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Pathways to Homelessness: Exploring the Mental Health Experiences of Refugees Experiencing Homelessness in Canada

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ABSTRACT

BACKGROUND: Homelessness among refugees continues to be a growing issue in Canada. Recent reports indicate the rapidly growing population of refugees, most especially refugee claimants, accessing emergency shelters in Canada. Research to date has been limited on how the diversity of factors, such as refugee's mental health experiences, could potentially play a role as pathways to shelter. The purpose of this study therefore is to explore the mental health experiences of refugees through their pathways to homelessness in Canada.

METHODS: This study, a secondary analysis, is framed within the critical theoretical perspective and an intersectional lens. The study sample included 15 participants who were all refugee claimants residing in emergency shelters in two Canadian cities. The data was derived from a primary study that investigated pathways to homelessness among refugees. A qualitative thematic methodology was used in analyzing the data to understand how mental health experiences among refugees influence their pathways to homelessness. NVivo software was used in managing the development of themes from the data.

RESULTS: Three themes are proposed that examine the role of mental health in pathways to homelessness. The first, *Compounding Marginalization*, reflects the several points of marginalization faced by refugees both in their home country and upon arrival in Canada. The second theme, *Mental Health is Precarious*, highlights how homelessness has a negative impact on the mental health of refugees. The third theme, *Homelessness is Caused by a Lack of Housing*, reflects how participants in this study attributed their homelessness not to poor mental health but to a lack of affordable housing.

CONCLUSION: Results from the study indicate that while refugee claimants experience mental health stressors, these do not necessarily influence their pathways to homelessness.

Rather, homelessness among this population stems from a lack of financial resources emanating from their inability to secure jobs, unrecognized status, language barriers, low social assistance rates, and the lack of affordable housing. However, homelessness among refugees was suggested to predispose them to a deterioration in mental health and experiences of mental stressors.

Keywords: Refugees, homelessness, mental health, emergency shelter, critical theory, Intersectionality.

SUMMARY FOR LAY AUDIENCE

Canada maintains an ongoing commitment to accepting refugees from across the globe. However, there have been recent concerns about the number of refugees, especially refugee claimants, experiencing homelessness. Most refugee claimants arrive in Canada with little or no support towards their housing. This can include lack of documents, a lack of money, or a lack of English language skills. It is possible that arriving homeless into Canada is bad for one's mental health. Additionally, research shows that individuals with mental health challenges are prone to homelessness. Therefore, it is surprising that very few studies have explored the relationship between the mental health of refugees and experiences of homelessness in Canada. To help fill this gap, this study looked at the mental health experiences of refugee claimants and their stories of becoming homeless. In this study, in-depth interviews with 15 homeless refugee claimants were conducted. The participants were from two mid-size cities in Ontario and they were asked if their mental health challenges played a role in their homelessness and what could be done to assist them in improving both their housing and their mental health. The findings of the study revealed that while the participants experienced some mental health challenges, they did not see these as the cause of their homelessness. Rather, the lack of money, lack of jobs, and lack of affordable housing made them homeless. However, they did mention that not having housing added mental stress.

CO-AUTHORSHIP STATEMENT

This study was carried out under the supervision of Dr. Oudshoorn and Dr. Benbow who will be co-authors on any publications resulting from this manuscript.

DEDICATION

I dedicate this work to all the participants who sacrificed their time to share their stories and experiences to make this study a reality. I also dedicate this work to my late Mother, Mary-Adu-Gyamfi for all her tireless effort and the many sacrifices she made for me while alive. May her soul rest in perfect peace.

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Thank you to the Arthur Labatt Family school of Nursing, for this great opportunity to be a part of this community and for all the support and guidance throughout my study.

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CHAPTER ONE

INTRODUCTION

A home is not merely a physical structure, rather it is a place where one feels a sense of belonging, safety, and kinship. For many, a home is also a place for relaxation after a hard day's work (Gillsjo, Schwartz-Barcott & von Post, 2009). Regardless of the different conceptualizations of home, it is unequivocally one of the most important assets of one's life and a core determinant of health (Mikkonen & Raphael, 2010). However, many individuals in Canada are experiencing housing loss, becoming temporarily, episodically, or chronically homeless. Homelessness continues to be a persistent social issue in Canada despite its known negative economic and health implications (Steffler, 2016). Homelessness is defined as the absence of permanent, stable and suitable housing for an individual or a family, and a lack of resources to acquire such (Canadian Observatory on Homelessness, 2012).

While federal, provincial, and municipal governments have committed to reducing or ending homelessness, emergency shelters continue to record high occupancy rates, with some shelters in large urban areas having consistent occupancy above 100% (Government of Canada, 2018). However, the shelter occupancy rates only tell a part of the story as experiences of homelessness are heterogeneous. This experience varies across social locations, such as gender, ability, class, Indigeneity, race, and rural versus urban populations (Tabibi & Baker, 2017). In Canada, the homeless population is defined by three main categories namely; the unsheltered homeless, emergency sheltered homeless, and the provisionally accommodated (Canadian Observatory on Homelessness, 2012). Although homelessness varies among different populations in Canada, it is most common

among certain vulnerable groups such as refugee claimants and Canadians born into persistent poverty (Wayland, 2007; Mott, Moore & Rothwell, 2012).

Among the Canadian population, several factors and experiences such as mental health challenges, substance use problems, childhood maltreatment, disability, racism, violence, and being victims of crime have been revealed as pathways to homelessness (Tabibi & Baker, 2017). With refugees, there are similar risk factors, but in addition to these are challenges related to legal status, acculturation, and resettlement stressors (Assefa, Petrov, Radan & Sonnenberg, 2017). Structural pathways into homelessness intersect with one's health and well-being, as homelessness can impact negatively on the health of an individual, while health challenges in turn increase the risk of homelessness. Among the several pathways that lead to homelessness, this project focuses specifically on the mental health experiences of refugees experiencing homelessness.

This study is a secondary analysis of a primary study (Oudshoorn, et al., unpublished) exploring the pathways through which refugees (including those categorized as government assisted, privately sponsored, and claimants) end up in emergency shelters. The main aim of this secondary analysis is to understand the experiences of homelessness among refugees in emergency shelter with a particular focus on exploring how mental health challenges or experiences may play a role in their pathways to homelessness. While the analysis is open to all categories of refugees, asylum seekers/refugee claimants will be the primary focus as these individuals constitute the majority of refugees currently accessing emergency shelters in Canada.

Study Background

Peressini (2009) conducted a study exploring the pathways into homelessness, testing the hypothesis that different subgroups have different pathways into homelessness.

While this study focused primarily on Canadian-born sub-groups, they did indeed find that while there were common societal factors, these are experienced differently by different populations. This study adds to the concern that mental health experiences play a role in the pathway to homelessness. However, while it is known that refugees are at particular risk of mental health challenges, the connection between this risk and refugee pathways has not been clearly made.

Refugees experience numerous losses such as losing their homeland, their careers, their culture and sometimes losing friends and relatives (Center for Addiction and mental health, 2018). Most refugees have past experiences of trauma or have been witnesses to previous traumatic events which predisposes them to suffering various mental health challenges (Center for Addiction and mental health, 2018). Aside from their previous experiences, refugees especially refugee claimants are faced with different stressors during their integration in their new host countries and these stressors may equally impact their mental health.

The primary study on which this secondary analysis is based aimed to explore the pathways to homelessness among refugees found in two emergency shelters in a large and a mid-sized Canadian city (Oudshoorn, unpublished). The primary project sought to understand factors that cause the different category of refugees to access emergency shelter. This study is essential in considering the most important system responses to prevent or rapidly end homelessness as experienced by refugees. The data collection for the primary study included 15 interviews conducted among refugees who were residing in various emergency shelters in London and Toronto, Canada. Participants of the study included a purposive sample of any refugee accessing the two participating shelters. The primary study was situated within the critical research paradigm while employing a

narrative inquiry methodology. This enabled researchers to investigate the unique pathways for refugees through their transition to Canada and into homelessness while exploring any shared commonalities. The findings of the study indicate that as opposed to Canadian-born populations, refugees and particularly refugee claimants may not be good candidates for homelessness prevention through shelter diversion. Rather, due to a complete lack of resources and knowledge of local systems, accessing shelter became a starting point for finding housing and other supports.

Statement of Problem

While the social aspects of resettlement have been well researched (Simich, Beiser, & Mawani, 2003; Simich, 2003), a particular focus on housing loss has been less prevalent, with a gap in understanding the current surge of refugees accessing emergency shelters. Additionally, while mental health challenges are a known element of pathways into homelessness for Canadian populations (Canadian Institute for Health Information, 2007), it is not known how mental health does or does not impact homeless experiences for refugee claimants.

The mental health of refugees is vital to successful integration, especially for refugee youth, as most are vulnerable to the long-term effects of trauma and conflict from their home country, as well as during the resettlement process (Assefa, Petrov, Radan, & Sonnenberg, 2017). It is therefore reasonable to consider that mental health challenges may potentially play a role in the experiences of homelessness for refugee claimants and all refugees due to high risk factors. However, research on refugee homelessness to date has spoken primarily to structural issues (Morella-Bellai, Georing & Katherine, 2000) or familial breakdown (Serge, Eberle, Goldberg, Sullivan & Dudding, 2002) with limited consideration of the interplay of these issues with mental health. A study by Piat and

colleagues (2014) explored pathways into homelessness that included the role of mental health challenges, however the study sample did not specifically focus on refugees. Similarly, while Thurston and colleagues (2013) examined pathways in and out of homelessness for immigrant women, the experiences of immigrants and refugees cannot be presumed to be equal. Ultimately, considering the growing population of refugees most especially refugee claimants in Canada coupled with the high risk for past traumatic experiences and the high demand for emergency shelter beds in recent times due to homelessness, there is a need to explore the potential mental health experiences of refugees through their pathways to homelessness as this will contribute to effective policy formulation to improve their health and well-being.

Purpose of the Study and Research Question

Pressures on emergency shelters related to increasing use by refugee claimants have led to questions regarding the best way to support this population into housing (Carbone, 2018). The city of Toronto, for example, has indicated that they have exhausted all their resources to meet the current needs of the various emergency shelters due to the influx of refugee claimants. There is a possibility that this situation is being shaped by or worsened due to unacknowledged and unaddressed mental health challenges of refugees. Acknowledging the stressors being faced by these refugee claimants, the purpose of this study is to explore the mental health experiences of refugees through their pathways to homelessness using a qualitative secondary analysis approach. A focus on mental health experiences of refugees will allow for a consideration of both structural (i.e. the refugee claimant system in Canada) and personal (i.e. mental health concerns) factors and how they may interact in pathways to homelessness. Using secondary analysis, the guiding research

question for this study is: How do the mental health experiences of refugees shape their pathways to homelessness?

