep.2020.108078

Kerman, N., Kidd, S., Voronov, J., Marshall, C., O'Shaughnessy, B., Abramovich, A., & Stergiopoulos, V. (2023a). Victimization, safety, and overdose in homeless shelters: A systematic review and narrative synthesis. *Health and Place, 83,* 103092-103092. https://doi.org/10.1016/j.healthplace.2023.103092

Kerman, N., Kidd, S., Mutschler, C., Sylvestre, J., Henwood, B., Oudshoorn, A., Marshall, C., Aubry, T., & Stergiopoulos, V. (2023b). Managing high-risk behaviours and challenges to prevent housing loss in permanent supportive housing: A rapid review. *Harm Reduction Journal, 20*(1), 1-140. https://doi.org/10.1186/s12954-023-00873-z

Khubchandani, J., Bustos, E., Chowdhury, S., Biswas, N., & Keller, T. (2022). COVID-19 vaccine refusal among nurses worldwide: Review of the trends and predictors. *Vaccines, 10(*2), 230. https://doi.org/10.3390/vaccines10020230

Krendl, A., & Lorenzo-Luaces, L. (2022). Identifying peaks in attrition after clients initiate mental health treatment in a university training clinic. *Psychological Services, 19*(3), 519-526. https://doi-org.ezproxy.library.yorku.ca/10.1037/ser0000469

Labonte, R., & Stuckler, D. (2016). The rise of neoliberalism: How bad economics imperils health and what to do about it. *Journal of Epidemiology and Community Health, 70*(3), 312-318. https://www.jstor.org/stable/44017712

Lamin, S., Teboh, C., & Chamberlain, J. (2016). Police social work and community policing. *Cogent Social Services, 2*(1), 1212636. https://doi.org/10.1080/23311886.2016.1212636

Lancaster, K., Santana, L., Madden, A., & Ritter, A. (2015). Stigma and subjectivities: Examining the textured relationship between lived experience and opinions about drug policy among people who inject drugs. *Drugs Education, Prevention and Policy, 22*(3), 224-231. https://doi-org.ezproxy.library.yorku.ca/10.3109/09687637.2014.970516

Lavergne, M., & Kephart, M. (2012). Examining variations in health within rural Canada. *Rural and Remote Health, 12*, 1848, 1-13. https://pubmed.ncbi.nlm.nih.gov/22384808/

Leung, C., Ho, M., Kiss, A., Gundlapalli, A., & Hwang, S. (2008). Homelessness and the response to emerging infectious disease outbreaks: Lessons from SARS. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 85*(3), 402-410. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2329752/pdf/11524_2008_Article_9270.pdf

Lincoln, YS. & Guba, EG. (1985). Naturalistic Inquiry. Newbury Park, CA: Sage Publications.

Liu, M. & Hwang, S. (2021). Healthcare for homeless people. *Nature Reviews. Disease Primers, 7*(1), 5-5. https://www.nature.com/articles/s41572-020-00241-2.pdf

Lived Experience Advisory Council. (2016). Nothing about us without us: Seven principles for leadership and inclusion of people with lived experience of homelessness. Toronto: The Homeless Hub Press. https://homelesshub.ca/sites/default/files/LEAC-7principles-final.pdf

MacDonald, S-A., & Gaulin, D. (2020). The invisibility of rural homelessness in a Canadian context. *Journal of Social Distress and The Homeless, 29(*2), 169-183. https://doi-org.ezproxy.library.yorku.ca/10.1080/10530789.2019.1688540

MacDonnell, J. (2011). Gender, sexuality and the participatory dimensions of a comparative life history policy study. *Nursing Inquiry, 18*(4), 313-324. https://doi-org.ezproxy.library.yorku.ca/10.1111/j.1440-1800.2011.00524.x

MacLeod, T., Worton, K., & Nelson, G. (2016). Bridging perspectives and balancing priorities: New directions for housing policy in Canada. *Canadian Journal of Community Mental Health, 35*(3), 55-68. https://doi-org.ezproxy.library.yorku.ca/10.7870/cjcmh-2016-038

Macnaughton, E., Nelson, G., & Goering, P. (2013). Bringing policies and evidence together: Policy entrepreneurship and the conception of the At Home/Chez Soi Housing First Initiative for addressing homelessness and mental illness in Canada. *Social Science & Medicine, 82*, 100-107. https://doi-org.ezproxy.library.yorku.ca/10.1016/j.socscimed.2013.01.033

Madison, D-S. (2020). Critical Ethnography: Methods, ethics, and performance. (3rd ed.). Sage Publications Inc.

Magnus, A. M., & Advincula, P. (2021). Those who go without: An ethnographic analysis of the lived experiences of rural mental health and healthcare infrastructure. *Journal of Rural Studies, 83,* 37-49. https://doi-org.ezproxy.library.yorku.ca/10.1016/j.jrurstud.2021.02.019

Marquis, B., & Huston, C. (2006). Leadership Roles and Management Functions in Nursing: Theory and Application (5th ed.). Lippincott Williams & Wilkins.

May, K., & Shelley, J. (2023). A scan of Ontario cities' COVID-19 policies and their impacts on people living in homelessness. *International Journal on Homelessness. 3*(1), 61-82. https://ojs.lib.uwo.ca/index.php/ijoh/article/view/14968

McGinty, E., & Barry, C. (2020). Stigma reduction to combat the addiction crisis: Developing an evidence base. *New England Journal of Medicine, 382*(14), 1291-1292. https://doi.org/10.1056/NEJMp2000227

McNeely, J., Kumar, P., Rieckmann, T., Sedlander, E., Farkas, S., Chollak, C., Kannry, J., Vega, A., Waite, E., Peccoralo, L., Rosenthal, R., McCarty, D., & Rotrosen, J. (2018). Barriers and facilitators affecting the implementation of substance use screening in primary care clinics: A qualitative study of patients, providers, and staff. *Addiction Science & Clinical Practice, 13*(8). https://doi.org/10.1186/s13722-018-0110-8

Mental Health Commission of Canada (MHCC). (2012). *Changing Directions, changing lives: The mental health strategy for Canada.* MHCC. Calgary, AB. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/MHStrategy_Strategy_ENG.pdf

Mental Health Commission of Canada (MHCC). (2021). *The impact of COVID-19 on rural and remote mental health and substance use*. MHCC. https://mentalhealthcommission.ca/resource/the-impact-of-covid-19-on-rural-and-remote-mental-health-and-substance-use/

Mental Health Commission of Canada (MHCC) & The Centre for Addiction and Mental Health [CAMH]. (2012). *Turning the Key: Assessing housing and related supports for persons living with mental health problems and illnesses*. MHCC. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/PrimaryCare_Turning_the_Key_Summary_ENG_0_1.pdf

McGibbon, E. (2016). *Oppressions and access to healthcare: Deepening the conversation.* In D. Raphael (Ed.). The Social Determinants of Health, 4th Ed. (491-520). Toronto: Canada. Scholar's Press.

McGibbon, E., & Lukeman, S. (2019). Critical social justice: The moral imperative for critical perspectives in nursing. *The Canadian Journal of Critical Nursing, 1*(1), 3-12. https://doi.org/10.25071/2291-5796.21

McGibbon, E., Fierlbeck, K., & Ajadi, T. (2021). Health equity and institutional ethnography: Mapping the problem of policy change. *The Canadian Journal of Critical Nursing Discourse, 3*(2), 64-80. https://doi.org/10.25071.2291.117

McGinty, E., Pescosolido, B., Kennedy-Hendricks, A., & Barry, C. (2018). Communication strategies to counter stigma and improve mental illness and substance use disorder policy. *Psychiatric Services, 69*(2), 136-146.

