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'An Inkling of Hope': Understanding Personal Recovery in Individuals Transitioning out of Chronic Homelessness: A Transatlantic Qualitative Study

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Abstract

Individuals with serious mental illness (SMI) who are homeless are a client group with complex but often misunderstood and unmet health and social care needs. Although adopted by mental health policies and programmes in many developed countries, personal (mental health) recovery has remained markedly underresearched and undertheorised in relation to socio-structural disadvantage such as homelessness. This transatlantic qualitative participatory study aimed to address those knowledge and explanatory deficits by exploring how individuals with a history of SMI and chronic homelessness made sense of their personal recovery, as well as what the barriers to, and facilitators of, their recovery were. This study also endeavoured to unravel the socio-structural and contextual influences shaping recovery, as well as how individuals navigated and negotiated those to enable better well-being and recovery. The life stories and present-day narratives of 18 clients of temporary accommodation services in the U.S. and Scotland were elicited using in-depth interviews and a mobile phone diary between February and September 2018. Data from 45 interviews and more than 200 diary entries were analysed using interpretative phenomenological analysis (IPA) and abductive-retroductive, critical realist analysis. The IPA revealed the significance of 'owning' one's recovery, as well as that of safety and constancy, insight, coping and symptom management, nurturing a strong and positive sense of self, meaning in life, and feeling *'wanted, accepted and needed*'. Those super-ordinate themes captured the processes of envisioning and enacting recovery amidst homelessness. The critical realist analysis produced an explanatory model of personal recovery, whereby recovery was the emergent outcome of the interplay between the conditioning effects of certain social structures and cultures and participants' own agential capacities manifested in autonomous or fractured reflexive deliberations. Mental health and homelessness services should be designed and delivered in ways that enable clients' intrinsic capacities for self-reflection, self-directedness and emotional connectedness.

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Chapter One

Thesis Overview

Logic of the Chapter

This opening chapter provides a concise overview of the context, rationale, scope and objectives, as well as the theoretical and methodological positioning, of the current study. This chapter begins by situating this investigation in the epidemiological and policy context of homelessness in the U.S. and the U.K. and highlighting the self-perpetuating nature of the complex needs, particularly SMI, observed in a considerable proportion of contemporary homelessness in those countries. The landscape of persistent homelessness and the associated health inequalities in those countries is counterpoised against the recovery approach. Personal recovery is introduced as a programme for mental health system transformation*,* as a research concept *and* as lived experience. Gaps in the research literature pertaining to how individuals engage in recovery in the context of homelessness motivated the present qualitative transatlantic study. The research questions of the current study are presented, together with the scope and assumptions of the study. The theoretical and practical significance of understanding recovery in individuals experiencing homelessness, especially chronic homelessness, is rationalised. The chapter concludes with an overview of the chapter organisation of this work.

Policy and Research Context of the Study

Contemporary homelessness represents a pervasive socio-economic, socio-political, public health and humanitarian problem (Shinn, 2010; Aldridge et al., 2018; Fazel et al., 2014). The profound infringement upon the health capabilities, human rights and citizenship of persons without a home has led some to aptly describe homelessness as the embodiment of disadvantage and inequality (Rolnik, 2010). This rhetoric is well-grounded in epidemiological data showing the disproportionately adverse quality of life, mortality and morbidity outcomes in homeless populations compared to the general population (Shinn, 2010; Aldridge et al., 2018; Fazel et al., 2014). The prevalence of SMI in individuals who are homeless, in particular, tends to be disproportionately high compared to the general population and can range between 25% and 90% (Toro, 2007; SAMHSA, 2015; Homeless Link, 2016). SMI and co-occurring issues such as substance use problems tend to be even more concentrated among those facing chronic and repeat homelessness (Farrell, 2010; Olivet et al., 2010; United States Interagency Council on Homelessness, 2015). This co-occurrence of adverse life experiences often creates a self-perpetuating cycle of housing instability, unmet mental health needs and poor quality of life (Culhane et al., 2011). As a result of the confluence of adverse biographical, institutional and macro-structural factors, clients with a history of chronic homelessness and multiple needs are often argued to be the '*hardest-to-reach'*, '*hardest-to-help*' and '*most challenging*' to provide coordinated and effective mental health and housing support to (Farrell, 2012, p. 338; Farrell, 2010; Olivet et al., 2010).