Theoretical Perspective

The issue of homelessness is multidimensional, perpetuated by diverse factors. An individual's housing need is considered a core social determinant of health (Mikkonen & Raphael, 2010). Although there have been suggested connections between health and the physical environment, the field of nursing lacks distinct models or theoretical explanations for the relationship between individuals, their housing needs, and their health. This secondary analysis employed the critical theoretical perspective and intersectionality theory to address the research question. In the critical theoretical perspective, there is a focus on structural impacts on health together with social issues such as oppression. Guba and Lincoln (1994), described this theory as one where reality is socially constructed and is influenced by the intersection of social, political, economic, and ethnic determinants. Homelessness as described by Gaetz, Gullier, Richter, and Marsolais (2014) is a social challenge connected both to individual and relational factors, as well as structural and system failure. This study equally employed an intersectional theoretical lens as the intent is to understand the experiences of a particular population occupying a marginalized social location. The health of an individual is seen to be impacted by social locations and experiences which causes differences in health outcomes (Davies, 2008). Intersectionality takes into consideration gender, race, cultural ideologies, social practices, and power relations (Davies, 2008). According to Crenshaw (1993), intersectionality investigates the 'Crossroads' or the intersection of several experiences which includes marginalization and exclusion. Through this lens, this study investigates mental health experiences of refugees and is attuned to the structural marginalities faced by refugees and refugee claimants. The

study of homelessness among refugees is one where race and cultural considerations intersect with other social locations such as class, religion, and language. Some nursing studies such as that of Benbow, Forchuk and Ray (2011) have successfully employed intersectionality theory in analyzing homelessness among mothers. As this secondary analysis looks into the mental health experiences of refugees, it is well situated in the critical theoretical perspective as well as in intersectionality theory.

Methodology

A qualitative secondary analysis as described by Heaton (2004) is the chosen methodology for this study. According to Heaton (2004), secondary analysis involves the use of an existing data in conducting a new research study. In the early 1990's, secondary analysis was mostly employed to analyze quantitative primary data due to the lack of a defined approach for qualitative secondary analysis. However, qualitative secondary analysis gained recognition when studies by Hinds, Vogel and Clarke-Steffen (1997), Sandelowski (1997), and Thorne (1994) argued in favour of conducting secondary analysis in qualitative studies. These studies indicated that secondary analysis could be employed in qualitative research to produce new knowledge or generate new hypotheses while reducing the burden of data collection.

Heaton (2004) further identified three main purposes of secondary analysis: evaluating a new research question, validating, refuting or improving existing research, and synthesizing research across studies. This study aligns with the first purpose of evaluating a new research question in relation to the data from the primary study to gain further insight into refugees' pathways to homelessness with a focus on their mental health experiences through these pathways.

Heaton (2004) also reported three ways in which data collection or sharing is done in qualitative secondary analysis: a) the primary researcher making available the primary data for the secondary analysis without any participation; b) two independent researchers sharing their various data sets for a particular secondary study; and c) the primary researcher sharing data for the secondary study and equally partaking in the secondary study. In this secondary analysis, the third approach is applied and thus the primary researcher is a part of the secondary study as the thesis supervisor. Heaton (2004) suggests that if the primary researcher is to take part in the supplementary analysis when conducting further research with the existing data, re-connecting with participants is not needed.

Additionally, Heaton (2004) indicates five types of secondary data analysis in qualitative research. These include: amplified analysis, assorted analysis, supplementary analysis, re-analysis, and supra analysis. Supplementary analysis is an in-depth analysis of portions of the data that are not addressed in the primary study (Heaton, 2008). In this secondary analysis, a supplementary analysis is used to guide this study as particular attention is given to the role of the mental health experiences of refugees, which were not specifically addressed in the primary study. Although Heaton (2008) indicated supplementary analysis is the most frequently used type of secondary analysis, it has some limitations. For example, supplementary analysis is an extension of the primary data, thus may lead to duplication in the research findings in both primary and secondary studies (Heaton, 2004).

Further limitations of secondary analysis identified by Heaton (2008) include three potential issues: '*problem of data fit*' – "whether data collected for one purpose (primary study) can be re-used for another study" (p. 40), the "*problem of not having been there*" – where researchers in secondary analysis interpret data gathered by other researchers and

lastly the “*issue of verification*”- referring to the ability to re-use qualitative data to confirm, revise or verify a primary study using statistical methods (Heaton 2008, p. 40). However, the problem of “*data fit*” is most likely to be associated with the supplementary secondary analysis due to the derivation of research questions from the same previous data in the primary study. In a qualitative study where researchers are supposed to document both verbal and non-verbal cues, employing secondary analysis, which involves the use of an existing data, can be identified as a key concern for qualitative researchers. These concerns are mitigated in two ways herein, by being involved with data collection on the primary study, and by having the principal investigator from the primary study as the research supervisor for the secondary analysis.

Besides the epistemological issues, there are ethical issues that may potentially arise in secondary analysis, such as the need for informed consent (Heaton, 2004). However, this is addressed through various strategies such as gaining a prospective or retrospective consent. With a prospective consent, participants in a primary study are informed that data collected will be used in future studies, while with retrospective consent, participants from a previous study are re-contacted. Prospective consent for secondary analysis was included on the consent form for the primary study.

In conclusion, this secondary study, situated in the critical theoretical perspective and an intersectional lens, sheds light on the mental health experiences of refugees accessing emergency shelters. This study is relevant to nurses due to their responsibility to enhance health equity through care of vulnerable populations. Nurses in particular pay keen attention to the issue of homelessness due to diverse health challenges it presents (Stafford & Wood, 2017). As such, having evidenced based knowledge about the challenges faced by this population would enable health providers to play a more pivotal role and administer

culturally sensitive care that is required by this population. An evidenced based knowledge regarding the health needs of vulnerable populations is the starting point for quality health interventions.

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CHAPTER TWO

MANUSCRIPT

Background and Significance of the Study

Canada continues to be a destination of choice for refugees from various countries. This is in line with the country being a signatory to the United Nations 1951 convention relating to the status of refugees and its 1967 protocol (UNHCR, 2015). The aim of accepting refugees is to grant a safe abode to individuals from countries which are experiencing war and other human or natural disasters. According to the Immigration, Refugee, and Citizenship Canada (IRRC) 2017 annual report, more than 62,000 refugees were resettled in Canada through 2016. Additionally, a total of about 40,081 Syrian refugees were estimated to have resettled in Canada as of January 2017 (Citizenship Immigration Canada, 2017). The IRCC and the Canada Border Services Agency (CBSA) 2018, also indicated that about 55,025 asylum claims were made in the year 2018. Refugees in Canada are classified under three main categories; Government-assisted refugees (GAR), Privately Sponsored Refugee (PSR) and Refugee Claimants (RC) also known as asylum seekers (Government of Canada, 2017). GAR are individuals or families sponsored and transported into Canada by the federal government, whereas PSR are people who come into Canada with sponsorship from private entities, often non-governmental agencies or religious/cultural organizations. Refugee claimants are individuals who come into the country or arrive on its borders on their own and apply for status as a refugee.

While fulfilling Canada's humanitarian requirements, accepting refugees has also been demonstrated to boost Canada's economy as most of these refugees when settled ultimately become engaged in economic activities. Demographically, refugees and other immigrant groups help balance the aging population in Canadian cities that are faced with

population decline, including rural communities (Teixeira & Drolet, 2018). However, for refugees and immigrants to effectively settle and ultimately contribute to Canada's economy, they have to be well integrated. A key element of the integration process is housing, as all people need access to safe, affordable, quality, and permanent housing as a determinant of their health. Nevertheless, housing access for refugees continues to be a challenge in Canada, with frequent experiences of homelessness among this population, in particular asylum seekers (Teixeira & Halliday, 2010). For nurses, the issue of homelessness is of concern due to diverse health challenges that are faced by this population (Stafford & Wood, 2017). In particular, this study is relevant to nurses as they are key in supporting the health, including of mental health, of diverse populations. Further, the Registered Nurses Association of Ontario (RNAO) indicates the need for nurses to be advocates for the homeless population thus reiterating the significance of this study to the nursing profession.

For refugee claimants, barriers such as high unemployment rates, lack of legal status, language barriers, low financial status, racial discrimination in the rental markets among others have been revealed as contributing factors to homelessness (Danso 2002; Murdie, 2008). Despite these known factors accounting for homelessness, the precise pathways to homelessness remain unclear for refugees in Canada. In recent times, provinces and cities across Canada have reported an influx of refugees in municipal emergency shelters. On April 26, 2018, the mayor of Toronto indicated that the city of Toronto needed urgent help to deal with the surge of refugee claimants who account for 40% of the city's emergency shelter population (Gray, 2018). Not only in Toronto, but several other cities have also indicated facing similar challenges and strains. This situation has necessitated further research into the factors accounting for the increasing utilization

of emergency shelters by refugees most especially refugee claimants. Apart from these pathways studied in the primary study, this study seeks to add knowledge on refugees' potential mental health experiences and how these may shape their pathways into homelessness. This is essential in informing interventions and support services to improve the housing outcomes of refugees and ultimately promote their health.

Literature Review

A literature search was performed to unveil and understand the experiences of refugees on their pathways to homelessness using a narrative review approach (King & He, 2005). The literature search was conducted via various databases including Scopus, PubMed, Google Scholar and Homeless Hub. Only peer reviewed articles written in English from the years of 2000 to 2018 were included in this review. Since the study is conducted in Canada, the primary target for the literature search focused on Canadian literature. However, review papers from other international sources were included to aid in comparison while providing additional examples of interventions. Although research based on other countries may have limited applicability and the experiences in these contexts may vary, several studies have confirmed that refugees from other countries also experience homelessness and mental health concerns.

The search employed the use of multiple search terms such as “Refugees”, “Homelessness”, “Homeless”, “Mental Health”, “Pathways”, “Health” and “Housing” together with Boolean operators “OR” and “AND”. Relevant articles were identified by reading the abstracts of the article list generated through the search. To identify additional relevant literature for the study, the reference lists of the identified articles were also reviewed. The summary of this review will begin with the definition of the key concepts within the study. Subsequently, the review has been organized by categories with the first

part concentrating on pathways to homelessness, the next section discussing refugees and homelessness, while further sections discuss homelessness and health, refugees and their mental health and housing, and refugee's mental health.

Definition of Key Terms

Refugee

A refugee refers to any individual who flees their home country under compulsion due to violence, natural disaster, or any form of suppression (United Nations Refugee Agency, 2018). Mostly, refugees are not able to return to their home country due to the fear of persecution or safety because of their religion, sexual orientation, race, nationality, or their membership with certain social or ethnic groups, or because of a regional catastrophe. Refugees are considered a part of the vulnerable population in many societies including Canada partly due to social exclusion and complex experiences of loss. Exclusion may be due to speaking a language other than English or French, or differences based in culture, ethnicity, religion, and low economic status (Nick et al. 2009).

Homelessness

Homelessness as defined by the Canadian observatory on Homelessness, is a state in which an individual or family lacks permanent, safe and stable housing as well as the resources needed to acquire such. This is caused by personal factors such as familial breakdown, and systemic or societal barriers such as lack of affordable housing or inadequate social assistance (Canadian Observatory on Homelessness, 2012). The Canadian definition includes four typologies of homelessness which are unsheltered, emergency sheltered, provisionally accommodated, and at risk of homelessness (Gaetz, et al. 2012). The unsheltered typology constitutes the absolutely homeless individuals or families living on the streets or in places not considered as suitable for human habitation.