McKenna, S., & Main, D. (2013). The role and influence of key informants in community-engaged research: A critical perspective. *Action Research, 11*(2), 113-124. https://doi-org.ezproxy.library.yorku.ca/10.1177/1476750312473342

Middleby-Clements, J., & Grenyer, B. (2007). Zero tolerance approach to aggression and its impact on mental health staff attitudes. *Australian and New Zealand Journal of Psychiatry, 41*(2), 187-191. https://doi-org.ezproxy.library.yorku.ca/10.1080/00048670601109972

Ministry of Health and Long-Term Care (MOHLTC) (2020). *COVID-19 Guidance: Homeless Shelters*. MOHLTC. https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_homeless_shelters_guidance.pdf

Mitchell, D., & LeBel, J. (2023). *How more homeless encampments in Ontario signal a housing crisis out of control.* Global News. https://globalnews.ca/news/9926529/homeless-encampments-housing-crisis-ontario/

Moon, K., & Blackman, D. (2014). A guide to understanding social science research for natural scientists. *Conservation Biology, 28*(5), 1167-1177. https://doi-org.ezproxy.library.yorku.ca/10.1111/cobi.12326

Moore, J. (2016). What is the sense of agency and why does it matter? *Frontiers in Psychology, 7,* 1272-1277. https://doi-org.10.3389/fpsyg.2016.01272

Moroz, N., Moroz, I., & D'Angelo, M. (2020). Mental health services in Canada: Barriers and cost-effective solutions to increase access. *Healthcare Management Forum, 33*(6), 282-287. https://doi-org.ezproxy.library.yorku.ca/10.1177/0840470420933911

Morrow, M., & Malcoe, L.H. (Eds.). (2017). Critical inquiries for social justice in mental health. University of Toronto Press. https://ebookcentral.proquest.com/lib/york/detail.action?docID=4884264&pq-origsite=primo

Morrow, M., Bryson, S., Lal, R., Hoong, P., Jiang, C., Jordan, S., Patel, N., & Guruge, S. (2019). Intersectionality as an analytic framework for understanding the experiences of mental health stigma among racialized men. *International Journal of Mental Health and Addiction*. *18*(5), 1304-1317. https://doi.org/10.1007/s11469-019-00140-y

Mullins, R., Kelly, B., Chiappalone, P., & Lewis, V. (2021). 'No one has listened to anything I've got to say before': Co-design with people who are sleeping rough. *Health Expectations.24*(3), 930-939. https://doi.org/10.1111/hex.13235

National Academies of Sciences, Engineering, and Medicine (NASEM). (2016). *The evidence for stigma change: Ending discrimination against people with mental and substance use disorders.* NASEM. Washington, DC: The National Academies Press. https://doi.org/10.17226/23442

National Academies of Sciences, Engineering, and Medicine (NASEM). (2017). *Communities in action: Pathways to health equity*. NASEM. Washington, DC: The National Academies Press. https://doi.org/10.17226/24624

National Collaborating Centre for Determinants of Health (NCCDH). (2013). *Let's talk: Public health roles for improving health equity.* Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University. https://nccdh.ca/images/uploads/PHR_EN_Final.pdf

National Collaborating Centre for Determinants of Health (NCCDH). (2023). *Let's talk: Redistributing power to advance health equity.* Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University. https://nccdh.ca/images/uploads/NCCDH_Lets_Talk_Redistributing_Power_to_Advance_Health_Equity_EN.pdf

Navarro, V. (2007). Neoliberalism as a class ideology; or, the political causes of the growth of inequalities. *International Journal of Health Services, 37*(1), 47-62. https://doi-org.ezproxy.library.yorku.ca/10.2190/AP65-X154-4513-R520

Norman, T., & Pauly, B. (2013). Including people who experience homelessness: A scoping review of the literature. *International Journal of Sociology and Social Policy, 33*(3/4), 136-151. https://doi-org.ezproxy.library.yorku.ca/10.1108/01443331311308203

Norman, T., Pauly, B., Marks, H., & Palazzo, D. (2015). Taking a leap of faith: Meaningful participation of people with experiences of homelessness in solutions to address homelessness. *Journal of Social Inclusion, 6*(2), 29-35. https://josi.journals.griffith.edu.au/index.php/inclusion/article/view/500

Olivet, J., Bassuk, E., Elstad, E., Kenney, R., & Jassil, L. (2010). Outreach and engagement in homeless services: A review of the literature. *The Open Health Services and Policy Journal, 3*(2). https://www.homelesshub.ca/sites/default/files/m1tifkgu.pdf

Olson, N., & Pauly, B. (2023). 'Forced to become a community': Encampment residents' perspectives on systemic failures, precarity, and constrained choice. *International Journal on Homelessness, 3*(2), 124-138. https://doi-org.10.5206/ijoh.2022.2.14431

Ontario Human Rights Commission (OHRC). (n.d.). *Fact Sheet #1: The Ontario Human Rights Code.* OHRC. https://www.ohrc.on.ca/en/students'-handouts/fact-sheet-1-ontario-human-rights-code

Oudshoorn, A., Ward-Griffin, C., Forchuk, C., Berman, H., & Poland, B. (2013). Client-provider relationships in a community health clinic for people who are experiencing homelessness. *Nursing Inquiry, 20*(4), 317-328. https://doi-org.ezproxy.library.yorku.ca/10.1111/nin.12007

Oudshoorn, A., Benjamin, T., Smith-Carrier, T., Benbow, S., Marshall, C-A., Kennedy, R., Hall, J., Caxaj, S., Berman, H., & Befus, D. (2021). A rapid review of practices to support people experiencing homelessness during COVID-19. *Housing, Care and Support, 24*(3/4), 105-122. https://doi.org/10.1108/HCS-11-2020-0018

Owadally, T., & Grundy, Q. (2023). From a criminal to a human-rights issue: Re-imagining policy solutions to homelessness. *Policy, Politics, & Nursing Practice, 24*(3), 178-186. https://doi-org.ezproxy.library.yorku.ca/10.1177/15271544231176255

Padgett, D., & Henwood, B. (2012). Qualitative research for and in practice: Findings from studies with homeless adults who have serious mental illness and co-occurring substance abuse. *Clinical Social Work Journal, 40*(2), 87-193. https://doi-org.10.1007/s10615-011-0354-1.

Paniagua, H., Bond, P., & Thompson, A. (2009). Providing an alternative to zero tolerance policies. *Workplace Violence*, *18*(10), 619-623. https://pubmed.ncbi.nlm.nih.gov/19491736/

Paquette, C., Syversteen, J., & Pollini, R. (2018). Stigma at every turn: Health services experiences among people who inject drugs. *International Journal of Drug Policy, 57,* 104-110. https://doi-org.ezproxy.library.yorku.ca/10.1016/j.drugpo.2018.04.004

Paradis, E. (2016). Outsiders within: Claiming discursive space at national homelessness conferences in Canada. *Social Inclusion, 4*(4), 97-107. https://doi.org/10.17645/si.v4i4.670

Paradis, E., Bardy, S., Cummings-Diaz, P., Athumani, A., & Pereira, I. (2011). *We're not asking, we're telling: An inventory of practices promoting the dignity, autonomy, and self-determination of women and families facing homelessness.* Toronto: The Canadian Homelessness Research Network Press. https://yorkspace.library.yorku.ca/xmlui/bitstream/handle/10315/29385/goodpractice_report.pdf?sequence=1&isAllowed=y

Paradis-Gagne, E., & Pariseau-Legault, P. (2020). Critical ethnography of outreach nurses-perceptions of the clinical issues associated with social disaffiliation and stigma. *Journal of Advanced Nursing, 77*(3), 1357-1367. https://doi-org.ezproxy.library.yorku.ca/10.1111/jan.14671

Pascoe, R., Rush, B., & Rotondi, N. (2013). Wait times for publicly funded addiction and problem gambling treatment agencies in Ontario, Canada. *BMC Health Services Research, 13*(483). http://www.biomedcentral.com/1472-6963/13/483

Patterson, M., Markey, M., & Somers, J. (2012). Multiple paths to just ends: Using narrative interviews and timelines to explore health equity and homelessness. *International Journal of Qualitative Methods, 11*(2), 132-151. https://doi-org.ezproxy.library.yorku.ca/10.1177/160940691201100202

Peart, J., & MacKinnon, K. (2018). Cultivating praxis through Chinn and Kramer's emancipatory knowing. *Advances in Nursing Science, 41*(4), 351-358. https://doi-org.10.1097/ANS.0000000000000232

Phillippi, J., & Lauderdale, J. (2018). A guide to field notes for qualitative research: Context and conversation. *Qualitative Health Research, 28*(3), 381-388. https://doi-org.ezproxy.library.yorku.ca/10.1177/1049732317697102

Piat, M., Polvere, L., Kirst, M., Voronka, J., Zabkiewicz, D., Plante, M-C., Isaak, C., Nolin, D., Nelson, G., & Goering, P. (2015). Pathways into homelessness: understanding how both individual and structural factors contribute to and sustain homelessness in Canada. *Urban Studies, 52*(13), 2366-2382. https://doi-org.ezproxy.library.yorku.ca/10.1177/0042098014548138

Polit, D., & Beck, C. (2017). Nursing Research: Generating and Assessing Evidence for Nursing Practice (10th ed.). Wolters Kluwer.