The severity of the needs of clients without a home who have SMI tends to be exacerbated by support services that are inaccessible, inappropriate, insensitive and even outright discriminatory and demeaning (Farrell, 2012; 2010; Olivet et al., 2010; Fowler et al., 2019). Furthermore, in many jurisdictions, including the U.S. and Scotland, housing shortages and housing sector inefficiencies, in addition to the inadequate coordination between health and social care services, have resulted in both frequent episodes of street (roofless) homelessness and extended stays in temporary accommodation facilities that are often '*not fit for purpose*' (Watts et al., 2018, p. 14) and can further diminish clients' quality of life, well-being, autonomy and housing prospects (Watts et al., 2018; Moffa et al., 2019; Coalition for the Homeless, 2018).

In recent years, there have been concerted efforts to improve the availability, cohesion and effectiveness of healthcare, social care and housing services in both the U.S. and Scotland (NYC Government, 2017; United States Interagency Council on Homelessness, 2016; Shelter Scotland, 2016a; Public Health England, 2018). Those have included innovative, client-centred approaches such as Housing First and the commissioning of low-threshold services such as safe havens (Padgett et al., 2016; NYC Government, 2017). The success of many of those initiatives has been partial, however. Persistent systemic barriers, in addition to the rising rates and complexity of homelessness, have led to the severe underserving of clients who are homeless and have complex needs (van den Berk-Clark, 2016; Greenwood et al., 2013; Clarke et al., 2019). While there has been widespread recognition of the importance of a '*sustainable and holistic, person centred and needs led response to homelessness in place'* (Glasgow City Health and Social Care Partnership, 2016, p. 56), its implementation has been challenging and ambiguous (Gillis et al., 2010).

How Recovery Happens: A Focus on Homelessness

Originating from the psychiatric survivor movement, the '*recovery approach'* has been one such influential person-centred and holistic philosophy of mental health service delivery and community reintegration (Slade et al., 2008; Le Boutillier et al., 2015; Smith-Merry et al., 2011; US Department of Health and Human Services, 2003). *Personal recovery* denotes the individual's unique journey towards regaining a meaningful, satisfying and productive life despite the chronic nature of their mental health difficulties (Anthony, 1993; Department of Health, 2011). Personal recovery encompasses the multiple facets of individuals' lives-including social integration, vocational realisation and the acquisition of the skills, autonomy and the sense of purpose to lead a self-directed life (Department of Health, 2011).

Due to its inclusiveness and multiple facets, the recovery approach has been notoriously difficult to implement in different service contexts without compromising its original meaning of hope, self-determination and empowerment (Hopper, 2007; Farkas, 2007; Smith-Merry et al., 2011). This '*translational gap*' (Le Boutillier et al., 2015, p. 430) seems especially wide in the homelessness services provision, whereby dominant service delivery models, ethos and practices have commonly been antithetic to the realisation of the core recovery principles (Cornes et al., 2014).

Understanding clients' lives and needs in context is arguably integral to embodying the recovery philosophy (Conlon et al., 2015). This mandate emphasises the significance of empirical research into individuals' experience of mental well-being and recovery (Pilgrim & McCranie, 2013; Slade et al., 2014). A growing body of research has expanded the understanding of personal recovery as a multidimensional, subjective, dynamic and contextually-embedded phenomenon (Leamy et al., 2011; Tew et al., 2012). Despite this progress, personal recovery has remained relatively underresearched and undertheorised in relation to individuals experiencing severe forms of socio-structural disadvantage such as homelessness (Karadzhov et al., 2020; Stuart et al., 2017). This has resulted in a gap in the understanding of how individuals who are homeless and have SMI make sense of, and navigate, their recovery journeys amidst the *anti-recovery* conditions of financial struggles, housing insecurity and other forms of social marginalisation. Relatedly, *underproblematised* in the context of socio-structural disadvantage and inequalities have largely remained core recovery processes such as hope, empowerment and a positive identity. For instance, relatively less is known about *how* hope, optimism, a positive self-identity and other recovery-relevant processes are envisioned, initiated, negotiated and sustained by individuals who are homeless and who endure chronic and systemic disempowerment, discrimination and victimisation (Meanwell, 2012).

More fundamentally, neglecting the roles of inequalities, disadvantage and other structural conditions risks succumbing to a reductionist and potentially harmful view of recovery, and mental well-being, respectively, as constituting little more than a function of individuals' cognition, emotions and volition (Hopper, 2007; Rose, 2014; Harper & Speed, 2012; Watts, 2014; Woods et al., 2019). There is a need, therefore, to comprehensively examine how individuals exercise and sustain their recovery in the face of systemic adversity.