Emergency sheltered includes those who spend nights in emergency shelters, while the provisionally accommodated refers to individuals or families who live in a temporary accommodation such as hospital or with friends. Finally, being at risk of homelessness involves people who are currently not facing homelessness but given their low economic status are in a precarious situation and predisposed to housing loss. This study focuses on refugees who are homeless due to their current stay in emergency shelters.

Mental Health

Mental health as defined by the World Health Organization (WHO) is the state of well-being in which a person becomes fully aware of their capabilities and can contribute meaningfully to their community through productive work (WHO, 2014). Within mental health is the concept of ‘mental illness’, which is defined as a range of disorders characterized by changes in mood, behavior or thinking as well as marked impaired functioning (Public Health Agency of Canada, 2015). For the purpose of this study, the language “mental health experiences” and “mental health challenges” were adopted to depict the mental health of the participants. The use of language is important in mental health research and as confirmed by (Richards, 2018), adopting an appropriate language in mental health care provides clarity and avoids further stigmatization.

Pathways to Homelessness

Homelessness has been extensively researched across a variety of time periods and national contexts. Several researchers have explored the pathways through which people become homeless and potential factors that lead to homelessness. The pathways through which individuals become chronically homeless have been associated with two major factors: structural/systemic factors and personal/individual factors. The table below gives

some examples of studies that indicate these factors as major causes of homelessness (Table 1).

Table 1: Factors influencing pathways to homelessness.

Personal Factors	Structural Factors	Sample Population	Authors
Childhood abuse, substance use, mental health challenges	Poverty, unemployment, high rental rates	29 homeless adults	Morrell-Bellai, Georing & Katherine, 2000
Substance use, intimate partner violence, eviction from home, discharge from an institution.	Unemployment	Homeless adults (4,497 males and 2,727 females)	Tessler, Rosenheck and Gamache (2001).
Sexual orientation (LGBTQ2S),		84 homeless persons identifying as LGBTQ2S	Cochran, Stewart, Ginzler & Cauce (2002)
Family conflicts and leaving foster care early		40 homeless youth	Serge, Eberle, Goldberg, Sullivan and Dudding (2002)
Mental health challenges, race, gender and ethnicity		Mental healthcare patients (10,340)	Folsom, Hawthorne, Lindamer, Gilmer, Bailey, Golshan, Garcia, Unutzer, Hough and Jeste (2005)
Conflicts, mental health challenges and substance use	High rental rates, poverty	Homeless individuals (219).	Piat, Polvere, Kirst, Voronka, Zabkiewicz, Plante, Isaak, Nelson & Goering (2015).
Substance use problems, mental health challenges	Poor social support, low socioeconomic status	Homeless older adults (350)	Brown, Goodman, Guzman, Tieu, Ponath and Kushel (2016)

Personal Factors

The distinction between personal factors and systemic factors can be somewhat arbitrary, as often it is how personal factors intersect with systemic elements that put individuals at higher risk of housing loss. For example, individuals of diverse sexual orientations experience greater risk of homelessness, and this risk is often related to how

families respond to these sexual orientations in a cultural context of homophobia. Cochran et al. (2002) in their study on challenges faced by gay, lesbian, bisexual and transgender people revealed that people of the minority sexual groups (LGBTQ2S), particularly youth, often leave home due to familial conflict in relation to their sexual orientation. This study conducted among youth who were a part of the Seattle homeless youth research and education project uncovered that LGBTQ2S youth left home 12.38 times more than heterosexual youth as a result of physical abuse in their homes. In addition, this group experiences higher levels of mental health challenges and substance use, which can contribute to their risk of homelessness. This demonstrates the interplay between personal and structural factors that can predispose certain subpopulations to a greater risk of homelessness.

Thinking more generally about age as a social location and risk of homelessness, a pilot study on Child Welfare System and Homelessness among Canadian Youth by Serge, Eberle, Goldberg, Sullivan and Dudding (2002), revealed that homelessness among youth mostly results from family conflicts or leaving care homes early. The youth recruited for this study were from four main Canadian cities; Vancouver, Winnipeg, Toronto and Montreal. Among the 40 participants who engaged in the study with ages ranging from 22-25 years, it emerged that the youth who grew up with positive experiences of care were less likely to experience homelessness. Positive experiences of care in this study meant growing up in foster homes instead of group homes and having more stable placements. On the other hand, youth who left care early and those who were found in group homes struggled to survive on their own as young adults and dealing with difficult behaviours leading many into substance abuse. Again, this study illustrates how personal factors, such as a choice to leave care, intersect with systemic elements, such as the quality of support

provided to youth while in care. The study also confirmed the need for further research among homeless youth to fully uncover the experiences of these youth and their pathways to homelessness.

In San Diego, Folsom et al (2005) examined the prevalence and risk factors for homelessness as well as the utilization of mental health services among people who experience mental illnesses within a public mental health system. The study involved 10,340 respondents with various mental health challenges such as schizophrenia, bipolar disorder and major depression. Although the findings indicated mental health is a contributing factor for homelessness, the findings also highlight how this intersects with other social locations such as gender and ethnicity. For example, being a male of African American ethnicity was associated with a high prevalence of homelessness whereas Asian Americans and Latinos were less likely to face homelessness. This reveals a likely interaction of personal factors such as ethnicity with structural elements, such as racialization.

Structural and Systemic Factors

Apart from personal factors, systemic elements play a significant role in pushing people into homelessness. A qualitative study by Morrell-Bellai, Georing and Boydell (2000) examined ways individuals become and remain homeless. This study involved 29 homeless adults in Toronto, Canada. The participants of this study were engaged in in-depth interviews and findings from the study revealed that people become and remain homeless due to the interaction between macro level factors such as poverty, unemployment, high rental rates and personal factors such as childhood abuse, substance use and mental health challenges. The study also indicated that chronically homeless individuals often experienced some form of childhood neglect and constant substance use

challenges. Overall this study highlighted that while systemic elements are interactive causes of homelessness, the system similarly lacks sufficient supports to assist those who become homeless.

The gendered nature of homelessness illustrates well how what might be deemed a personal factor (ie. sex) is actually more of a systemic factor when inequitable outcomes exist. Tessler, Rosenheck and Gamache (2001) in their study on gender differences among people experiencing homelessness indicated that the pathways to homelessness among males and females varied. Interviewing 4,497 homeless men and 2,727 homeless women who were part of the Access to Community and Effective Services and Supports program in the United States, the findings outlined that “loss of job, discharge from an institution, drug problems” were mostly associated with homelessness among men. However, with women, eviction from home, interpersonal conflict or intimate partner violence were reasons cited for homelessness. Given the variant reasons for homelessness among men and women, the authors argue that homelessness is socially constructed and that reasons for homelessness are tied to gender roles, which create unique vulnerabilities.

A study by Piat et al. (2015) also assessed the pathways into homelessness by seeking to understand how structural factors contribute to and sustain homelessness in Canada. This qualitative study involved 219 participants and employed a social ecological theoretical framework. Findings from the study indicated that while individual factors such as substance use, mental health challenges and conflicts in relationships contributed to homelessness, it was structural factors such as poverty and high rental rates which, among others, primarily lead to homelessness while exacerbating individual factors. Unfortunately, the study did not ultimately emphasize the need for interventions and

policies that address these structural factors. Therefore, there is a need to further consider how a systems approach can be used to address both personal and structural risk factors.

Lastly, a study by Brown, Goodman, Guzman, Tieu, Ponath and Kushel (2016) sought to examine pathways into homelessness among older adults in California, United States of America. The study recruited 350 participants through a population- based sampling and the participants were engaged in interviews. Findings from this study spoke both to the personal mental health challenges of participants, as well as the structural issue of low socioeconomic status as elements of their pathways into homelessness. The researches indicated the need to identify and adapt suitable services and interventions to meet the needs of the homeless population. Therefore, it can be seen how both personal and structural factors interact in pathways to homelessness, including but not limited to mental health concerns.

Refugees and Homelessness

Refugees, like other newcomer groups, are at increased risk of homelessness as compared to the general population (Preston et al. 2009). However, the rate of homelessness among refugees may vary in different contexts. This can include differing experiences by refugee ‘class’, also known as ‘legal status’, such as Government Assisted Refugees (GARs), Privately Sponsored Refugees (PSRs), and Refugee Claimants (RCs). Research among homeless refugees highlights common themes such as low income due to low social assistance, social isolation, unemployment, inadequate language skills to secure jobs and housing, household size, and refugee/legal status as contributing factors to refugee’s inability to secure housing (Murdie, 2010). In this section, research on refugees and housing challenges is presented.

A study by Sherrell (2010) on the housing experiences among refugees in Winnipeg and Vancouver examined the housing outcomes of Government Assisted Refugees and refugee claimants. This study included 20 key informants working in the settlement sector and 80 refugees who were interviewed about their housing experiences. The study revealed that refugee's legal status influenced their income security, access to settlement services, and housing outcomes. For example, refugees who had legal permit to live in Canada (GARs and PSRs) could gain employment to boost their financial standings and secure appropriate housing, while claimants could not. The study also revealed that refugee's location equally influenced outcomes as services vary from one community to another. In the study, while both GARs and RCs in Winnipeg had access to orientation services and temporary accommodations, RCs in Vancouver were excluded from these services. Although this study pointed out salient issues facing the homeless refugee population, further research is needed to identify other factors that contribute to homelessness among refugees.

Murdie (2008) in his study on pathways to housing among refugees evaluated the experiences of refugees in accessing permanent housing in Toronto. The study analyzed the assumption that Refugee Claimants in Toronto experienced greater difficulty in acquiring a home than Government Assisted Refugees. The results confirmed the assumption that refugee claimants faced more difficult pathways given their temporal legal status. However, housing affordability remained a challenge for both groups due to high rental rates. The authors indicated the need for further research on ways to reduce homelessness especially among refugee claimants as the most vulnerable sub-category of refugees in Canada.

Other studies have revealed factors such as social support and ethnic background as contributing to homelessness among refugees. Sherrell, D'Addario and Hiebert (2007) investigated precarious housing conditions among refugee claimants who have successfully obtained their refugee status in the Greater Vancouver Regional District. This study highlighted barriers such as colour, race, gender, and ethnicity as barriers which sometimes impede immigrant's access to housing. The findings of the study indicated that most house owners were unwilling to rent to refugees because of their race, colour, ethnic background and gender. Again, the study indicates some structural barriers such as high rental rates, low vacancy rates and lower financial standings of refugee claimants and thus contributing to their housing challenges. Overall, this study highlights the barriers impeding refugee's, most especially RC's, access to adequate housing.

A similar study by D'Addario, Hiebert and Sherrell (2007) examined the role of social capital in housing trajectories of immigrants. The study was based on results obtained from the study of absolute and relative homelessness among refugees and other immigrant groups in Canada. The findings revealed that social support plays a significant role in refugee's access to housing while lack of social networks or support contributes to homelessness or precarious housing. Refugee Claimants who had low social support were reported to face high rates of hidden homelessness. However, not much is known about the support systems most especially for refugee claimants. With GAR and PSR, several studies have equally indicated the support systems for these groups are inadequate, subsequently leading to mental stressors and risk of homelessness. With the increasing number of refugees in the country, most especially with Refugee Claimants, there is a need for more research on their social capital and support systems to effectively develop interventions needed to address and prevent homelessness among this population. In summary, several

studies reveal structural and personal factors as major causes of homelessness among refugees yet the relationship between the mental health of refugees and its potential role in pathways to homelessness has not been explored.