Polvere, L., MacLeod, T., Macnaughton, E., Caplan, R., Piat, M., Nelson, G., Gaetz, S., & Goering, P. (2014). *Canadian Housing First Toolkit: The At Home/Chez Soi experience. Calgary and Toronto:* Mental Health Commission and The Homeless Hub. https://housingfirsttoolkit.ca/wp-content/uploads/CanadianHousingFirstToolkit.pdf

Ponterotto, J. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology, 52*(2), 126-136. https://doi-org.ezproxy.library.yorku.ca/10.1037/0022-0167.52.2.250

Public Health Agency of Canada (2020). *From Risk to resilience: An equity approach to COVID-19.* Government of Canada. Ottawa, ON. https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/from-risk-resilience-equity-approach-covid-19/cpho-covid-report-eng.pdf

Public Health Ontario (PHO). (2023). *Eight steps to building healthy public policies.* PHO. https://www.publichealthontario.ca/-/media/Documents/E/2012/eight-steps-policy-development.pdf?rev=7cc382e97cb04b65bec86301ec758272&sc_lang=en

Purkey, E., & MacKenzie, M. (2019). Experience of healthcare among the homeless and vulnerably housed a qualitative study: opportunities for equity-oriented healthcare. *International Journal for Equity in Health, 18*(1), 101-101. https://doi.org/10.1186/s12939-019-1004-4

Raphael, D. (2020). Poverty in Canada: Implications for Health and Quality of Life (3rd ed.). Canadian Scholars. http://ebookcentral.proquest.com/lib/york/detail.action?docID=6413896.

Rashid, M., Caine, V., & Goez, H. (2015). The encounters and challenges of ethnography as a methodology in health research. *International Journal of Qualitative Methods, 14*(5), 160940691562142. https://doi.org/10.1177/1609406915621421

Ray, M., & Turkel, M. (2014). Caring as emancipatory nursing praxis: The theory of relational caring complexity. *Advances in Nursing Science, 37*(2), 132-146. https://doi.org/10.1097/ANS.0000000000000024.

Registered Nurses Association of Ontario (RNAO). (2015). *Taking Action: A toolkit for becoming politically involved.* RNAO. https://rnao.ca/sites/rnao-ca/files/Taking_Action_Political_Action_Toolkit_Final_0.pdf

Registered Nurses Association of Ontario (RNAO). (2023). *Who We Are?* RNAO. https://rnao.ca/about

Restall, G., & Kaufert, J. (2011). Understanding how context shapes citizen-user involvement in policy making. *Healthcare Policy, 7*(2), 68-82. https://pubmed-ncbi-nlm-nih-gov.ezproxy.library.yorku.ca/23115571/

Saldana, J., & Omasta, M. (2018). Qualitative Research: Analyzing Life. Sage Publications Inc.

Sanon, M-A., Spigner, C., & McCullagh, M. (2016). Transnational and hypertension self-management among Haitian immigrants. *Journal of Transcultural Nursing, 27*(2), 147-156. https://pubmed.ncbi.nlm.nih.gov/25062700/

Schiff, R., Wilkinson, A., Kelford, T., Pelletier, S., Waegemakers Schiff, J. (2022). Counting the undercounted: Enumerating rural homelessness in Canada. *International Journal on Homelessness, 3*(2), 51-67. https://doi.org/10.5206/ijoh.2022.2.14633

Schwan, K., Versteegh, A., Perri, A., Caplan, M., Baig, K., Dej, E., Jenkinson, J., Brais, H., Eiboff, F., & Pahlevan-Chaleshtari, T. (2020). *The state of women's housing need & homelessness in Canada: A Literature review.* Hache, A., Nelson, A., Kratochvil, E., Malenfant, J. (Eds.). Toronto, ON: Canadian Observatory on Homelessness Press.

Scotland, J. (2012). Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English Language Teaching, 5*(9), 9-16. http://dx.doi.org/10.5539/elt.v5n9p9

Segaert, A. (2016). *Period prevalence vs. point-in-time.* Employment and Social Development Canada. Community Development and Homelessness Partnership Directorate. The Homeless Hub. https://www.homelesshub.ca/sites/default/files/Aaron%20Seagart-HPS-Period%20Prevalence%20vs%20PiT%20Count.pdf

Shah, T., Clark, A., Seabrook, J., Sibbald, S., & Gilliland, J. (2020). Geographic accessibility to primary care providers: Comparing rural and urban areas in Southwestern Ontario. *The Canadian Geographer, 64(*1), 65-78. https://doi-org.ezproxy.library.yorku.ca/10.1111/cag.12557

Silva, D., Smith, M., & Upshur, R. (2013). Disadvantaging the disadvantaged: When public health policies and practices negatively affect marginalized populations. *Canadian Journal of Public Health, 104*(5), 410-412. https://doi-org.ezproxy.library.yorku.ca/10.17269/cjph.104.3895

Skiba, R. (2014). The failure of zero tolerance. *Reclaiming Children and Youth, 22(*4). https://reclaimingjournal.com/sites/default/files/journal-article-pdfs/22_4_Skiba.pdf

Skosireva, A., O’Campo, P., Zerger, S., Chambers, C., Gapka, S., & Stergiopoulos, V. (2014). Different faces of discrimination: Perceived discrimination among homeless adults with mental illness in healthcare setting. *BMC Health Services Research, 14*(376). http://www.biomedcentral.com/1472-6963/14/376

Slevin, E., & Sines, D. (2013). Enhancing the truthfulness, consistency and transferability of a qualitative study: utilising a manifold of approaches. *Nurse Researcher*, *7*(2), p. 79-97.

Smith, E., Moore, P., & Canham, S. (2021). Examining the needs of persons experiencing homelessness: Bringing the voice of lived experience to policy priorities. *International Journal on Homelessness, 1*(1), 14-31. https://doi.org/10.5206/ijoh.2021.1.13651

Smith, T., McNeil, K., Mitchell, R., Boyle, B., & Ries, N. (2019). A study of macro-, meso- and micro- barriers and enablers affecting extended scopes of practice: The case of rural nurse practitioners in Australia. *BMC Nursing, 18*(14), https://doi.org/10.1186/s12912-019-0337-z

Smith-Maddox, R., Brown, L., Katz, S., & Newmyer, R. (2020). Developing a policy advocacy practice for preventing and ending homelessness. *Journal of Social Work Education, 56*(s1), s4-s15. https://doi.org/10.1080/10437797.2020.1723761

Snelling, C. (2017) Right to a Home? Rethinking homelessness in rural communities. Institute for Public Policy Research. http://www.ippr.org/publications/right-to-home

Snell-Rood, C., Pollini, R., & Willging, C. (2021). Barriers to integrated medication-assisted treatment for rural patients with co-occurring disorders: The gap in managing addiction. *Psychiatry Services, 72*(8), 935-942. https://doi-org.ezproxy.library.yorku.ca/10.1176/appi.ps.202000312

Snyder, H., Witell, L., Gustafsson, A., & McColl-Kennedy, J. (2022). Consumer lying behaviour in service encounters. *Journal of Business Research, 141*, 755-769. https://doi-org.ezproxy.library.yorku.ca/10.1016/j.jbusres.2021.11.075

Southwell, B, Otero-Machuca, J., Cherry, S., Burnside, M., & Barrett, N. (2023). Health misinformation exposure and health disparities: Observations and opportunities. Annual *Review of Public Health, 44*, 113-130. https://doi-org.ezproxy.library.yorku.ca/10.1146/annurev-publhealth-071321-031118

South West Local Health Integration Network (SWLHIN) (2021). *Geography facts.* SWLHIN. http://www.southwestlhin.on.ca/aboutus/facts.aspx

Stafford, A., & Wood, L. (2017). Tackling health disparities for people who are homeless? Start with social determinants. *International Journal of Environmental Research and Public Health, 14*(12), 1535, doi:10.3390/ijerph14121535

Statistics Canada (2016) Erie St Clair Census. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=HR&Code1=3501&Geo2=PR&Code2=01&SearchText=Erie%20St.%20Clair&SearchType=Begins&SearchPR=01&B1=All&GeoLevel=PR&GeoCo

Statistics Canada (2018). Rural Area (RA). https://www150.statcan.gc.ca/n1/pub/92-195-x/2011001/geo/ra-rr/ra-rr-eng.htm

Stefancic, A., Henwood, B., Melton, H., Shin, S-M., Lawrence-Gomez, R., & Tsemberis, S. (2013). Implementing Housing First in rural areas: Pathways Vermont. *American Journal of Public Health*, *103*(S2), S203-S209. https://ezproxy.library.yorku.ca/login?url=https://www.proquest.com/scholarly-journals/implementing-housing-first-rural-areas-pathways/docview/1468675602/se-2

Stergiopoulos, V., O'Campo, P., Hwang, S., Godzik, A., Jeyaratnam, J., Misir, V., Nisenbaum, R., Zerger, S., & Kirst, M. (2014*). At Home/Chez Soi Project: Toronto Site Final Report.* Calgary, AB: Mental Health Commission of Canada. http://www.mentalhealthcommission.ca

Strega, S., & Brown, L. (2015). Research as Resistance: Revisiting critical, indigenous, and anti-oppressive approach (2nd ed.). Canadian Scholars' Press Inc.