Objectives of the Study

The objectives of the present study were informed by (a) the need to comprehensively address the complex needs and improve the mental well-being and rehousing outcomes of adults who are homeless, and (b) the inadequate research into, and theorisation about, personal recovery in the context of severe socio-structural disadvantage such as homelessness. In particular, the present study endeavoured to explore how adults who have SMI and a history of chronic homelessness made sense of, and conceptualised, personal recovery, as well as what the (perceived) facilitators and barriers of recovery were. In addition, this study aimed to unravel what socio-structural conditions and contexts were implicated in the recovery process, and how, as well as how those individuals navigated those conditions to enable better well-being and recovery. To expand the practical utility and theoretical usefulness of the findings, the present study gathered data from both Scotland and the U.S.

Theoretical and Methodological Positioning of the Study

The qualitative research tradition-encompassing ethnography, oral history, narrative research and other genres-has made significant contributions to understanding the nature, facets and lived experience of recovery (Davidson, Sells, Songster, & O'Connell, 2005; Foster et al., 2006; Rennick-Egglestone et al., 2019). Informed by the offerings of qualitative, including narrative and participatory, research for unpacking how individuals make sense of their recovery and what the barriers to, and facilitators of, their recovery are within the individuals' unique contexts, the present study utilised a qualitative methodology (Pope et al., 2002). The qualitative research paradigm was deemed apposite for meeting the two over-arching analytic goals of the current empirical investigation: (a) to *understand* (in a phenomenological sense) how the participants make sense of, and experience personal recovery; and (b) to *explain* (in a theoretical sense) how recovery is shaped by the participants' socio-structural conditions and contexts, as well as by participants' own navigation and negotiation of those circumstances (Maxwell, 2012b).

To achieve those aims, the study combined in-depth interviewing, the diary method and participant-generated photography (via the mobile phone diary). The repeated qualitative interviews elicited participants' life story narratives, as well as their narratives about their present-day lives, priorities and hopes for the future, reflections about the conditions of their existence (such as poverty, the healthcare system, the housing sector and support services), among other topics. This *pluralistic approach* to the qualitative research design not only strengthened the participatory component of this study, but also allowed for diverse manifestations and facets of recovery to emerge as occurring within participants' biographies and present-day lives. The life story approach to interviewing is particularly suited for eliciting information about significant life events (positive and negative) and their antecedents and consequences, and individuals' evaluations of them. In addition, life stories also encompass individuals' life projects, ideologies, decisions, priorities and sense-making thereof (Gubrium & Holstein, 2001; McAdams, 2012; Atkinson, 2012). Moreover, because life story narratives are essentially narratives about transitions, life story interviews can help explore participants' well-being and recovery as dynamic, temporally- and contextually-embedded phenomena (McAdams, 2012; Bauer & McAdams, 2004). This allowed for comprehensively addressing the research questions, while also encouraging participant autonomy and control as to what was shared during the interviews.

Incorporating the mobile diary method and participant-generated photography further enhanced the elicitation of participants' sense-making about themselves, their lives and their recovery (Guillemin & Drew, 2010; Bagnoli, 2004). Th use of the mobile phone diary as a data collection tool allowed for the naturalistic enquiry about participants' daily reflections, practices and contexts, which has been shown to be able to yield '*provocative, experiential and sensorial insight into participants' lives'* (Hagen & Rowland, 2010, para. 12). The use of visual images, on the other hand, enhanced participants' capacities to articulate sensitive, complex and/or ambiguous experiences (Han & Oliffe, 2016; Padgett et al., 2013).

Another major design characteristic of the current study is its multi-site, transatlantic data collection strategy-involving clients of accommodation services for the homeless in both Glasgow (Scotland) and New York City (the U.S.). This sampling approach allowed for capturing diverse experiences of mental health and recovery in adults of different ethnicities, housing histories, support needs, as well as varied contextual conditions that could potentially be implicated in those individuals' recovery (such as culture, the housing sector, the organisation of services, the welfare system and others). This allowed for a more comprehensive examination of the role of context in shaping personal recovery amidst homelessness (Slade et al., 2012; Brijnath, 2015; Davidson, Borg, Marin, Topor, Mezzina, & Sells, 2005).

The philosophical orientation of this study was *critical realism* (Bhaskar, 1989; Danermark et al., 2005). Critical realism recognises the importance of subjective interpretations of experience while also seeking to generate an explanatory account of social phenomena that integrates the influences of both social structures and individual agents (Sayer, 1992). Critical realism has strong emancipatory roots in that it focuses on identifying and removing the structural constraints impeding human well-being, flourishing and emancipation (Houston, 2001; McNeill & Nicholas, 2019). Therefore, critical realism is an appropriate philosophical framework guiding the current empirical investigation.