Homelessness and Health

Access to safe, adequate and affordable housing is integral to one's health. People experiencing homelessness have high levels of morbidity and high mortality rates (Hwang, 2001). As illustrated below, they are at risk of a wide range of health complications including mental health challenges and infectious diseases. Compared to the general population, those experiencing homelessness are at an increased risk of premature death due to factors such as poverty, non-adherence to medical prescriptions, and delay in seeking medical treatment (Montgomery, Szymkowiak, Marcus, Howard and Culhane, 2016). Findings related to homelessness and health are summarized in Table 2, and key studies on physical and mental health will be presented before focusing more particularly on the mental health of refugees.

A study by Hwang (2001) in partnership with the Canadian Medical Association explored the relationship between homelessness and health. This quantitative study was based on homelessness data collected by statistics Canada. In the study, the homeless population were known to experience common medical problems such as seizures, chronic obstructive pulmonary disease, arthritis and various skin and foot problems. Infectious diseases including Tuberculosis and HIV are also known to be prevalent among people experiencing homelessness. As a recommendation, Hwang (2001) suggested that more research is needed to unveil other health complications faced by people experiencing homelessness and identify better ways to deliver care to this population.

Table 2. Homelessness and health.

Author	Title	Sample population	Findings
Hwang (2001)	Homelessness and health	Homeless adults	The study conducted based on the homeless data by Statistics Canada revealed <ul style="list-style-type: none"> • Medical problems (seizures, COPD, skin and foot diseases, HIV and Tuberculosis) as prevalent among the homeless population.
Haldenby, Berman and Forchuk (2007).	Homelessness and Health in Adolescents.	Homeless adolescents	<ul style="list-style-type: none"> • Negative health outcomes ranging from physical health to mental health challenges. • Unsafe sexual practices and substance abuse leading to poor health outcomes.
Schanzer, Dominguez, Shrout and Canton (2007).	Homelessness, health status and health care use.	Homeless adults	<ul style="list-style-type: none"> • Residential instability lead to increased levels of physical diseases and mental health challenges. • Access to medical services in shelter homes improved their health outcomes.
Fazel, Khosla, Doll and Geddes (2008)	The Prevalence of Mental Disorders among the Homeless in Western Countries.	Homeless adults	Mental health challenges (major depression) was common among the homeless due to high alcohol dependence and substance abuse which leads to homelessness.
Bruce, Stall, Fata and Campbell (2014)	Modelling minority stress effects on homelessness and health disparities among young men who have sex with men.	Homeless young men who identify as LGBTQ	<ul style="list-style-type: none"> • Homelessness and stigma contributed to negative health outcomes notably major depression. • (African, American, and Latinos) homosexual's reported higher frequency of

			stigma leading to high levels of substance abuse and homelessness.
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A study by Haldenby, Berman and Forchuk (2007) investigated the experiences of homelessness among adolescents and its impacts on their health. The qualitative study which involved 13 respondents, six girls and 7 boys, revealed that homelessness had an extensive impact on health. The study also pointed out that homeless adolescents experienced mental health challenges as well as physical health challenges. Many homeless youths were engaged in unsafe sexual practices such as “survival sex” where they exchanged sex for money and this made them highly susceptible to infections like HIV. However, the study revealed that despite the numerous health challenges faced by this population, the respondents perceived they received little support. The authors therefore suggest the need for further research on the health of homeless adolescents and services to support them.

Schanzer, Dominguez, Shrout and Canton (2007), in their study, explored the health status of individuals who had recently become homeless in the United States as well as their access to health care. This longitudinal study included 445 participants who had spent a maximum of 18 months in various shelters. The study revealed that the newly homeless population were impacted substantially by their residential instability and experienced high levels of physical diseases and mental illness. Most especially, they experienced high levels of major depression, anxiety and substance use disorders. However, as participants stayed in the shelters for some time their health status improved due to access to medical care available in the shelters. This therefore suggests the need for more research on the homeless population exploring the relationship between their health and access to stable housing.

Fazel, Khosla, Doll and Geddes (2008) conducted a study to explore the prevalence of mental disorders among homeless adults in western countries. This quantitative study involving 5,684 respondents indicated that mental health challenges such as major depression were common among those experiencing homelessness and this was mainly due to alcohol dependence and substance use. Among the sample, increased dependence on alcohol negatively affected mental health leading to poor mental health outcomes and sometimes homelessness. However, a more nuanced understanding of the bi-directional nature of substance use and mental health is important, as is connecting personal factors of substance use and mental health to structural factors such as racism, social exclusion, or other social challenges impacting refugees.

Among those who identify as LGBTQ2S, a study by Bruce, Stall, Fata and Campbell (2014) examined in particular the health disparities among homeless homosexual men in New York. This quantitative study involving 200 participants explored the relationship between the stigma related to their sexual orientation, homelessness, and the experience of major depressive symptoms. This study revealed that homosexual men who faced homelessness, aside from the stigmatisation, experienced negative health outcomes with multiple paths to major depression. The study also indicated that immigrant men (African and Latino) who are homosexual report higher frequency of stigma and this contributed to high levels of substance use and homelessness amongst them, leading to health challenges such as major depression. This study provides a clearer interconnection between structural factors, personal factors, and the experience of homelessness.

Refugees and Their Mental Health

Being forced to leave one's home in and of itself can be a traumatizing experience. Additionally, the causes of forced migration often include violence, loss, and other

traumatizing experiences (Kirmayer, 2011). Therefore, refugees are at increased risk of mental health challenges based on complex and compounded traumas (Kirmayer, 2011). This is supported by data, as socially marginalised groups such as immigrants and refugees experience a higher rate of mental illness than the general population (Hanson, Tuck, Lurie & McKenzie, 2012). Particular research on the mental health challenges of refugees is presented next.

Agic (2002) together with the Centre for Addiction and Metal Health (CAMH) examined the mental health status of immigrants including refugees. In their report, they indicated that participant's mental health was influenced by refugee status, length of residence, age at arrival, country of origin, and visible minority status. The study indicated that refugees had higher rates of mental health challenges such as post-traumatic stress disorder and psychotic disorders. This study, therefore, confirms the high prevalence of mental health challenges among refugees.

Another study by Fazel, Wheeler, and Danesh (2005), investigated the prevalence of mental illness among refugees. This quantitative study employed a systematic review approach to evaluate psychiatric surveys conducted among refugee populations who were diagnosed with any major psychiatric disorder such as post-traumatic stress disorder, anxiety, or major depression. 20 eligible surveys were included in the review and the results included 6743 refugees from seven western countries. The study suggests that about 1 in 10 refugees in western countries experience post-traumatic stress disorder, about 1 in every 20-experience major depression and about 1 in 25 experience an anxiety disorder. Interestingly, this study indicated that the prevalence rate of major mental health challenges may actually be low as compared to the commonly cited claims of refugees having higher rates of mental health challenges. However, it is a notable risk that making assumptions

based on having a formal diagnosis can be problematic as certain populations may face barriers to access to care and may therefore be under-diagnosed.

Kirmayer and colleagues (2011) conducted a review on the common mental health problems among immigrants and refugees in Canada. The study also examined the influence of migration on the mental health status of refugees and immigrants. The findings revealed that the types of mental health problems among refugees and immigrants were influenced by the nature of their migration experience. Experiences of adversities among refugees prior to their migration and after resettlement led to higher rates of mental health challenges. The triggers of these challenges were related to common settlement challenges such as language barriers, cultural differences, acculturation stress, and unemployment.

In spite of the Fazel, Wheeler, and Danesh (2005) findings outlined above, among refugee women, mental health challenges are found to be highly prevalent when explored through small, qualitative studies. Ahmed, Bowen, & Feng (2017) confirmed this in their study that explored maternal depression among Syrian refugee women who had recently migrated to Canada. This mixed method research involved 12 Syrian refugee women who migrated to Saskatoon between the years of 2015 and 2016. The results of this study indicated that most of these refugee women screened positive for possible depression and anxiety. Although this study involved a smaller sample size, the findings revealed that refugees, most especially refugee women, are predisposed to mental health challenges due to barriers faced in accessing health care and the stresses faced during their integration. A more personal and subjective study might also provide a safer venue for refugees to explore their mental health concerns than large surveys and wouldn't be skewed by the requirement for a formal diagnosis.

Housing and Refugee Mental Health

In this final section of this literature review, we look to research that has pulled together all components of housing, mental health, homelessness, and the experience of refugees. Similar to the general population, the absence of safe, adequate housing for newcomers or refugees has the potential of impacting their physical and mental health. However, as noted above, this is also in the context of refugees potentially being at greater risk of experiencing mental health challenges in general. Apart from acculturation stressors such as unemployment and language barriers, housing instability may significantly impact the health and wellbeing of refugees.

Most relevant to this concern is a report by the Canadian Mental Health Association (2014), which explored homelessness among newcomer and immigrant youth. This study revealed that newcomer youth who faced challenges with settlement and housing services reported high levels of mental health challenges. This emanates from the unsafe environments in which they found themselves due to the absence of safe, affordable, permanent, and adequate housing. Ultimately, this report begins to show how refugees enter into homelessness, and the relationship this may have with mental health challenges, both as cause and as outcome. However, what is lacking here is an understanding beyond housing challenges generically to pathways into homelessness in particular.

In a similar vein, Ziersch, Walsh, Due and Duivesteyn (2017) conducted a study exploring the relationship between housing and health for refugees and asylum seekers in Australia. This qualitative study was conducted with 50 refugees in South Australia. Unsurprisingly, the results of the study indicated that housing was a key component of health and wellbeing for newcomers. The respondents, most especially Refugee Claimants, who lived in poor housing conditions experienced negative health effects, including poor

mental health. Again, however, poor housing conditions are different than absolute housing loss. Therefore, what tips the balance from those struggling with their housing and mental health to becoming homeless? While the study confirmed the need for improving housing quality, stability, and affordability among refugees to improve their health outcomes, there is further work required to particularly explore homelessness among refugees.

Critique of the Literature

There are few studies examining the mental health experiences of refugees through their pathways to emergency shelter. In most studies, homelessness among refugees is investigated in light of systemic factors such as unemployment, low socioeconomic status among others with less emphasis on factors such as mental health in spite of the consistent findings that homeless individuals disproportionately suffer mental health challenges (Goering et al. 2002). Likewise, most research about homelessness does not explicitly indicate its significance to nursing or nurses. While some studies have explored the mental health experiences of the homeless population and homeless immigrants, rarely do studies explore the unique mental health experiences of refugees through their pathways to emergency shelter.