Streubert, H., & Carpenter, D. (2011). Qualitative Research in Nursing: Advancing the Humanistic Imperative (5th ed.). Wolters Kluwer.

Strike, C., & Watson, T. (2017). Relationships between needle and syringe programs and police: An exploratory analysis of the potential role of in-service training. *Drug and Alcohol Dependence, 175,* 51-54. https://doi-org.ezproxy.library.yorku.ca/10.1016/j.drugalcdep.2017.01.031

Strobel, S., Burcul, I., Hong Dai, J., Ma, Z., Jamani, S., & Hossain, R. (2021). Characterizing people experiencing homelessness and trends in homelessness using population-level emergency department visit data in Ontario, Canada. Statistics Canada: *Health Report, 32*(1). https://www150.statcan.gc.ca/n1/en/pub/82-003-x/2021001/article/00002-eng.pdf?st=DtKnjf8K

Switzer, S., Carusone, S., Guta, A., & Strike, C. (2019). A seat at the table: Designing an activity-based community advisory committee with people living with HIV who use drugs. *Qualitative Health Research*, *29*(7), 1029-1042. https://doi-org.ezproxy.library.yorku.ca/10.1177/1049732318812773

Taha, S., Maloney-Hall, B., & Buxton, J. (2019). Lessons learned from the opioid crisis across the pillars of the Canadian drugs and substances strategy. *Substance Abuse Treatment, Prevention, and Policy*, 14(1), 32-32. https://doi.org/10.1186/s13011-019-0220-7

Tam, T. (2019). *Addressing Stigma: Towards a More Inclusive Health System. The Chief Public Health Officer's Report on the State of Public Health in Canada.* Public Health Agency of Canada. https://www.canada.ca/en/public-health/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-toward-more-inclusive-health-system.html

Thomas, J. (1993). Doing Critical Ethnography: Qualitative Research Methods Series 26. Sage Publications.

Ti, L., Tzemis, D., & Buxton, J. (2012). Engaging people who use drugs in policy and program development: A review of the literature. *Substance Abuse Treatment, Prevention, and Policy, 7*(1), 47-47. https://doi.org/10.1186/1747-597X-7-47

Turner, A. (2016). A Way Home: Youth Homelessness Community Planning Toolkit. The Homeless Hub. https://www.homelesshub.ca/toolkit/appendix-ontario’s-housing-and-homelessness-system

van Draanen, J., Jeyaratnam, J., O’Campo, P., Hwang, S., Harriott, D., & Koo, M. (2013). Meaningful inclusion of consumers in research and service delivery. *Psychiatric Rehabilitation Journal, 36*(3), 180-186. https://doi-org.ezproxy.library.yorku.ca/10.1037/prj0000014

Varcoe, C., Browne, A., & Cender, L. (2014). Promoting social justice and equity by practicing nursing to address structural inequities and structural violence. In Kagan, P., Smith, M., & Chinn, P. (Eds.), Philosophies and Practices of Emancipatory Nursing Social Justice as Praxis (pp.266-284). Taylor & Francis.

Voronka, J., Wise Harris, D., Grant, J., Komaroff, J., Boyle, D., & Kennedy, A. (2014). Un/Helpful help and its discontents: Peer researchers paying attention to street life narrative to inform social work policy and practice. *Social Work in Mental Health, 12*(3), 249-279. https://doi-org.ezproxy.library.yorku.ca/10.1080/15332985.2013.875504

Waegemakers Schiff, J., Schiff, R., Turner, A., & Bernard K. (2015). Rural homelessness in Canada: Directions for planning and research. *Journal of Rural and Community Development, 10*(4), 85-106. https://journals.brandonu.ca/jrcd/article/view/1230/293

Wein, S. (2013). *Exploring the virtues (and vices) of zero tolerance arguments.* OSSA Conference Archive. 171. https://scholar.uwindsor.ca/ossaarchive/OSSA10/papersandcommentaries/171

White, J. (1995). Patterns of knowing: Review, critique, and update. *Advances in Nursing Science, 17*(4), 73-86.

Williams, I. (2020). A reappraisal of contemporary homelessness policy: The new role for transitional housing programmes. *International Journal of Housing Policy, 20*(4), 578-587. https://doi-org.ezproxy.library.yorku.ca/10.1080/19491247.2019.1663070

Wilson, K., & Rosenberg, M. (2004). Accessibility and the Canadian healthcare system: Squaring perceptions and realities. *Health Policy, 67*(2), 137-148. https://doi-org.ezproxy.library.yorku.ca/10.1016/S0168-8510(03)00101-5

Wilson, R., Rourke, J., Oandasan, I., & Bosco, C. (2020). Rural recommendations: Progress made on access to rural healthcare in Canada. *Canadian Journal of Rural Medicine, 25*(1), 14-19.

Woodhall-Melnik, J., & Dunn, J. (2016). A systematic review of outcomes associated with participation in Housing First programs. *Housing Studies, 31*(3), 287-304. https://doi-org.ezproxy.library.yorku.ca/10.1080/02673037.2015.1080816

Woodward, E., & Richmond, R. (2019). Smoking Bans in Psychiatric Units: An Issue of Medical Ethics, *Frontiers in Psychiatry, 10*, 134, 1-4. https://doi.org/10.3389/fpsyt.2019.00134

World Health Organization (WHO). (n.d.). *Health Policy*. WHO. https://www.euro.who.int/en/health-topics/health-policy

World Health Organization (WHO). (1986). *The Ottawa Charter for Health Promotion.* WHO. https://www.who.int/teams/health-promotion/enhanced-wellbeing/first-global-conference

Yilmaz, K. (2013). Comparison of quantitative and qualitative research traditions: epistemological, theoretical, and methodological difference. European Journal of Education, 48(2), 311-325. https://doi-org.ezproxy.library.yorku.ca/10.1111/ejed.12014

Appendix A

Consent to Participate for People Facing MHACH (Written)

Informed Consent Form

Date: June, 2022

Study Name: The Relevance of Policy and Other Dynamics in the Lives of People Facing Mental Health and Addictions Challenges and Homelessness in Rural Ontario

Principal Investigator:
Jacqueline Harris, RN, Master of Science in Nursing Student, York University
Harris71@yorku.ca

Introduction

My name is Jacqueline Harris, and I am a student in the Masters of Science in Nursing program at York University. My supervisor is Dr. Judith MacDonnell. I am conducting research for my thesis about the everyday lives of people facing mental health and addictions challenges and homelessness in rural communities.

Thank you for expressing an interest in participating in my study.

Before we begin, we need to talk about a few items: the purpose of my research, what I will be asking you to do, any potential risks or benefits to you, informed consent, and how I will keep your information confidential. I will give you a copy of this informed consent form for you to review and so you have my contact information as well as my supervisor's contact information.

I am going to review the items now. Please feel free to ask any questions, or if you need me to clarify something.

Participation is voluntary.

Purpose of the Research:

The purpose of this study is to explore how policies and other dynamics (i.e., stigma, discrimination) shape the lives of those facing mental health and addictions challenges (MHACH) in rural communities. I will be conducting a critical ethnographic study. The results will be presented as a thesis and key messages will be shared with the community.