Ethical Considerations

Individuals who are homeless and have complex needs represent a multiply marginalised and vulnerable participant population-by virtue of their likely history of chronic life adversity, including the exposure to physical and psycho-emotional threats of homeless living; their potential mental health symptomatology and possible co-occurring physical health problems; and their dependence on welfare, housing and other institutional provision. Their status as vulnerable participants mandates considerable measures to ensure the ethical conduct of research investigations. Accordingly, the present study ensured its high degrees of procedural ethics and situational ethics as they particularly relate to informed consent, non-coercion, sensitive qualitative interviewing, the management of participant burden, participant autonomy and ownership, participant representation and others (discussed in detail in the '*Study Design*' section of '*Chapter Five'*).

Significance of the Study

Understanding *how recovery happens* (or does not happen) for individuals facing severe and multiple disadvantage is integral to comprehensively responding to the complex needs of this client group. The research focus on the recovery experiences of clients with complex needs is also instrumental in identifying the biographical, relational, institutional and cultural events, practices and processes that enable and/or hinder individuals' capacities for recovery as they transition from chronic homelessness. This contextualised knowledge of those 'hard-to-reach' clients' experiences, in turn, is likely to inform the alignment of mental health, social care and homelessness services with the core principles of the recovery approach and person-centredness. Understanding personal recovery in individuals in such circumstances is likely to inform approaches for optimally supporting them in navigating services, successfully transitioning out of homelessness, pursuing and attaining a satisfying and meaningful life, and regaining their full and active citizenship.

On a theoretical level, the present study's findings are likely to aid the advancement of the theorising about personal recovery. As Pilgrim and McCranie (2013, p. 1) posit, '[…] *in order to evaluate the empowering potential of the idea* [of recovery], *we must be honest about its traps and weaknesses, particularly those that might be convenient to ignore.'.* Indeed, the empirical literature on personal recovery has tended to neglect or downplay the importance of the socio-structural context for how hope, positive identity, empowerment and other core recovery processes are envisioned, exercised and attained by individuals (Harper & Speed, 2012; Morrow & Weisser, 2012). This has led to the overly individualised, psychologised notions of recovery, which tend to reduce recovery to a set of intrasubjective phenomena related to how individuals think and feel (Hopper, 2007; Price-Robertson et al., 2017a). The exploration of recovery in the context of homelessness offers the valuable opportunity to problematise the processes thought to constitute recovery through the lens of socio-structural disadvantage (Yanos et al., 2007). Mobilising the sociological concepts of social structure and individual agency offers fertile opportunities to generate a multi-layered conceptualisation of personal recovery as influenced by socio-structural, relational and individual factors.

Roadmap for this Thesis

The present work is organised into eight chapters-each attending to a distinct component of the current qualitative investigation. '**Chapter Two**' outlines the scale and complexity of co-existing homelessness and SMI in two jurisdictions, Scotland and the U.S. Their strategic contexts, including epidemiology, policy frameworks and organisation of support services, are overviewed. The importance of understanding and responding to the complexity of need in homelessness through a whole-person approach is emphasised.

‘**Chapter Three**’ is dedicated to critically reviewing the theoretical and empirical evidence base for personal recovery, with a particular focus on qualitative, including narrative, recovery research. The contributions and limitations (methodological and theoretical) of this body of research are distilled. The chapter then proceeds to problematise the dominant conceptualisation of personal recovery and its core components in the context of socio-structural disadvantage. This critique illuminates the scarcity of empirical research and the paucity of sociologically-informed theorisation regarding how recovery is shaped by the socio-structural conditions of living. Those inadequacies are especially pertinent to homelessness research, whereby empirical investigations of personal recovery have remained few and undertheorised. Those critical insights inform the research questions of the current study, which are presented at the end of ‘*Chapter Three*’.

‘Chapter Four’ presents the philosophical framework underpinning the current study-critical realism. The main tenets of critical realism are briefly discussed, together with the justification of the appositeness of critical realism for addressing this study’s research questions. Then, the conceptual framework of the current study, the morphogenetic model, is detailed.

‘Chapter Five’ situates the study methodologically and provides a detailed step-by-step account of the data collection and data analysis procedures. The demographic characteristics of the current sample are presented. Ethical considerations are discussed throughout this chapter and the strategies for methodological and ethical rigour-outlined.