Ethical Considerations

Ethics approval for the primary study was granted by the Western University's Health Sciences Research Ethics Board, which included an approval for secondary analysis. Prospective informed consent was obtained in the primary study and so participants were not re-contacted for this secondary study (see appendix A: letter of information and consent). Data was well protected and secured to maintain participant's confidentiality and protect their security. Data from the primary study were already made anonymous through the removal of identifiers including names. Finally, data were saved

on a password encrypted drive and when the analysis was finalized, data were deleted from the drive.

Methodology

A qualitative secondary analysis was used to explore the mental health experiences of refugees who were facing homelessness in two Canadian cities. The data for this study were derived from a primary study which investigated the pathways through which refugees ended up in emergency shelters. Secondary analysis as defined by Heaton (2004) includes the use of an existing data set extracted from previous studies and dwells more on data that were sourced from transcripts of interviews, tapes, or field notes of the primary study.

The three main reasons for conducting a secondary analysis as per Heaton (2004) are: conducting a new study by posing new research questions, improving upon an existing research and synthesizing research across studies. In this study, the use of secondary analysis was to address a new research question that seeks to develop new findings among refugees facing homelessness. The primary study identified some factors that influenced refugees' pathways into emergency shelters and some strategies to prevent this. With this secondary analysis, the focus is to specifically explore how the mental health experiences of refugees may influence their pathways into homelessness.

Sample and Setting

A purposive sampling technique was employed in the primary study to recruit participants. The participants for the study included any refugee 16 years and older, facing homelessness, living in emergency shelter, and who consented to partake in the study. Refugees who participated in the study were of diverse ethnicities (African, Asian, Arab) with different primary languages, which were mostly English and Arabic. The interviews

were conducted primarily in English, or Arabic with interpretation into English. The study sample included 15 refugees who were residing in two emergency shelters in a mid-sized and a large urban area in Ontario. The sites were chosen due to local media reports of high patronage of these emergency shelters by refugees. The secondary analysis focused on all transcripts from these interviews. A total of 15 refugee claimants constituting 11 males and 4 females were included in this study. Out of this, 13 migrated from African countries and 2 from Asia. Due to some of the participants inability to speak conversational English, two participants required the services of an interpreter during the interviews.

Data Collection

Qualitative data was collected in the primary study through semi-structured interviews (see Appendix B: Semi-structured Interview Guide). The interviews were conducted in the emergency shelters where participants were residing or at more public spaces such as coffee shops based on participant preference. Interviews were audio-recorded and transcribed verbatim. These interviews lasted on average thirty to sixty minutes, and each participant was interviewed once with no follow-up interviews. The semi-structured interviews were guided by questions which explored areas such as: Where participants were coming from geographically; When they started facing difficulties in their countries of origin; At what point did they consider leaving their country and why they chose Canada; How they arrived in Canada; What led them to accessing shelters; Their well-being including their physical and mental health and any influence on their decision to access emergency shelter; Their experiences of discrimination or prejudice and how they were faring in shelters; Their ability to access social assistance and the refugee claimant processes; and their future plans for living in Canada.

Data Analysis

In this study, the data analysis is both inductive and deductive. It is deductive as mental health experiences is the concept of focus as a supplementary secondary analysis. It is equally inductive in that a thematic analysis approach is employed, and themes were generated with reference to the research question. Thematic analysis as outlined by Braun and Clarke (2006) was used to analyze the data. This approach was chosen due to its fittingness to this data. According to Braun and Clarke (2006), thematic analysis is used in analyzing narrative materials or life stories and its description and interpretation are both inductive and deductive. Also, thematic analysis as a flexible research approach, yet, provides complex description of the data.

First, transcripts were read to gain insight into the data. The audio tapes were also accessed to understand intonation within the interviews. The transcripts were read for a second time, before a preliminary coding scheme was developed. The qualitative software NVIVO was used to aid data analysis and data management. With the use of functions like word frequency, common words that were utilized contributed to the development of the initial codes. Participant's words were considered in the generation of codes, especially the text that related to the major concept of mental health experiences. The initial codes were shared with my research supervisor, who is also the principal investigator for the primary study, for refinement and further analysis.

From these codes, preliminary themes were drafted and submitted to my research supervisor who served as for a source of validation. The themes that were finally developed formed the structure of my findings for this study and they are presented herein. As per Braun and Clarke (2006), the writing of findings and research team revisions formed the final phase of analysis of the study. My involvement as a research assistant in the data

collection process for the primary study also gave me a first-hand information about the participants. This helped me in the analysis of the data as I reflected on my field notes that were gathered during my interaction with the participants.

Rigour

To maintain rigour in this secondary analysis, the principles of (Guba, 1981; Lincoln & Guba 1986) and (Szabo & Strang, 1997) were applied. First and foremost, I position myself as an outsider due to the fact that I have not experienced homelessness personally and am not a refugee. While this perceivably may lead to limitations such as a lack of understanding of lived experiences or systems and support for the homeless in a Canadian context, I worked with my research supervisors as a source of expertise. Their understanding of homelessness, family homelessness, and Canada's refugee and immigration systems assisted me in understanding how participant stories fit within broader social structures and pointed me to the most pertinent existing research to situate my findings. Personally, I committed to reading extensively on the field of homelessness and refugees. Through my various assignments and reviewing my literature, I committed to gaining deeper knowledge and becoming well versed in this area of study. I also volunteered to be a part of the team during the data collection for the primary study and as such this gave me deeper insight into this field. My participation in the primary study also provided me first-hand information and engagement with the data set used in this secondary analysis. This enabled me to overcome the limitation of the lack of access to data sets which is frequently associated with secondary analysis (Szabo & Strang, 1997). Also, in a qualitative study where researchers are supposed to attend to both verbal and non-verbal cues, employing secondary analysis which involves the use of an existing dataset can also be identified as a concern. However, as mentioned, these concerns are mitigated in two

ways, by being involved with data collection on the primary study and by having the principal investigator from the primary study as the research supervisor for the secondary analysis.

Furthermore, constant communication with my supervisor who is the principal investigator for the primary study enhanced fittingness and credibility. We discussed findings from both the primary study and from my analysis in order to collaboratively validate the themes I generated from the data. The primary study interviews were conducted with support of an interpreter when necessary. These enabled participants to speak using their first languages. According to Thomas (1993), using respondent's first language in the data collection complements the process of identifying the implied meanings of participant's words and thus limits some risk of making assumptions about the data. Also, the inclusion of diverse viewpoints of participants in the data enriches the credibility of a study (Lincoln & Guba, 1986), and participants in the primary study for this secondary analysis had a diverse range of pathways to homelessness. I embraced diversity as a part of the analysis as I valued the varied and diverse perspectives and was not looking out for only one truth. With transferability or applicability, (Guba, 1981) indicates that ensuring fittingness of a study enriches its applicability while employing purposive sampling methods deepened a study's transferability (Bitsch, 2005). For confirmability within this study, I maintained a reflective journal throughout to note my feelings, personal biases, thoughts about homelessness, and my perceptions to remind me of my own positionality and perceptions throughout the analysis. Lastly, dependability is sought by providing a rich description of the research methods and by connecting quotes to the explanation of the findings to demonstrate the relationship to findings (Szabo and Strang, 1997).

Findings

In this secondary analysis, data were sought to address the research question: *How do the mental health experiences of refugees shape their pathways to homelessness?* The analysis is presented in three themes that explains how the mental health experiences of refugee's shape or do not shape their pathways to homelessness. The themes are: (a) *Compounding marginalization*, (b) *Mental health is precarious*, and (c) *Homelessness is caused by a lack of housing*.

Compounding Marginalization

Through an intersectional lens, it is notable that many of the participants experienced several points of marginalization, both within their home country and upon arrival into Canada. Most participants left their home countries due to threats to their lives such as constant persecution from government or families and a sense of insecurity they faced in their home countries. While analyzing the text from the data gathered, one common theme that was reported among most participants was the fear of threat to life. One example of a common experience was that refugees from an African background who are LGBTQ2S reported a consistent sense of insecurity in terms of their safety. These participants indicated that once their families or communities got to know of their sexual orientation it was difficult for them to remain in their home environment. Other participants indicated they were arrested by the police for imprisonment or had their partners arrested when their communities or families became aware of their sexual orientation, causing them to flee from their homes.

Participants noted that these concerns were related to both legal and cultural ramifications of identifying as LGBTQ2S in many nations. For these individuals, marginal sexual identities were part of the preliminary pathway to homelessness in Canada. A

participant stated, “I left my country because I was caught with my lesbian partner. And to escape police arrest my dad told me it was not safe to live in the country and so asked me to leave the country. I arrived in Canada with no known contacts but with an agent and false identity”. The goal of seeking safety due to hardship was common among all participants as most left at the urging of family members to seek safety and security. Other participants migrated from secondary countries, such as the United States, due to discrimination they faced there and an unsuccessful refugee claim.

Many participants lived the marginality of poverty in their home communities. This led to their inability to access legal immigration processes which can be very costly. Therefore, most participants were irregular migrants, often seeking the services of more affordable but not necessarily legal “agents” to assist them with their migration to Canada. Some participants stated, “Our families contacted agents who helped with our migration to Canada, but we couldn’t verify if these agents were genuine or swindlers.” Another participant confirmed that he migrated to Canada with false documents. This marginalization due to poverty also meant that most participants arrived in Canada with limited knowledge of the host society and limited financial support to access basic needs such as housing. Hence, they had to resort to emergency shelters as temporary homes, which later became long term homes due to their vulnerable situation post-migration. This was expressed by a participant who stated, “My mother paid an agent to bring me here to Canada. I did not know anything about Canada or anybody here. Once I got here, the Agent told me he was returning back meaning I had to fend for myself.” Another participant stated, “My family paid an agent to bring me here and the agent provided me with fake documents and so I was detained at immigration.”

These experiences of marginality continued upon arrival in Canada as participants experienced discrimination while homeless and in shelter. Some of this discrimination was experienced from staff of housing and social services. A participant noted, “We face discrimination in the shelter due to our color and we also face discrimination because sometimes staff perceive us as we have intentionally decided to stay homeless and so resort to treating us unfairly and verbally abusing us.” Another participant stated, “One staff was very rude to me and that kept calling me refugee, telling me I am a refugee and that I came with a fake visa.” To the participant, this act was disrespectful and felt discriminatory as all shelter residents were in the same situation of being homeless but only she was identified by her citizenship status.

To be a “refugee” was a marginalized identity even within service organizations such as emergency shelters for families. Participants expressed a sense of the marginality of experiencing homelessness, sensing that this identity was also a point of social exclusion. As a participant noted, “We sometimes feel rejected due to our homeless state.” They worried whether they could escape this experience, find home, and achieve belonging.

Participants also experienced the marginality of their position when seeking health care assistance. Although participants qualified for the Interim Federal Health Program, they were required to provide documentation in order to access this service which was a challenge for many. Firstly, participants described how they were required to have made an official refugee claim, which most times was delayed due to their inability to understand the process and provide documentation required for a successful claim. A participant stated, “We were assisted by staff in the shelters to make our refugee claim but was sometimes delayed.” Secondly, care covered is only what is generally covered under

provincial health plans, meaning that costs such as medication are not included. As such, participants reported a delay in seeking care for health concerns, including mental health concerns. A participant noted, “Sometimes I am scared to go to the hospital even when I am sick. When my room mates and the shelter staffs ask me to go to the hospital I tell them no, I do not want to go to the hospital.” This is because the participant was afraid to visit the hospital because she had not successfully gone through the refugee claimant process and feared being deported back home if accessing public services.