What You Will Be Asked to Do in the Research:

If you agree to participate, you will be invited to participate in a 1:1 confidential interview that will take approximately 60 to 90 minutes. I will ask you questions about your experiences with homelessness and your interview will be audio recorded with your permission. You may skip questions if you are not comfortable answering them. I will later listen to the recording and write down your answers. The recording and writings will be kept confidential. I will assign a pseudonym to your information that is collected, or you may provide your own (i.e., code name). I will also need to collect some demographic information that will also be kept confidential and separate from your interview information. You will be provided with $30 cash for your participation. If you decide to withdraw from the study at any time, you will still receive the $30 cash. I will also cover transportation costs to the interview location, as well as child care costs for your children if required. Child care costs will include compensation for travel time to and from the interview.

Risks and Discomforts:
I do not foresee any risks or discomfort from your participation in the research. However, it is possible that some questions may trigger you or may cause an emotional response. You may choose to skip a question. In the event you experience discomfort with the interview, we can end the interview and it will not influence your relationship with me or the person that referred you. You will still be compensated for your time. I will provide transportation costs to a mental health agency or crisis centre if you require further support (e.g., the cost of a taxi). Here is a phone number that you can also call for support. REACH OUT: 1-866-933-2023.
Because we are in a small community, pseudonyms will be assigned (or you may provide your own) so you can not be identified in the research findings. Interview locations will be explored with you to ensure you are safe, comfortable and in a private space.

Benefits of the Research and Benefits to You:
Findings from this study may be used to influence public policy development in rural communities and may contribute to improving the lives of people experiencing mental health and addictions challenges, and homelessness (MHACH) in rural communities. This study will also provide the opportunity to give voice to people experiencing MHACH who are often not heard.

Voluntary Participation and Withdrawal:

Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer, to stop participating, or to refuse to answer particular questions will not influence the nature of the ongoing relationship you may have with the researchers or study staff, or the nature of your relationship with York University either now, or in the future.

If you decide to stop participating, you may withdraw without penalty, financial or otherwise, and you will still receive the promised inducement.

In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible. Should you wish to withdraw after the study, you will have the option to also withdraw your data up until the analysis is complete. Data analysis will occur **_______** (insert date).

Confidentiality:

Data will be collected using an audio recorder on my password protected cell phone. These recordings will be transcribed electronically and will be saved on an encrypted USB. I will also capture hand written notes during the interview. Your data will be securely stored in a locked filing cabinet in my home office. Demographic data will be stored separately from the transcripts. I will be the only person who will have access to this data.

Data will be stored according to York University's record retention policy (until April 30, 2028). After five years, audio recordings and electronic data will be deleted and all paper data will be destroyed by shredding. The final thesis document will be kept in a repository on the York University website permanently.

Unless you choose otherwise, all information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of the research.

Confidentiality will be provided to the fullest extent possible by law.

This study may use the Zoom platform to collect data, which is an externally hosted cloud-based service. When information is transmitted over the internet privacy cannot be guaranteed. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). Further, while York University researchers will not collect or use IP addresses or other information which could link your participation to your computer or electronic devices without informing you, there is a small risk with any platform such as this of data that is collected on external servers falling outside the control of the research team. If you are concerned about this, we would be happy to make alternative arrangements (where possible) for you to participate, perhaps via telephone. Please contact the researcher for further information.

Recordings (audio/video) will be saved in a password protected file to research team members' local computer, not the cloud-based service. Please note that it is the expectation that participants agree not to make any unauthorized recordings of the content of a meeting / data collection session.

Questions About the Research?

If you have questions about the research in general or about your role in the study, please feel free to contact me at harris71@yorku.ca or my supervisor, Dr. Judith MacDonnell at jmacdonn@yorku.ca. You may also contact the Graduate Program in Nursing at York University at gradnurs@yorku.ca

This research has received ethics review and approval by the Delegated Ethics Review Committee, which is delegated authority to review research ethics protocols by the Human Participants Review Sub-Committee, York University's Ethics Review Board, and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, Kaneff Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).

Legal Rights and Signatures:

I____, consent to participate in The relevance of policy and other dynamics in the lives of people facing mental health and addictions challenges and homeless in rural communities study conducted by Jacqueline Harris. I have understood the nature of this project and wish to participate. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature______________________ **Date**____________________
Participant

Signature______________________ **Date**____________________
Principal Investigator

Additional consent (where applicable)

1. **Audio recording**

☐ I consent to the audio-recording of my interview(s).

Signature_________________________ **Date**_____________________
Participant

Signature_________________________ **Date**_____________________
Principal Investigator

2. **Video recording (Zoom platform)**

☐ I consent to the video-recording of my interview(s).

Signature_________________________ **Date**_____________________
Participant

Signature_________________________ **Date**_____________________
Principal Investigator

Appendix B

Consent to Participate for Key Informants (Written)

Informed Consent Form

Date: June, 2022

Study Name: The Relevance of Policy and Other Dynamics in the Lives of People Facing Mental Health and Addictions Challenges and Homelessness in Rural Ontario.

Principal Investigator:
Jacqueline Harris, RN, Master of Science in Nursing Student, York University
Harris71@yorku.ca

Introduction

My name is Jacqueline Harris, and I am a student in the Masters of Science in Nursing program at York University. My supervisor is Dr. Judith MacDonnell. I am conducting research for my thesis about the everyday lives of people facing mental health and addictions challenges and homelessness in rural communities.

Thank you for expressing an interest in participating in my study.

Before we begin, we need to talk about a few items: the purpose of my research, what I will be asking you to do, any potential risks or benefits to you, informed consent, and how I will keep your information confidential. I will give you a copy of this informed consent form for you to review and so you have my contact information as well as my supervisor's contact information.

I am going to review the items now. Please feel free to ask any questions, or if you need me to clarify something.

Participation is voluntary.

Purpose of the Research:

The purpose of this study is to explore how policies and other dynamics (i.e., stigma, discrimination) shape the lives of those facing mental health and addictions challenges (MHACH) in rural communities. I will be conducting a critical ethnographic study. The results will be presented as a thesis and key messages will be shared with the community.

What You Will Be Asked to Do in the Research:

If you agree to participate, you will be invited to participate in a confidential 1:1 interview that will take approximately 60 to 90 minutes. I will ask you questions about your experiences working with people facing mental health and addictions challenges and homelessness. Your interview will be audio recorded with your permission. You may skip questions if you are not comfortable answering them. I will later listen to the recording and write down your answers. The recording and writings will be kept confidential. I will assign a pseudonym to your information that is collected, or you may provide your own (i.e., code name). I will also need to collect some demographic information that will also be kept confidential.

Risks and Discomforts:

I do not foresee any risks or discomfort from your participation in the research. However, it is possible that some questions may trigger you or may cause an emotional response. You may choose to skip a question. In the event you experience discomfort with the interview, we can end the interview and it will not influence your relationship with me or the person that referred you. Here is a phone number that you can also call for mental health and crisis services. REACH OUT: 1-866-933-2023.

Because we are in a small community, pseudonyms will be assigned so you or the situation/location you share cannot be identified in the research findings. Interview locations will be explored with you to ensure you are safe, comfortable and in a private space.

Benefits of the Research and Benefits to You:

Findings from this study may be used to influence public policy development in rural communities and may contribute to improving the lives of people experiencing mental health and addictions challenges and homelessness (MHACH) in rural communities. This study will also provide the opportunity to give voice to people experiencing MHACH who are often not heard.

Voluntary Participation and Withdrawal:

Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer, to stop participating, or to refuse to answer particular questions will not influence the nature of the ongoing relationship you may have with the researchers or study staff, or the nature of your relationship with York University either now, or in the future.

If you decide to stop participating, you may withdraw without penalty, financial or otherwise.

In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible. Should you wish to withdraw after the study, you will have the option to also withdraw your data up until the analysis is complete. Data analysis will occur _______ (insert date).

Confidentiality:

Data will be collected using an audio recorder on my password protected cell phone. These recordings will be transcribed electronically and saved on an encrypted USB. I will also capture hand written notes during the interview. Your data will be securely stored in a locked filing cabinet in my home office. Demographic data will be stored separately from the transcripts. I will be the only person who will have access to this data.

Data will be stored according to York University's record retention policy (until April 30, 2028). After five years, audio recordings and electronic data will be deleted and all paper data will be destroyed by shredding. The final thesis document will be kept in a repository on the school website permanently.

Unless you choose otherwise, all information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of the research.

Confidentiality will be provided to the fullest extent possible by law.