‘Chapter Six’ is dedicated to the findings from the IPA analytic phase. The thematic structure generated by the IPA is presented and each over-arching, super-ordinate and sub-theme is reported using a narrative format and a tabular format for the entire sample (i.e. including both the American and the Scottish study arms). Case summaries are also included to preserve the entirety of the participants' life stories and to illustrate the biographical continuities or discontinuities of the IPA themes under discussion. This chapter also features a commentary on the similarities and discrepancies between the American and the Scottish data sets. The chapter concludes by presenting the participants' reflections on their participation in the study.

'Chapter Seven' presents the findings from the second layer of analysis-the critical realist, abductive-retroductive, analysis. The aims and procedure for this type of analysis are distinguished from those of the IPA and are discussed in relation to the research questions. This analysis represents the application of the morphogenetic model to the empirical data in order to generate a theoretically-informed explanation of the socio-structural conditions and contexts that were implicated in participants' personal recovery, and of how participants navigated and negotiated those conditions and contexts to enable better well-being and recovery.

'Chapter Eight' synthesises the findings from both analytic phases in response to the four research questions. The findings are then situated within the reviewed literature on personal recovery, complexity of need in homelessness, and the structure-agency dialectic as illuminative of individuals' efforts to attain better mental well-being amidst severe and multiple disadvantage. The convergences and discrepancies of the present findings with the extant research are highlighted. The strengths and limitations of the current study-its design, data analysis strategy and theoretical underpinnings-are then critically assessed. The chapter concludes by proposing recommendations for theory development, directions for future empirical research, as well as recommendations for social work and mental health practice and policy. Special consideration is given to conceptualising and implementing person-centred care for persons with SMI experiencing homelessness and transitioning to permanent housing.

Conclusion

This chapter offered an overview of the context, objectives, methodological and philosophical orientation, and significance of the present study. The present qualitative study aimed to explore the experiences of personal recovery in adults with SMI and a history of chronic homelessness in Scotland and the U.S. The next chapter elaborates on the strategic policy and service provision context of homelessness and complex needs in Scotland and the U.S.

Chapter Two

Homelessness and Complex Needs: Introduction and Strategic Context

Logic of the Chapter

This chapter outlines the scale and complexity of co-existing homelessness and SMI in two jurisdictions, Scotland and the U.S. Their strategic contexts, including epidemiology, policy frameworks and organisation of support services, are overviewed. The high complexity of need and the limited access to services observed in clients without a home are discussed from a health inequalities perspective. Adequately responding to the complexity of need in clients without a home necessitates an in-depth understanding of their lived experience of multiple disadvantage.

Introduction to Homelessness: More than a Housing Crisis

Homelessness is an umbrella term that denotes a continuum of housing exclusion that ranges from inadequate or unsafe housing to rooflessness (Amore et al., 2011). Individuals and families that are categorised as homeless, precariously housed or threatened with homelessness may find themselves in a range of circumstances-including sleeping rough, residing in temporary accommodation (such as a night shelter or emergency accommodation), as well as living in overcrowded or otherwise unsuitable housing (Amore et al., 2011). One conceptual definition of homelessness proposed by the European Observatory on Homelessness (ETHOS) states that it refers to '*[l]iving in a place of habitation (during the reference period) that is below a minimum adequacy standard* [and] [l]*acking access to adequate housing.*' (Amore et al., 2011, p. 32). ETHOS also recognises that homelessness encompasses at least three domains-the physical domain (e.g. residing in physically inadequate structures), the legal domain (e.g. not having the legal right to occupy suitable housing) and the social domain (e.g. living in circumstances that deprive one of privacy and security; Amore et al., 2011).

Homelessness signifies both a legal category *and* the unique human experience of marginalisation, disenfranchisement and exclusion. Beyond a politico-economic crisis of housing unavailability and unaffordability, homelessness represents a public health and a human rights emergency. Those who find themselves without a home often face deprivations in the rights to adequate housing and non-discrimination, as well as limited access to the economic, social and cultural resources that are vital for social participation and active citizenship (Rolnik, 2010). Furthermore, the multiple and mutually curbing health issues experienced by many people without a home represent an assault on those individuals' right to life and right to health (Watson et al., 2016; Homeless Link, 2014; Hodgetts et al., 2007). Across geographical locations, individuals who are homeless have reported a range of physical and mental health (behavioural) problems including infectious diseases, chronic medical conditions, mental health difficulties such as depression, anxiety and post-traumatic stress disorder, as well as risky health-related behaviours (Aldridge et al., 2018; Watson et al., 2016; Homeless Link, 2014; Fitzpatrick et al., 2013). In addition, unaccommodated individuals have been shown to have disproportionately high mortality, morbidity and disability rates, compared to the general population (Aldridge et al., 2018).