In the rental market, refugees also face discrimination. Some participants indicated that they were rejected by potential landlords if they disclosed their identities as refugees. A participant stated, “I have tried several times to get a house, but it’s really hard. Even the housing office is helping but it is still hard, when you go to look for the house, then the owners get to know you are a refugee, they just give up.”

Mental Health is Precarious

Refugees, like other immigrants, mostly arrive in good physical and mental health as compared to the general Canadian population, exhibiting the “healthy immigrant effect” (Vang, Sigouin, Flenon, & Gagnon, 2017). However, it is also known that their health declines after having lived in their new environment for some time, in part due to the challenges they may face with their integration (Vang, Sigouin, Flenon, & Gagnon, 2017). Living compounded marginal identities as a newcomer may affect one’s health, especially mental health. However, while mental health challenges are a known risk factor causing homelessness among other populations, a different story emerged from the participants in our research. For these individuals, it was much more of a case of declining mental health in part related to homelessness, than pre-existing mental health challenges leading to homelessness. Participants did not identify mental health challenges as particularly

significant in their lack of housing. A participant stated, “Even though I am stressed and sometimes I am depressed due to what I went through back in my country, it is not the cause of my homelessness.” Another participant also indicated, “I was stressed prior to leaving my country but I am becoming more stressed living in this shelter with no permanent home for me and my family.”

While participants did not identify mental health challenges as a cause of their homelessness, they did identify that their mental health was precarious. For many participants, their journey to Canada in and of itself was traumatizing and that may potentially negatively affect their mental health. A participant spoke to the stress she went through with the immigration process before she was allowed into the country stating, “I was detained at the border for days for entering the country with fake documents. I had to sleep on the bare floor for days and I was so depressed.” Nonetheless she added that this mental stress did not influence her decision to access emergency shelter, but rather the lack of contacts and as well as the inadequate resources to acquire a place for herself led her to being homeless. Another participant spoke to his ongoing mental stressors related to financial challenges, but again indicated this stress did not itself lead him into emergency shelter, rather it was the financial limitations.

Several participants noted the effects of homelessness on their mental health. A participant illustrates this saying, “After staying in this shelter home for months, I am getting more stressed and sometimes feel depressed. My wife occasionally breaks into tears because we are homeless, and we do not have a place on our own to be able to take care of our children very well. My children are new to the food here, but we cannot cook home meals for them because we do not have a place of our own. We occasionally go out to the restaurant that sells food they like but we cannot do that often due to insufficient funds.”

Another participant stated “I feel more sad and depressed staying in this shelter. I am a pregnant woman and I do not feel comfortable here due to the strict schedules here in the shelter. I get hungry more often, but I am not allowed to save food since it is against the rules of this shelter and I am not equally allowed to buy food outside and bring it here. So, I most times starve as a pregnant woman and this is getting me more stressed and depressed.” She added she was not depressed before coming to this shelter but was now becoming depressed. Participants indicated the conditions of some shelters as depressing and the thought of being homeless and having to live their lives under certain rules and regulations as depressing.

Experiencing homelessness also causes the fear of an unknown future and this influences participant’s mental health. Participants noted that the thoughts of obtaining stable housing while simultaneously worrying about their status in the country is very stressful. Most participants indicated that they experienced the worries of integration while also being homeless. A participant indicated that, “I am homeless and so I cannot do anything meaningful with my life now. I need to have my family well sheltered to be able to have the peace of mind to commit to other things. I cannot even find work because I am homeless, and this stresses me a lot.” Another participant indicated, “While in the shelter home, sometimes I feel like going crazy and sometimes...I have those thoughts of like to kill myself or just harm myself so all what I can do is to tell the staff sometimes and ask for help.”

Homelessness is Caused by a Lack of Housing

Homelessness among participants in this study is not caused by mental stressors but rather due to a lack of housing. Most participants arrived in Canada without predetermined accommodations. They escaped from their home country to Canada with no

known contacts here or enough resources to temporarily rent a home, and thus resort to accessing various emergency shelters for accommodation. In this sample, unofficial or irregular means of arriving in Canada was mentioned by some of the participants. They expressed their heightened need to leave their home country due to potential threats to life and thus resorted to paying money to various “agents” in order to process their travel documents. However, the lack of social networks as well as low financial status renders them homeless upon arrival.

Aside from this, the “agents” they involved in their migration processes most times provided them with unoriginal documents, rendering these documents useless over the long-term and adding further barriers which prevents them from becoming established in Canada. One participant indicated: “It was urgent for me to leave my country when my family members and community got to know I had a different sexual orientation. So, in order to save my life and save my family from shame, my mother contacted an agent and paid huge amounts of money to the agent to get me out of the country. Initially I did not even know the country I was travelling to until I was later told that I was coming to Canada, but then with another person’s passport and documents.”

Arriving without proper documentation created a huge barrier to accessing housing and income to support housing. Essentially, urgency to migrate led to use of alternative sources of travel, but these alternative sources created significant limitations to housing access upon arrival. Aside from their irregular status, most participants faced barriers to obtaining an adequate income through employment due to the lack of appropriate skill sets, lack of documentation, unacknowledged educational credentials from their home country, or language barriers, thus preventing financial stability. A participant indicated, “When I got to Canada, people could barely understand what I say. Even to locate a shelter was difficult

for me because no one understood what I said.” Later they stated, “It was when I met someone who was also from my home country who could understand me, and he helped me locate a shelter.” This language barrier was another hurdle to overcome to achieve income stability and sufficient income for housing. Although the participants indicated that this experience was stressful and a depressing one, the stress and depression was not the reason for accessing shelter, rather it was due to a lack of housing.

Participants noted that their lack of housing was related to lack of financial means, no credit history, and discrimination they experienced from potential landlords. While this created mental stress for participants, their pathway into shelter was not due to this mental stress. Participants spoke to the challenges of obtaining rental housing with no credit history, “We are denied anywhere to get affordable rental suites due to [no] credit history.” Other participants indicated, “We do not have any credit history at all but that is one of the most important things being asked once we go in for a negotiation on rental units, and so we are not able to secure homes for ourselves and family.” For participants, housing challenges were the cause of their homelessness. Their mental health experiences were stressors to them but were not identified as precipitating homelessness. Although most participants expressed feelings of sadness, stress and occasionally depression, they felt this did not influence their decision to access emergency shelter. One participant stated, “Although I sometimes feel sad or depressed, that was not the reason for me accessing this shelter. I accessed it because I just did not know anybody here in Canada.”

Discussion

The first theme ‘Compounding Marginalization’ depicts how refugee claimants faced marginalization both within their home country and after arrival in Canada. For many refugees, especially refugee claimants who fled their home countries, they faced

threats to themselves and to their families in addition to living in extreme poverty. For several participants, threat to life was as a result of their LGBTQ2S identity. In many countries, expressing a sexual orientation other than being heterosexual is considered illegal and punishable by imprisonment and even death (World Report, 2019). In this study, some participants described how they were imprisoned or had their partners jailed when their communities or families became aware of their sexual orientation, which made them choose to flee home. Alternatively, some participants faced threats to life as a result of political instability. Fleeing one's home country meant arriving with limited means, often no contacts, and no connection to local communities. Other participants fled from secondary countries, such as the United States, due to discrimination they faced there, and little hope of a successful refugee claim in spite of experiencing persecution. This is consistent with the previous reports on marginalization faced by the LGBTQ2S community. For example, the United Nations Refugee Agency (2019) noted that the LGBTQ community continuously face discrimination in several parts of the world on a daily basis and so they seek asylum in other countries. Similarly, a report by the World Economic Forum (2019) also confirmed that the LGBTQ2S community in many countries faces discrimination. Even in countries where there were no criminal charges against LGBTQ2S people, traditions, social norms or customs may make life difficult for this population.

Aside from the marginalization faced prior to their arrival in Canada, it is noted that participants also faced marginalization upon their arrival in Canada. While experiencing homelessness, participants revealed that they also experienced discrimination and unfair treatment by shelter staff as well as housing providers. This confirms the work of Colley (2017) which revealed that refugees in Halifax experienced housing discrimination due to

the refusal of some landlords to rent their units to them. By residing in an emergency shelter, participants felt left out of society. In terms of social service staff, participants noted at times a lack of cultural sensitivity or disrespect related to one's refugee status. In the context of these compounded marginalities, it is perceivable that mental health will be precarious.

“Mental Health is Precarious” is the second theme proposed from the data. This theme highlights how refugees are at risk of experiencing mental health challenges, particularly in the context of homelessness. Refugees, like other immigrants, mostly arrive in good physical and mental health as compared to the general Canadian population, exhibiting the “healthy immigrant effect” (Vang, Sigouin, Flenon, & Gagnon, 2017). However, it is also known that their health declines after having lived in their new environment for some time, in part due to the challenges they may face with their integration (Vang, Sigouin, Flenon, & Gagnon, 2017). It has well been established that mental health is a major contributing factor to homelessness among the Canadian population. However, among the refugee claimants in this study, mental health concerns were not identified as the cause of their homelessness but instead arose in the context of homelessness. Munn-Rivard (2014) confirms in his report that housing is a determinant of mental health and that homelessness predisposes people to poor mental health. Good housing positively impacts an individual's well-being and promotes independent functioning as well as social connectedness (Munn-Rivard, 2014). He further indicates that individuals facing homelessness experienced high levels of stress, poor support resources, and feelings of hopelessness (Munn-Rivard, 2014). Another study by Aleman (2016) also indicated that people experiencing homelessness were susceptible to poorer mental health status than individuals who are housed. This study also confirmed this relationship by

indicating that about 20-25% of the homeless population suffer from some form of mental illness. For participants in this study, most had experienced or witnessed some form of trauma prior to their arrival in Canada or through their migration experience, and thus are at risk of mental health concerns. However, the stress, sadness, depression, and even suicidal ideation named by participants were all post-homelessness. Therefore, we highlight that mental health is precarious in the context of refugees experiencing homelessness but as identified by the participants in this study, it does not inherently occupy the same causal position in pathways to emergency shelter as seen within Canadian resident populations.

While mental illness in this study was not identified as part of the pathway for refugee claimants to access emergency shelter, lack of housing and lack of funds to acquiring housing were identified as the cause of their homelessness. Therefore, the third and final theme proposed from this study is “Homelessness is caused by a lack of housing.” This theme emphasises that homelessness among refugee and their usage of emergency shelters was identified by participants as related to the lack of accommodations and absence of resources to acquire rental housing. For participants in this study, they were experiencing homelessness due to the lack of affordable housing. Factors such as not having a good credit history limit the ability of refugees to acquire a home. This finding was consistent with a study conducted by Hiebert (2011), which indicated the lack of credit score history as one of the barriers preventing refugees from acquiring a home. Likewise, the social assistance which is provided to newcomers was significantly below rental rates in the communities of study. While mental health stressors were evident among our participants, their pathway to shelter was a lack of housing opportunities.