This study may use the Zoom to collect data, which is an externally hosted cloud-based service. When information is transmitted over the internet privacy cannot be guaranteed. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). Further, while York University researchers will not collect or use IP addresses or other information which could link your participation to your computer or electronic devices without informing you, there is a small risk with any platform such as this of data that is collected on external servers falling outside the control of the research team. If you are concerned about this, we would be happy to make alternative arrangements (where possible) for you to participate, perhaps via telephone. Please contact the researcher for further information.

Recordings (audio/video) will be saved in a password protected file to research team members' local computer, not the cloud-based service

Please note that it is the expectation that participants agree not to make any unauthorized recordings of the content of a meeting / data collection session.

Questions About the Research?

If you have questions about the research in general or about your role in the study, please feel free to contact me at harris71@yorku.ca or my supervisor, Dr. Judith MacDonnell at jmacdonn@yorku.ca. You may also contact the Graduate Program in Nursing at York University at gradnurs@yorku.ca.

This research has received ethics review and approval by the Delegated Ethics Review Committee, which is delegated authority to review research ethics protocols by the Human Participants Review Sub-Committee, York University's Ethics Review Board, and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, Kaneff Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).

Legal Rights and Signatures:

I____, consent to participate in The relevance of policy and other dynamics in the lives of people facing mental health and addictions challenges and homeless in rural communities study conducted by Jacqueline Harris. I have understood the nature of this project and wish to participate. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature______________________ **Date___________________**
Participant

Signature______________________ **Date___________________**
Principal Investigator

Additional consent (where applicable)

1. Audio recording

☐ I consent to the audio-recording of my interview(s).

Signature ____________________ **Date** ____________________
Participant

Signature ____________________ **Date** ____________________
Principal Investigator

2. Video recording (Zoom platform)

☐ I consent to the video-recording of my interview(s).

Signature ____________________ **Date** ____________________
Participant

Signature ____________________ **Date** ____________________
Principal Investigator

Appendix C

Consent to Participate for People Facing MHACH (Verbal Consent)

Verbal consent will only be obtained in the event the participant is not able to sign the informed consent form due to extenuating circumstances. For example, geographical barriers requiring a virtual interview with limited access to technology to return the signed consent (e.g., scanner, email) or the participant does not feel comfortable signing the informed consent form.

Date: June, 2022

Study Name: The Relevance of Policy and Other Dynamics in the Lives of People Facing Mental Health and Addictions Challenges and Homelessness in Rural Ontario

Principal Investigator:
Jacqueline Harris, RN, Master of Science in Nursing Student, York University
Harris71@yorku.ca

Verbal Script

My name is Jacqueline Harris, and I am a student in the Masters of Science in Nursing program at York University. My supervisor is Dr. Judith MacDonnell. I am conducting research for my thesis about the everyday lives of people facing mental health and addictions challenges and homelessness in rural communities.

Thank you for expressing an interest in participating in my study.

Before we begin, we need to talk about a few items: the purpose of my research, what I will be asking you to do, any potential risks or benefits to you, informed consent, and how I will keep your information confidential. I will give you a copy of this informed consent form for you to review and so you have my contact information as well as my supervisor's contact information.

I am going to review the items now. Please feel free to ask any questions, or if you need me to clarify something.

Participation is voluntary.(*review each heading with the potential participant)

Purpose of the Research:

The purpose of this study is to explore how policies and other dynamics (i.e., stigma, discrimination) shape the lives of those facing mental health and addictions challenges (MHACH) in rural communities. I will be conducting a critical ethnographic study. The results will be presented as a thesis and key messages will be shared with the community.

What You Will Be Asked to Do in the Research:

If you agree to participate, you will be invited to participate in a 1:1 confidential interview that will take approximately 60 to 90 minutes. I will ask you questions about your experiences with homelessness and your interview will be audio recorded with your permission. You may skip questions if you are not comfortable answering them. I will later listen to the recording and write down your answers. The recording and writings will be kept confidential. I will assign a pseudonym to your information that is collected, or you may provide your own (i.e., code name). I will also need to collect some demographic information that will also be kept confidential and separate from your interview information. You will be provided with $30 cash for your participation. If you decide to withdraw from the study at any time, you will still receive the $30 cash. I will also cover transportation costs to the interview location, as well as child care costs for your children if required. Child care costs will include compensation for travel time to and from the interview.

Risks and Discomforts:

I do not foresee any risks or discomfort from your participation in the research. However, it is possible that some questions may trigger you or may cause an emotional response. You may choose to skip a question. In the event you experience discomfort with the interview, we can end the interview and it will not influence your relationship with me or the person that referred you.

You will still be compensated for your time. I will provide transportation costs to a mental health agency or crisis centre if you require further support (e.g., the cost of a taxi). Here is a phone number that you can also call for support. REACH OUT: 1-866-933-2023.

Because we are in a small community, pseudonyms will be assigned (or you may provide your own) so you can not be identified in the research findings. Interview locations will be explored with you to ensure you are safe, comfortable and in a private space.

Benefits of the Research and Benefits to You:

Findings from this study may be used to influence public policy development in rural communities and may contribute to improving the lives of people experiencing mental health and addictions challenges, and homelessness (MHACH) in rural communities. This study will also provide the opportunity to give voice to people experiencing MHACH who are often not heard.

Voluntary Participation and Withdrawal:

Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer, to stop participating, or to refuse to answer particular questions will not influence the nature of the ongoing relationship you may have with the researchers or study staff, or the nature of your relationship with York University either now, or in the future.

If you decide to stop participating, you may withdraw without penalty, financial or otherwise, and you will still receive the promised inducement.

In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible. Should you wish to withdraw after the study, you will have the option to also withdraw your data up until the analysis is complete. Data analysis will occur **_______** (insert date).

Confidentiality:

Data will be collected using an audio recorder on my password protected cell phone. These recordings will be transcribed electronically and will be saved on an encrypted USB. I will also capture hand written notes during the interview. Your data will be securely stored in a locked filing cabinet in my home office. Demographic data will be stored separately from the transcripts. I will be the only person who will have access to this data.

Data will be stored according to York University's record retention policy (until April 30, 2028). After five years, audio recordings and electronic data will be deleted and all paper data will be destroyed by shredding. The final thesis document will be kept in a repository on the York University website permanently.

Unless you choose otherwise, all information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of the research.

Confidentiality will be provided to the fullest extent possible by law.

This study may use the Zoom platform to collect data, which is an externally hosted cloud-based service. When information is transmitted over the internet privacy cannot be guaranteed. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). Further, while York University researchers will not collect or use IP addresses or other information which could link your participation to your computer or electronic devices without informing you, there is a small risk with any platform such as this of data that is collected on external servers falling outside the control of the research team. If you are concerned about this, we would be happy to make alternative arrangements (where possible) for you to participate, perhaps via telephone. Please contact the researcher for further information.

Recordings (audio/video) will be saved in a password protected file to research team members' local computer, not the cloud-based service

Please note that it is the expectation that participants agree not to make any unauthorized recordings of the content of a meeting / data collection session.

Questions About the Research?

If you have questions about the research in general or about your role in the study, please feel free to contact me at harris71@yorku.ca or my supervisor, Dr. Judith MacDonnell at jmacdonn@yorku.ca. You may also contact the Graduate Program in Nursing at York University at gradnurs@yorku.ca

This research has received ethics review and approval by the Delegated Ethics Review Committee, which is delegated authority to review research ethics protocols by the Human Participants Review Sub-Committee, York University's Ethics Review Board, and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, Kaneff Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).

Legal Rights and Signatures:

Verbal Script

I, ________________________consent to participate in The Relevance of Policy and Other Dynamics in the Lives of People Facing Mental Health and Addictions Challenges and Homelessness in Rural Communities study conducted by Jacqueline Harris. I have understood the nature of this project and wish to participate.

My researcher's signature indicates that I have informed each participants of my role as a student, the purpose of the study, the conditions of confidentiality and their right to end the interview at any time. It also indicates that I have provided each participant with an opportunity to ask, and have addressed, any questions that they may have about the study.

Signature______________________ **Date**____________________
Participant

Signature______________________ **Date**____________________
Principal Investigator

Additional consent (where applicable)

1. **Audio recording**

☐ I consent to the audio-recording of my interview(s).

Signature______________________ **Date**____________________
Participant

Signature______________________ **Date**____________________
Principal Investigator

2. **Video recording (Zoom platform)**

☐ I consent to the video-recording of my interview(s).