The disproportionately adverse health-related outcomes observed in many homeless populations tend to be exacerbated by the multitude of structural and cultural barriers to attaining better health and well-being and stable housing that those individuals tend to face (Aldridge et al., 2018; Fazel et al., 2014). Those include inadequate, inappropriate and/or uncoordinated health and social care services, professional stigma, discriminatory and/or dehumanising social policies, poor awareness of available services, fear of discrimination, mistrust in services, restricted financial means for accessing services, low social support, substance use, and others (Aldridge et al., 2018; Crosby et al., 2018; Hamilton et al., 2012; Kerman et al., 2019).

Many types of homelessness are the extreme sequela of severe social exclusion such as chronic poverty and discrimination, and other forms of structural violence (Watson et al., 2016). Homelessness has been shown to be a multidetermined phenomenon, which can be triggered and perpetuated by a myriad of exclusionary structural forces such as inefficient housing systems, welfare regimes, institutionalisation, intergenerational poverty, systemic violence, negative public perceptions, and others (Watson et al., 2016; Zufferey, 2016). Adding to this complexity are the differing policy and public constructions of homelessness in different jurisdictions (Pleace, 1998; Shinn, 2007; Somerville, 2013; Fitzpatrick, 2005; Fitzpatrick & Stephens, 2014). This has been mirrored by research debates surrounding the causes of homelessness, which have involved individual-based explanations, structural explanations, and the more recent 'new orthodoxy', which combines the ideas of structural fundamental causes and of individual vulnerability (Pleace, 1998; Fitzpatrick, 2005; Busch-Geertsema et al., 2010; Fazel et al., 2014). In brief, possible structural factors include housing and economic conditions (particularly recessions, unemployment and less generous welfare regimes), demographic trends, the social policy landscape, the prevalence of illicit substance use, and many others (Lee et al., 2010). Researchers have also identified a plethora of individual-level risk factors, which have been speculated to undermine the individual's psychological resilience as well as tangible resources necessary to withstand acute adverse socio-economic shifts. Those include event-related factors (e.g. childhood trauma, domestic violence, incarceration, redundancy, bereavement, eviction, etc) and chronic factors (e.g. community violence, substance misuse, mental illness, physical disability; Lee et al., 2010).

According to Shinn's (2007) cross-national policy analysis, historically, developed countries have tended to conceptualise homelessness as a '*temporary emergency'* (p. 644) stemming from chronic housing shortages. The complex patterning of contemporary homelessness, and especially its frequent co-occurrence with SMI, however, necessitate an *intersectional health inequalities perspective.* An intersectional health inequalities perspective entails the recognition that homelessness is not a discrete socio-economic abnormality but rather the manifestation of the synergistic effects of macro-structural-economic, political and socio-cultural-processes. Crucially, those processes tend to have disproportionately adverse effects on individuals occupying one or more marginalised social locations based on gender, sexual orientation, ethnicity, disability, race, age, socio-economic status and others (Zufferey, 2016). This assertion is supported by international epidemiological and other empirical evidence showing that historically marginalised social groups such as ethnic minorities and those with physical and multiple disabilities tend to be overrepresented among homeless populations (SAMHSA, 2013; Shinn, 2007; Philippot et al., 2007; Toro, 2007).

Furthermore, evidence from both the epidemiological and the qualitative literatures has indicated that homelessness tends to be a racialised and a gendered experience (Johnson, 2010; Markowitz & Syverson, 2019; Paul et al., 2019). Certain minority populations, such as African-Americans in the U.S. and older women in Canada, for instance, tend to experience distinct trajectories into homelessness and co-occurring disadvantage, as well as uniquely complex barriers to coping with, and exiting, homelessness (Johnson, 2010; Whitzman, 2006; Paul et al., 2019). Those barriers tend to be rooted in oppressive socio-historical forces, disadvantageous service and welfare arrangements and discriminatory societal discourses and practices, among others (Johnson, 2010; Whitzman, 2006; Shinn, 2007).

Despite this marked diversity and multi-determination associated with contemporary homelessness in developed countries, homelessness often tends to be homogenised and depoliticised in public and policy discourses (Zufferey, 2016; Zufferey & Kerr, 2004; Baiocchi & Argüello, 2019). Examples of such practices and discourses are numerous and include unrealistic expectations by services towards service-users that neglect the wider context of health disparities; insensitivity towards service-users' cultural or ethnic background, or personal biography; being denied access to resources for meeting basic needs, and many others (Omerov et al., 2020). A common consequence of this tendency to homogenise the experience of homelessness and multiple disadvantage is the collective failure of policy-makers and service-providers to recognise, and cater to, the multiple and overlapping needs of different homeless sub-populations (Baiocchi & Argüello, 2019). This, in turn, tends to hinder the prevention and elimination of homelessness (Baiocchi & Argüello, 2019).