Implications

The results of this study speak to the relationship between homelessness and mental health among refugees. Munn-Rivard (2014) confirms in his report that housing is a determinant of mental health and that homelessness predisposes people to poor mental health. Good housing positively impacts an individual's well-being and promotes independent functioning as well as social connectedness (Munn-Rivard, 2014). He further indicates that individuals facing homelessness experience high levels of stress, poor support resources, and feelings of hopelessness (Munn-Rivard, 2014). Another study by Aleman (2016) also indicated that, people experiencing homelessness are susceptible to poorer mental health status than individuals who are housed and as such, about 20-25% of the homeless population suffer from some form of mental illness. The findings of this study support these concerns in that refugees facing homelessness are predisposed to deteriorating mental health status. Although poor mental health is a well-known predisposing factor for homelessness, for participants of this study this was not their focus. Their mental health experiences such as stress, depression or sadness were troubling, but they did not identify that as the cause of their homelessness. Instead, they became homeless due to a lack of housing and resources to obtain this housing.

Stories shared by our participants confirm the theory of Housing First (Gaetz, Scott & Gulliver, 2013). That is, housing is a foundation for health and wellness and supports for homeless refugees must focus on necessary resources to be able to meet their housing needs. Mental health support services that are culturally sensitive are also important, but so is a rapid exit from shelter into housing. Housing supports could include consideration of ways to address lack of credit, such as relationships between homeless serving organizations and potential landlords to help remove this requirement. While it is positive

that refugee claimants are able to access financial support through provincial social assistance, it is noted that current rates are insufficient to provide stable and safe housing. Housing portions of social assistance in Ontario, Canada range from a maximum of \$390 for an individual to a maximum of \$844 for a family of 6 or more (Ministry of Children, Community and Social Services, 2018). This means that most refugees do not have enough funds to secure homes on their own considering their income range and the high cost of rent, coupled with no credit history.

Again, this study speaks to the oppression and marginalization faced by this immigrant population. Although Canada as a country has committed to assisting refugees, there are still systems and issues that makes refugees feel marginalised and discriminated against. The participants in this study spoke to the oppression and discrimination they experienced in Canada. Aside from these interpersonal experiences, insufficient funds from social assistance can also be seen as structural oppression, which makes this population more marginalized.

Unemployment, lack of resources, and the lack of housing are major factors contributing to homelessness among refugees. According to Wayland (2007), the poor economic outcomes for refugees and other immigrant groups are largely due to lack of stable income. The gap in the employment rates among native born people and immigrants, including refugees, still persists (Wayland, 2007). Skilled refugees are likely to live with low income due to the inability to attain jobs that match their skills sets. Therefore, more job opportunities with flexible job requirements are needed to enable refugees who possess the right skill sets to acquire jobs and thus be able to secure housing for themselves. Additionally, refugee families in shelters with children require childcare support if the parents are to secure jobs. Currently, child care costs disproportionately affect refugee

families due to their low income. Although childcare subsidies are provided by municipalities across Canada, these are limited in number and most have waitlists (Johal & Granofsky, 2015). This means that families experiencing homelessness are in a way trapped on social assistance that is insufficient to meet housing costs. Hence, subsidized childcare spaces need to be increased and should be readily available to families in poverty.

A final implication of this study is that it continues to expose as a myth the idea that refugees and immigrants are arriving to Canada in ill health. Rather, most newcomers generally arrive in good health leading to the established concept of the “healthy immigrant effect” (Vang, Sigouin, Flenon, & Gagnon, 2017, pg. 210). However, structural vulnerabilities and systemic barriers such as housing challenges, discrimination, and difficult pathways to permanent settlement lead to barriers to the social determinants of health (Mikkonen & Raphael, 2010). This can lead to deterioration of their health over time, including mental health.

The findings of this study have implications for policies related to resource assistance, service-delivery, and models of support. In terms of resource assistance, adequacy and stability of income needs to be a priority, including both social assistance rates and pathways to employment. In regard to service-delivery, culturally safe care should be provided across sectors (Mangrio & Sjögren Forss, 2017), to ensure refugees are not experiencing discrimination while accessing housing or health services. Nurses and social service providers should consider respectful engagement with this population in order to provide culturally sensitive care. Research in the future should explore promising pathways to rapid re-housing for refugees in shelter as findings of this study revealed that the prolonged stay of participants in shelters negatively influenced their mental health

status. Additionally, research should uncover what mental health supports are ideal for homeless refugees as preventative measures.

Limitations

This study is a secondary analysis, and as such, there are limitations with regards to analysis of a research question that is peripheral to the subject of the primary data. Mental health experiences were not central to the primary study, hence data from some participants was limited. If this research was to be conducted as a primary study, several questions exploring the mental health experiences of participants would have been included in the interview guide. That said, there was sufficient data to address the question and in particular data from the primary study did address mental health services. Another limitation of this study is the interviews consisted of individual refugees and refugee families who had or were already experiencing homelessness and thus some participants having to reflect back on their pathways into homelessness and their mental health experiences included historical recall rather than recent or current experiences. Another limitation of this study is the use of an interpreter as participants may not be comfortable sharing very personal issues of marginalization through an interpreter. Finally, the lack of information on some demographic factors, such as participants' source of income or their sexual orientation, is another limitation of the study.

Conclusion

Three themes were identified in the findings of this study: *compounding marginalization, mental health is precarious, and homelessness is caused by lack of housing*. While mental health experiences are a known contributing factor in pathways to homelessness, for our participants, this was not the case. For these refugee claimants, mental health challenges were not identified as a factor in pathways to homelessness, but

more so homelessness predisposed them to experiencing mental health challenges. Instead, a common theme among homeless refugees, especially refugee claimants, was the insufficient resources and the lack of affordable housing services to support them. Therefore, by meeting the needs of refugees around housing, income, and employment, we can hopefully ensure rapid exits from homelessness.

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CHAPTER THREE

IMPLICATIONS

This qualitative secondary analysis sought to investigate pathways to homelessness among refugees with a focus on identifying how mental health experiences among refugees might influence their pathways to homelessness. Three themes emerged from the findings: 1) Compounding marginalization, 2) Mental health is precarious, and 3) Homelessness is caused by a lack of housing. The first theme, *compounding marginalization* refers to the multiple and intersecting forms of marginalization faced by the refugee population which influences their pathways to homelessness. The second theme, *mental health is precarious* depicts the various mental health stressors experienced by this population but highlights mental health challenges as a consequence rather than a cause of homelessness. The third theme, *homelessness is caused by a lack of housing* relates to how homelessness among refugee claimants is mainly attributed to the lack of affordable housing or stable income to obtain housing. This is linked to the lack of resources to acquire homes for themselves and compounding barriers to settlement, service access, and language acquisition. The implications of these identified themes are addressed in relation to policy, nursing practice, nursing education, and nursing research.

Implications for Policy

The findings of this study have implications for policies related to resource assistance, service-delivery, and models of support. In terms of resource assistance, adequacy and stability of income needs to be a priority, including both social assistance rates and pathways to employment. The issue of homelessness among refugees, especially refugee claimants, is related to lack of resources and partly due to an unrecognized immigration status. Among participants, the paramount concern was inadequate financial

resources. The primary source of income for this population is social assistance which comes from Ontario Works. However, barriers to applying for assistance include concerns about being identified as an irregular migrant, or cumbersome application processes. In light of this, it is important for government assistance providers to consider policies that will address the issue of financial constraints among this refugee population. At the provincial level, policies addressing the review of social assistance rates should be considered. The social assistance given to refugee families does not reflect their true cost of living, especially for housing. Participants cited the lack of funds for an attainable rent as the primary cause of their prolonged stays in shelters. This calls for an increase in the social assistance funds to help them obtain housing and to move out of shelters.

Refugees whose claims have not been processed fear accessing services for fear of been caught and deported. This could be addressed by deepening the ‘Sanctuary City’ model whereby cities provide municipal services regardless of one’s current citizenship status (Aery & Cheff, 2018). Also, policies that encourage health and social service organizations to provide culturally safe services to these vulnerable groups regardless of their current status should be considered. With respect to non-status refugees, adequate education and information about how to make their refugee claims and access support should be made readily available through services such as emergency shelters. Also, resource limitations that are delaying the processing of refugee claims could be addressed by designated institutions such as Immigration and refugee Board of Canada through the provision of more staffing. This could help non-status refugees attain their needed documentation to enable them to integrate fully into Canada. Some, participants described this process as tedious and lengthy, thereby influencing their stay in emergency shelters. From the Immigration and Refugee Board of Canada (IRB), the processing time for refuge

claims could take up to two years for some applicants due to the backlog of claims (IRB, 2019). While the IRB (2019) recently implemented a new fast track system to improve refugee claimant process and lessen the processing time, participants are still experiencing long processing times. This might be due in part to limitations around accessing this fast-track process. Policies around making the process less strenuous and shorter should be considered for this population. This could help prevent extended experiences of homelessness among this population.

In addition to increasing the social assistance rate, another policy approach will be to increase affordable housing units across all provinces to sufficiently meet the housing needs of low-income earners such as newcomers and refugees on assistance. The provincial government should consider the pace of developing new affordable housing, which is currently failing to meet demand, as indicated by growing social housing waitlists across Canada (Aleman, 2016). As well, housing support providers should have a tool whereby they can provide co-signing for folks trying to move out of shelter, thus addressing the barrier of needing to provide a credit history or employment history in order to obtain a lease. This would remove one of the obstacles to accessing housing.

Furthermore, policies that promote the training of health and social service sector providers to engage in culturally safe care should be deepened. The EQUIP Model (EQUIP Health Care, 2017) serves as an example of a promising intervention that might reduce the discriminatory encounters identified by participants. Emergency shelter staff and case workers should be aware of the psychological and emotional consequences of experiencing homelessness as a newcomer. Culturally safe care will improve the experiences of refugees while interacting with support systems.

Implications for Nursing Practice

Nurses form a core component of primary health care, community health care, and public health care for the homeless population, including refugees experiencing a housing crisis. As indicated in other research and by the participants of this study, mental health challenges are often associated with homelessness (Haldenby, Berman & Forchuk, 2007; Schanzer, Dominguez, Shrout & Canton, 2007; Fazel, Khosla, Doll and Geddes, 2008; and Bruce, Stall, Fata & Campbell, 2014). Participants in this study confirmed that they experienced mental health stressors with prolonged homelessness. Therefore, it is important that health services reach out to this vulnerable population and promote their well-being in a proactive way. Providing community based mental health support would allow immediate care for this population. This can be in the form of community-based support that involves an interdisciplinary team consisting of health care providers and social workers. The health care team will be tasked with meeting the health needs of this population while the social workers provide other forms of support such as finding suitable housing (Canadian Observatory on Homelessness, 2019). Furthermore, nurses who care for this population should provide culturally safe care to meet their needs and contribute to their well-being.