Signature______________________ **Date**____________________
Participant

Signature______________________ **Date**____________________
Principal Investigator

Appendix D

Consent to Participate for Key Informants (Verbal Consent)

Verbal consent will only be obtained in the event the participant is not able to sign the informed consent form due to extenuating circumstances. For example, geographical barriers requiring a virtual interview with limited access to technology to return the signed consent (e.g., scanner, email) or the participant does not feel comfortable signing the informed consent form.

Date: June, 2022

Study Name: The Relevance of Policy and Other Dynamics in the Lives of People Facing Mental Health and Addictions Challenges and Homelessness in Rural Ontario.

Principal Investigator:
Jacqueline Harris, RN, Master of Science in Nursing Student, York University
Harris71@yorku.ca

Verbal Script

My name is Jacqueline Harris, and I am a student in the Masters of Science in Nursing program at York University. My supervisor is Dr. Judith MacDonnell. I am conducting research for my thesis about the everyday lives of people facing mental health and addictions challenges and homelessness in rural communities.

Thank you for expressing an interest in participating in my study.

Before we begin, we need to talk about a few items: the purpose of my research, what I will be asking you to do, any potential risks or benefits to you, informed consent, and how I will keep your information confidential. I will give you a copy of this informed consent form for you to review and so you have my contact information as well as my supervisor's contact information.

I am going to review the items now. Please feel free to ask any questions, or if you need me to clarify something.

Participation is voluntary.(*review each heading with the potential participant)

Purpose of the Research:

The purpose of this study is to explore how policies and other dynamics (i.e., stigma, discrimination) shape the lives of those facing mental health and addictions challenges (MHACH) in rural communities. I will be conducting a critical ethnographic study. The results will be presented as a thesis and key messages will be shared with the community.

What You Will Be Asked to Do in the Research:

If you agree to participate, you will be invited to participate in a confidential 1:1 interview that will take approximately 60 to 90 minutes. I will ask you questions about your experiences working with people facing mental health and addictions challenges and homelessness. Your interview will be audio recorded with your permission. You may skip questions if you are not comfortable answering them. I will later listen to the recording and write down your answers. The recording and writings will be kept confidential. I will assign a pseudonym to your information that is collected, or you may provide your own (i.e., code name). I will also need to collect some demographic information that will also be kept confidential.

Risks and Discomforts:

I do not foresee any risks or discomfort from your participation in the research. However, it is possible that some questions may trigger you or may cause an emotional response. You may choose to skip a question. In the event you experience discomfort with the interview, we can end the interview and it will not influence your relationship with me or the person that referred you. Here is a phone number that you can also call for mental health and crisis services. REACH OUT: 1-866-933-2023.

Because we are in a small community, pseudonyms will be assigned so you or the situation/location you share cannot be identified in the research findings. Interview locations will be explored with you to ensure you are safe, comfortable and in a private space.

Benefits of the Research and Benefits to You:

Findings from this study may be used to influence public policy development in rural communities and may contribute to improving the lives of people experiencing mental health and addictions challenges and homelessness (MHACH) in rural communities. This study will also provide the opportunity to give voice to people experiencing MHACH who are often not heard.

Voluntary Participation and Withdrawal:

Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer, to stop participating, or to refuse to answer particular questions will not influence the nature of the ongoing relationship you may have with the researchers or study staff, or the nature of your relationship with York University either now, or in the future.

If you decide to stop participating, you may withdraw without penalty, financial or otherwise.

In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible. Should you wish to withdraw after the study, you will have the option to also withdraw your data up until the analysis is complete. Data analysis will occur **_______** (insert date).

Confidentiality:

Data will be collected using an audio recorder on my password protected cell phone. These recordings will be transcribed electronically and saved on an encrypted USB. I will also capture hand written notes during the interview. Your data will be securely stored in a locked filing cabinet in my home office. Demographic data will be stored separately from the transcripts. I will be the only person who will have access to this data.

Data will be stored according to York University's record retention policy (until April 30, 2028). After five years, audio recordings and electronic data will be deleted and all paper data will be destroyed by shredding. The final thesis document will be kept in a repository on the school website permanently.

Unless you choose otherwise, all information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of the research.

Confidentiality will be provided to the fullest extent possible by law.

This study may use the Zoom to collect data, which is an externally hosted cloud-based service. When information is transmitted over the internet privacy cannot be guaranteed. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). Further, while York University researchers will not collect or use IP addresses or other information which could link your participation to your computer or electronic devices without informing you, there is a small risk with any platform such as this of data that is collected on external servers falling outside the control of the research team. If you are concerned about this, we would be happy to make alternative arrangements (where possible) for you to participate, perhaps via telephone. Please contact the researcher for further information.

Recordings (audio/video) will be saved in a password protected file to research team members' local computer, not the cloud-based service. Please note that it is the expectation that participants agree not to make any unauthorized recordings of the content of a meeting / data collection session.

Questions About the Research?

If you have questions about the research in general or about your role in the study, please feel free to contact me at harris71@yorku.ca or my supervisor, Dr. Judith MacDonnell at jmacdonn@yorku.ca. You may also contact the Graduate Program in Nursing at York University at gradnurs@yorku.ca.

This research has received ethics review and approval by the Delegated Ethics Review Committee, which is delegated authority to review research ethics protocols by the Human Participants Review Sub-Committee, York University's Ethics Review Board, and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, Kaneff Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).

Legal Rights and Signatures:

Verbal Script

I____, consent to participate in The relevance of policy and other dynamics in the lives of people facing mental health and addictions challenges and homeless in rural communities study conducted by Jacqueline Harris. I have understood the nature of this project and wish to participate.

My (researcher's) signature indicates that I have informed each participant of my role as a student, the purpose of the study, the conditions of confidentiality and their right to end the interview at any time. It also indicates that I have provided each participant with an opportunity to ask, and have addressed, any questions that they may have about the study.

Signature______________________ **Date**____________________
Participant

Signature______________________ **Date**____________________
Principal Investigator

Additional consent (where applicable)

2. **Audio recording**

☐ I consent to the audio-recording of my interview(s).

Signature______________________ **Date**____________________
Participant

Signature______________________ **Date**____________________
Principal Investigator

3. **Video recording (Zoom platform)**

☐ I consent to the video-recording of my interview(s).

Signature______________________ **Date**____________________
Participant

Signature______________________ **Date**____________________
Principal Investigator

Appendix E:

Recruitment Poster: People Facing MHACH

ARE YOU EXPERIENCING HOMELESSNESS?

DO YOU HAVE A HISTORY OF MENTAL HEALTH & ADDICTIONS CHALLENGES?

I am a RN undertaking a Masters of Science in Nursing research thesis at York University.

I am interested in hearing about your everyday life in a rural community.

I welcome diverse experiences.

If you would like to participate in a confidential 60-90 minute, 1:1 interview, please contact me:

Jackie:
- **email: harris71@yorku.ca**
- **cell: (519) 808-7330**

Appendix F

Eligibility Screening Questionnaire for Participants Facing MHACH

I would like to ask you some personal questions to determine your eligibility to participate in this study. I am trying to recruit diverse adults who are experiencing mental health and addictions challenges and homelessness who live in rural communities. Some of the questions may be sensitive and are related to your mental health and substance use. You may skip some questions or prefer not to answer them.

1. What is your age?
   Record in years: _______ (if less than 19 years of age, NOT ELIGIBLE)
2. Are you currently experiencing homelessness?
   Yes ____ No______ (If no, NOT ELIGIBLE)
3. Where are you currently located?
   Record community/location:
   ____ (if outside of the SWLHIN catchment area, NOT ELIGIBLE)
4. Do you consider that you are facing a significant mental health and addictions challenge?
   Yes ____ No______
5. Have you ever been diagnosed with a mental health challenge? (such as anxiety, depression, bipolar, schizophrenia, personality disorder)
   Yes ____ No ____ (If no, NOT ELIGIBLE)
   If yes, what is your diagnosis?
   ____
6. Do you currently use alcohol or other drugs?(such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants)
   Yes _____ No ____ (if no, determine prior history of drug or alcohol use in question 7)
   If yes, what substance(s) do you currently use?
   ____
7. Have you ever had a drinking or other drug problem? (such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants)
   Yes _____ No ____ (if no, NOT ELIGIBLE)
   If yes, what substance(s) did you use?
   ____

Participants will be eligible if they are 19 years or older; currently experiencing homelessness; have a history of mental health and addictions challenges; and are currently located in the SWLHIN catchment area. Individuals will be excluded from this study if they are under the age of 19 or if there is a potential conflict of interest with the researcher.