Strategic Policy Context of Homelessness in Scotland, the U.K. and the U.S.

The lives of those without a home in Western urban societies are often the embodiment of concentrated disadvantage and deep-seated health and socio-economic inequalities. Despite methodological and conceptual differences in the measurement of homelessness across countries, evidence has consistently shown higher rates of homelessness in the U.S. and the U.K. than in many other developed countries (Shinn, 2007; Fazel et al., 2014). The compounding effects of welfare policy regimes, health and income inequalities, housing shortages and cycles of macro-economic fluctuations such as recessions have been suggested to have accounted for the observed persistently high homelessness estimates in those two jurisdictions (Shinn, 2007).

Scotland

Scotland is a country characterised by persistent health inequalities, including high levels of relative poverty and homelessness (Audit Scotland, 2012). Between April 2017 and April 2018, almost 35 000 homelessness applications were received (a slight increase from the preceding period), of which 82% were determined to be homeless or threatened with homelessness (Scottish Government, 2018b). Of those, the vast majority tend to be single men between 25-34 years of age of White Scottish ethnicity (Scottish Government, 2018b).

Repeat homelessness (operationalised as having at least two applications in a period of 12 months) has increased since 2012/13, with 6.4% (1,843) of adults falling into this category in 2017/18 (Scottish Government, 2018b). The most commonly cited reasons for homelessness application have been eviction, disputes/relationships breakdown and fleeing domestic violence, with 65% of applicants citing multiple reasons. Notably, when queried about the reasons for losing their accommodation, 43% of applicants in the 2017/18 period cited external factors (e.g. eviction, fire, harassment), 23%- mental health reasons, and 18%- financial difficulties, debt or unemployment. Other common reasons include the lack of support from family and friends, substance abuse, physical health problems and others (Scottish Government, 2018b). In terms of chronic or long-term homelessness in the country, the 2018-19 Scottish homelessness applications data offer proxy estimates only. For example, 14% (or almost 3 000) of the homeless households had been residing in temporary accommodation for one year or longer in the preceding year (Scottish Government, 2019).

The prevalence of support needs in homelessness applicants in Scotland has been relatively high, with half of all applicants citing one or more support needs. Mental health problems accounted for almost 50% of all support needs, independent living skills-for 47%, and substance use problems-for 24% (Scottish Government, 2018b). Statistical data from Scotland also show that at least 6% of all homeless persons had experienced a mental health condition, an alcohol problem *and* a substance use problem at some point in their lives (Scottish Government, 2018a). Finally, rough sleepers (those who are literally/absolutely homeless or roofless) accounted for 8% of all homelessness applicants in 2017/18 in Scotland.

As Scotland’s most populous city, Glasgow City receives the majority of homelessness applications (5 204 in 2017/18; Scottish Government, 2018b). Glasgow City also has the highest proportion of rough sleepers in the country, with almost one in every ten homeless adults experiencing rooflessness in the city (Scottish Government, 2018b). A recent Glasgow City Mission survey showed that between December 1, 2017 and March 31, 2018, 597 unique individuals stayed at a winter night shelter in the city, of whom 56% presented with complex needs such as mental health problems (Glasgow City Mission, 2018). Historically, Glasgow City Council has faced significant challenges with effectively responding to the homelessness emergency due to the complex needs of many unaccommodated persons, the shortage of temporary housing, as well as problems with accessing permanent social tenancies, including long waiting times (Scottish Housing Regulator, 2018; Fitzpatrick et al., 2015). This clustering of negative life experiences that characterises a significant proportion of the Scottish homeless population has been recognised as representing deep social exclusion (Fitzpatrick et al., 2013).