Implications for Nursing Education

Housing is an important determinant of health and as such nurses are required to possess the right skills and training to advocate for their patients who lack this determinant. To achieve this, nurses should be advocates for social justice (Davison, Edwards, Robinson, & Canadian Nurses' Association, 2006). This can be achieved by inculcating the concept of social justice into nursing education. According to the “*Universal Declaration of Human rights*” by the United Nations General Assembly (2019), “Everybody has the

right to security in the event of unemployment, disability, sickness, widowhood, old age or other lack of livelihood in circumstances” (Article 25.1). Nonetheless to achieve this universal declaration, nurses need to join in the role of advocacy for social justice and understand how to do this (College of Nurses of Ontario, 2018). This could be achieved through nursing education by teaching nursing students the principles of social justice. Again, learning about immigrant’s health and specifically homelessness among refugees is a foundational way of introducing students to issues of housing challenges among newcomers, social injustices, and human rights.

Also, nursing students through their education need to develop their understanding of how inequalities, inequities and social injustices cause homelessness. Therefore, courses undertaken by undergraduate students should uncover how issues of injustices and inequities influences the health of people and lead to denial of access to basic health determinants. Moreover, coursework for nursing students should include how socioeconomic and sociocultural factors such as politics, environment, religion, economy, racism, and social conditions affect an individual’s health (Government of Canada, 2019) and the nurse’s role in mitigating these factors. To achieve this, courses related to health literacy and global health should be integrated in nursing curricula to provide nursing students reasonable tools to combat such issues during their practice.

Nursing students should also be prepared to support vulnerable populations such as those experiencing homelessness and assist in meeting their complex needs as they battle the challenges and hardships of unstable housing alongside a lack of resources such as water, food and financial resources. They should also be prepared to provide culturally safe care during their practice to meet the diverse needs of the homeless population especially among homeless immigrants who come from different cultural background.

Student nurses must be equipped with the basic mental health care skills required to assess mental health status of all patients. Mental health assessment and support is very important among the homeless population in particular. As such, it is prudent to prepare all nursing students and equip them with basic mental health care skills and not only mental health nurses to provide the support needed by this population.

Implications for Nursing Research

This study revealed that mental health experiences among refugee claimants perceivably do not contribute to homelessness but instead homelessness leads to a deterioration of participant's mental health. As such, future research should provide opportunities for nurses to support newcomers especially refugees who are experiencing homelessness with the goal to improve their mental health. This provides nurses the opportunity to research into various interventions which are culturally safe and could be adopted to meet the mental health needs of the homeless especially homeless refugees. It is possible that past research about homelessness may over-emphasize the role that mental health plays in pathways to homelessness and thus equal attention should be given to structural factors such as affordable housing. In this way nurses can join in the call for increasing affordable housing access through their research and by developing interventions.

As revealed in the findings, a major cause of mental health challenges is related to the economic integration of immigrants. Therefore, research should also try to investigate and suggest interventions that could assist with the socioeconomic integration of refugees. This can include consideration of both pathways into employment as well as appropriate assistance for those experiencing temporary or long-term barriers to employment.

With the issue of illegal status, research could try and answer whether the duration to acquire a status influences homelessness among refugees especially refugee claimants and what possible interventions could be developed to expedite the processing of refugee claims.

Conclusion

Homeless refugees face numerous challenges with their integration in a new society. These challenges range from the lack of financial resources, living multiple forms of marginalization, difficulty in acquiring homes, and mental health risks. However, this study reveals that mental health experiences may not lead to homelessness among this particular population, rather being homeless results in a decline of their mental health status. In addition, refugees experiencing homelessness are vulnerable to poor health due to insufficient social support and access to housing. Therefore, this research serves as a platform to encourage further policy reform, services, and research among refugees to identify the unique challenges confronting refugees experiencing homelessness as well as policy changes or interventions that supports this population.

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Appendix A

Client's Letter of Information and Consent Form

Project Title: Refugees' Pathways into Emergency Shelter

Principal Investigator: Dr. Abe Oudshoorn, FIMS & Nursing Building, University of Western Ontario, London, Ontario, Canada, Phone: ()

Co-Investigators: Dr. Victoria Esses, Social Sciences Centre, University of Western Ontario, London, Ontario, Canada, Phone: (),

Dr. Linda Baker, Faculty of Education, University of Western Ontario, London, Ontario, Canada, Phone: ().

Dr. Sarah Benbow, Fanshawe College Blvd, London, ON,

Dear Potential Participant:

Purpose:

We are writing to invite you to participate in a research study. This project is exploring how refugees to Canada, including asylum seekers, end up in emergency shelters.

What is the purpose of the study?

The purpose of this project is to better understand pathways of refugees into emergency shelter. The guiding research question is: What are the pathways by which refugees are ending up in emergency shelters in London, Ontario, Canada?

What will I do?

If you consent to participate in the project you will be asked to participate in one 60-minute interview. This will take at a time of your choosing at the shelter where you are currently staying. At this interview you will be invited to reflect back on your past, before coming to Canada, your journey to Canada, what has happened since you arrived in Canada, and your hopes for the future.

There are no negative consequences with deciding not to participate or to withdraw from the study. Choosing not to participate in the research will not affect your access to programs, services, or supports in the shelter where you are staying or in Canada in general. Except in the case of disclosures of child abuse, suicidal ideation or homicidal ideation, your participation is not reported to any agency, it is confidential, and all findings are reported anonymously. Only the research team will have access to the interview data. You may end the interview at any time and ask for your data not to be included in the study. After the interview is complete and the research team has left, there will be no further opportunities for your data to be removed from the study. This interview will be audio-recorded, audio-recording is mandatory.

What are the risks and benefits of the study?

It is possible that the process of participating will lead you to think about traumatic experiences from your life. Talking about your journey to Canada and your experiences

here can be both difficult and/or healing. Because of this risk, we have provided contact numbers at the end of this letter to local support agencies. Please let the researcher know if at any point you would like to stop the interview.

You will be compensated \$20 for your participation.

We strive to ensure the confidentiality of your research-related records. Absolute confidentiality cannot be guaranteed, as the researcher may be required by law to disclose certain information to relevant authorities. Any disclosures of child abuse, suicidal ideation or homicidal ideation will be reported (e.g. police service, CAS, other emergency personnel) and addressed. You do not waive any legal right by signing this consent form.

The analysis will be de-identified. You will not be identified in any way in the research results. All identifying information will be removed from interviews when transcribed.

Only the research team will have access to the research information. Any hard copies of research data and informed consent letters will be kept in a locked file cabinet in the researcher's locked office at Western University. Digital data are encrypted on a password protected computer in the locked office of the lead researcher. Any personally identifying information such as names, dates, and locations will be removed from the interview data as it is transcribed. However, direct quotes may be used in presentation or publication of study findings. Digital data and hard copies of consent forms will be stored for 7 years post-publication with the potential for further analysis. Audio-recordings and digital data will be permanently erased at 7 years post-publication. Hard copies will be shredded through Western School of Nursing's confidential shredding service.

Prior to the destruction of data, it may be used for secondary analysis to address further research questions.

Is the study voluntary and confidential?

The decision to participate or not is entirely voluntary and confidential. You can withdraw at any time during the interview without explanation. All the information collected will have any identifying information removed. All participants must be 18 years or older to participate.

Results of the Study

The results of the study may be published in scholarly journals, presented at national/international conferences, or be used in student research. Should you like to receive copies of study results, you may contact the research team using the information below.

For More Information:

Representatives of The Western University Non-Medical Research Ethics Board require access to your study related records to monitor the conduct of the research. If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Human Research Ethics () email:()

Please call Abe Oudshoorn from Western University, Arthur Labatt Family School of Nursing at () extension () or email him at () with questions regarding the project.

Sincerely,

Dr. Abe Oudshoorn

I have read this letter of information: _____ (initial)

Resources for Refugees

London Cross Cultural Learner Centre (CCLC)

Dundas Street, London, Ontario

Telephone: ()

E-mail: ()

Resources for Mental Health

Canadian Mental Health Association

Huron St, London, ON

Phone: ()

Consent Form

Project Title: Refugees' Pathways into Emergency Shelter

Principal Investigators: Dr. Abe Oudshoorn, Dr. Victoria Esses, Dr. Linda Baker, Dr. Sarah Benbow

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

I agree that unidentifiable, direct quotes may be used in sharing the research: ☐ Yes ☐ No

If you do not agree to the use of direct quotes, your data will still be utilized in the analysis, but no direct quotes used in sharing the results of the study.

Participant's _____ Name _____ (please _____ print):

Participant's Signature: _____

Date: _____

Person Obtaining Informed Consent (please print): _____

Signature: _____

My signature means that I have explained the study to the participant named above and that I have answered all questions asked.

Date: _____

Appendix B

Semi-Structured Interview Guide

Open by asking if they have any other questions before beginning? Are they comfortable? Inform them that audio recording is starting.

- Can you start by taking me back to your home country, can you tell me about where you are from?
 - What was life like for you in your home country?
 - Tell me about the family you lived with?
 - Were you working, in school?
 - What were your dreams for the future?
- Can you tell me about when difficulties started in your home country?
 - What led to your displacement from your home?
 - When did you know that you had to leave?
 - How did you choose where to go?
 - Where were your stops along the way? How long? With whom?
- At what point did you consider coming to Canada?
 - How much choice did you have in coming to Canada?
 - How long did you wait to come?
 - Did you know anyone in Canada before coming?
 - Who came with you?
- Tell me about arriving in Canada?
 - What was the journey like?
 - Where did you arrive to?
 - What screening processes did you have to go through before and after arriving?
 - Where did you stay upon arriving?
- Tell me about your time in Canada between arriving and ending up in the shelter?
 - Where all have you been (cities)?
 - Where all have you stayed (organizations)?
 - Why and how did you end up in London?
- Tell me about the factors that led you to staying in shelter?
 - How did you hear about this shelter?
 - How did you get to this shelter?
 - Did you have any difficulties getting a bed in this shelter?
 - Are you still connected with family/friends?
 - Have you accessed any government income? Why/why not? Any difficulties with this access? Any issues with sufficiency of income?
 - Have you experienced violence? Discrimination? Prejudice? through your time in Canada?
- How are you doing in terms of your health and well-being?
 - How is your physical health?
 - How is your mental health?

- Any concerns that have continued since back home?
 - Any concerns that are new since coming to Canada?
 - Are you able to get assistance for health concerns if needed?
- Tell me about your hopes for the future?
 - Do you anticipate staying in London? Do you anticipate staying in Canada?
 - What is your plan for getting into housing?
 - What is your housing goal?
 - What does an ideal future look like for you?

Curriculum Vitae

Name:	Bridget Osei Henewaah Annor
Post-secondary Education and Degrees	University of Ghana, Legon, Ghana 2011-2015. B.Sc. N The University of Western Ontario London, Ontario, Canada 2017-2019 M.Sc. N
Honours and Awards:	Western Graduate Research Scholarship 2017-2019
Related Work Experience	Teaching Assistant The University of Western Ontario 2017-2019
Publications:	

Annor, B. O. H., & Oudshoorn, A. (2019). The health challenges of families experiencing homelessness. *Housing, Care and Support*, 22(2), 93-105, doi.org/10.1108/HCS-12-2018-0036