Appendix G

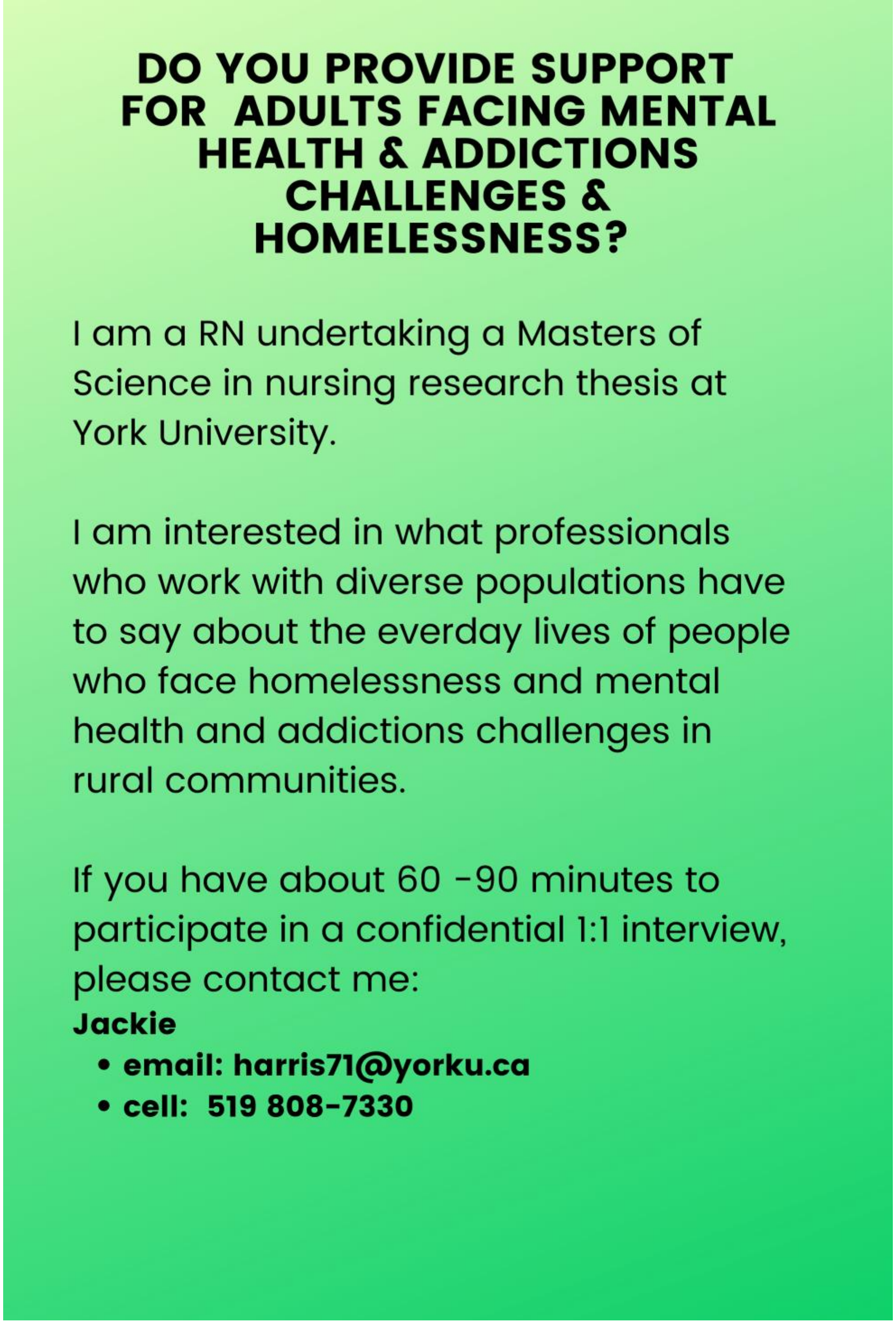
Demographic Questions for MHACH Participants

Now, I would like to get some more information on your background. I will read each question to you and check your answer. Please feel free to skip a question if you do not want to answer it.

1. What is your age in years? _______
2. What is your gender?
    Male ____. Female____ Transgendered/transsexual ____ Other (specify) ______
3. Are you:
    Single ______
    Married _____
    Common- law _____
4. Do you have any dependents (children)?
    Yes ______ No ______ (if yes, how many? _____).
5. What racial group or groups do you identify with? _________________________
6. Which if the following best describes your current housing situation?
    ____ unsheltered: absolutely homeless and living on the streets or in places not intended for human habitation;
    ____ emergency sheltered: those staying in overnight shelters (including women's abuse shelters);
    ____ provisionally accommodated: temporarily or precariously housed
    ____ other
7. Do you receive any income assistance?
    Yes ______ No _____
8. Are you currently using alcohol or any substance?
    Yes _____ No _____
9. How long have you been using?
    __ 6 months to less than 1 year
    __ 1 year to less than 2 years
    __ 2 years to less than 3 years
    __ 3 years to less than 5 years
    __ 5 years to less than 10 years
    __ more than 10 years
10. What is your preferred substance to use? _________________

Appendix H

Recruitment Poster: Key Informants



DO YOU PROVIDE SUPPORT FOR ADULTS FACING MENTAL HEALTH & ADDICTIONS CHALLENGES & HOMELESSNESS?

I am a RN undertaking a Masters of Science in nursing research thesis at York University.

I am interested in what professionals who work with diverse populations have to say about the everday lives of people who face homelessness and mental health and addictions challenges in rural communities.

If you have about 60 -90 minutes to participate in a confidential 1:1 interview, please contact me:

Jackie

- **email: harris71@yorku.ca**
- **cell: 519 808-7330**

Appendix I

Demographic Questionnaire for Key Informants

1. How long have you worked with people facing MHACH?
    - __ <2 years
    - __ 2 to 5 years
    - __ 5 to 10 years
    - __ 10 to 15 years
    - __ 15 to 20 years
    - __ more than 20 years
2. How would you describe your current practice setting?
    - __ social services
    - __ public health
    - __ community health centre
    - __ primary care
3. How long have your worked in your current practice setting?
    - __ <2 years
    - __ 2 to 5 years
    - __ 5 to 10 years
    - __ 10 to 15 years
    - __ 15 to 20 years
    - __ more than 20 years

Appendix J

Question guide for participants facing MHACH

It is important for me to understand your lived experience of homelessness and mental health and addictions challenges. I would like to ask you a few questions about your experiences, opinions and feelings. You may skip some questions or prefer not to answer them.

1. I would like to learn more about what it is like to experience homelessness while facing mental health and addictions challenges in a small community. Can you tell me about that?
2. Can you describe an average day in the streets in this community? Tell me a story to help me understand.
3. Can you describe the community you live in? For example, what places do you have access to and how do you access them?

   Are there any places that you do not have access to? If so, how to you access healthcare, food, clothing etc.?
4. Can you describe a day that you will never forget? (what did you do exactly, and how did you feel about it?)
5. Can you tell me about an experience that you had with someone in charge that said you have to follow a specific rule or policy to access services? How did that impact you?
6. What advice would you give to community leaders to help end homelessness? What do we need to put in place? What do they need to know?
7. What would be a useful way to share the findings of this study? How do you see yourself being involved so your voice is heard?

Appendix K

Interview Guide for Key Informants

As you are aware, homelessness in Canada is a national disaster and public health crisis. In rural communities, it is sometimes difficult to identify people experiencing homelessness as it is often hidden. Approximately 25-50% of people experiencing homeless have mental health and addictions challenges.

1. What is it like caring/supporting people facing MHACH in your practice setting?
2. Can you think of a story about one client you have cared for that experiences MHACH?
3. Can you share with me some examples of policies/programs or other dynamics (i.e., stigma, discrimination) that were implemented in your community that may have impacted people facing MHACH either positively or negatively?
    Why do you feel that was (positive or negative)?
4. How do you feel policies and other dynamics (i.e., stigma, discrimination) affect people who are situated in different ways? (for example, families, or LGBTQ individuals)
5. Occasionally some service agencies ban individuals from various establishments. How do you feel about that? How can we help that individual if they are not able to access services?
6. What do we need to put in place in rural communities to combat homelessness?
7. Is there anything else you would like to share with me?