The majority of homelessness applicants in Scotland tend to spend time in one or more types of temporary accommodation, with the duration of stay in temporary accommodation in Glasgow averaging between six and 12 months (Watts et al., 2018). Scottish data from 2017/18 show that, on average, households tend to spend extended periods of time (just under six months) in temporary housing, and that 13% of households tend to spend over one year in temporary housing (Scottish Government, 2018b). Temporary accommodation includes social rented sector temporary accommodation, hostels, bed and breakfast accommodation, and others (Watts et al., 2018). Scotland’s temporary accommodation system has been critiqued as ‘*not fit for purpose’* (Watts et al., 2018, p. 14) because, while short-term high-quality forms of temporary housing provision are typically available, many clients tend to report diminished autonomy, control and rehousing prospects, as well as undermined health and well-being (Watts et al., 2018). The mismatch between the temporary accommodation type and facilities on offer and clients' health and social care needs is typically associated with the highest rate of client dissatisfaction in the Scottish context (Watts et al., 2018). There is an urgent need to better align the temporary accommodation provision with the multifaceted needs of residents (Watts et al., 2018).

The Scottish Government has formally recognised the relationship between health outcomes, including mental health, housing, and poverty, and has committed to improving the service delivery, financing, early intervention and health and rehousing outcomes for homeless persons through cross-agency action (Glasgow City Health and Social Care Partnership, 2016; Scottish Public Health Network, 2015; Scottish Government, 2017). In its 2015 strategy for addressing homelessness, the Scottish Public Health Network positions homelessness in the wider context of pervasive poverty and inequalities (p. 4): *'Homelessness is both a consequence and a cause of poverty, social and health inequality. It is also, in many cases, a 'late marker' of severe and complex disadvantage which can be identified across the life course of individuals.'.* This formal recognition of homelessness, especially repeat homelessness, as a manifestation of multiple and interlacing forms of health and social disadvantage has several implications for policy and practice (Scottish Public Health Network, 2015). Among those has been the renewed interest in understanding pathways into and from homelessness, particularly in cases of multiple exclusion homelessness-defined as '[…] *a form of deep social exclusion including homelessness, mental health problems, drug and alcohol dependencies, street culture activities and institutional experiences* […]' (Scottish Public Health Network, 2015, p. 10).

Furthermore, in its 2016-2019 strategic plan, the Glasgow City Health and Social Care Partnership committed to delivering services at '*the right time, the right place and from the right person'* (2016, p. 32) by increasing the accessibility of care, enhancing clients' self-determination and choice and improving the continuity of service provision-particularly for clients deemed 'vulnerable'. With regards to the homeless services provision, the plan prioritises '[a] *sustainable and holistic, person centred and needs led response to homelessness in place'* (p. 56).

Concerted interagency efforts have been made to prevent and reduce homelessness (Scottish Public Health Network, 2015; Scottish Government, 2018a). In its 2018 *'Ending homelessness together: High level action plan'*, the Scottish Government (2018c) states its commitment to developing a well-functioning housing system that prioritises choice, safety and availability; embedding a person-centred approach to homeless care and housing services; minimising temporary accommodation stays and eliminating rough sleeping; creating a stigma-free social environment; and preventing homelessness by understanding and addressing common routes into homelessness. The Plan also features a range of funding and organisational arrangements that will be put in place to ensure the housing and social care services meet the needs of people who are homeless.

Despite its principled, strategic commitment to, and action on, eradicating and preventing homelessness in recent years, Scotland is facing persistent challenges to sustainably achieving those goals. In addition to the need for sufficient capital investment and expansion of affordable housing, a range of obstacles pertain to individuals' complex and often unmet needs, the effective navigation of services and reintegration into the community (Anderson, 2007; Fitzpatrick et al., 2019; Littlewood et al., 2017). Some of those challenges include: (a) accurately measuring, understanding the causes for, and ameliorating, acute forms of homelessness, including street homelessness; (b) reducing time spent in temporary accommodation and improving resettlement outcomes; (c) maximising political will and interagency collaboration, and others (Anderson, 2019; Fitzpatrick et al., 2019). In addition, uncertainty persists as to the nationwide scaling-up of innovative supportive housing models for clients with complex needs such as Housing First (Fitzpatrick et al., 2019).

United States

The structure and dynamics of contemporary homelessness in the United States are remarkably complex. A range of socio-structural factors have been implicated in causing and deepening the homelessness crisis in the country-including housing sector inefficiency and housing shortages; poverty; economic crises; fragmented health and social care services; weak welfare state protections; substance use epidemics; racism; the prison-industrial complex, and many others (Shinn, 2010; Montgomery et al., 2013; Somerville, 2013; Cronley, 2010; Mitchell, 2011; Coalition for the Homeless, 2018). Major health system reforms and the resultant deinstitutionalisation are other significant factors argued to account for the observed prevalence, persistence and socio-demographic patterning of homelessness in the country (Montgomery et al., 2013).

The diversity and complexity of homelessness in the U.S. were recognised in the McKinney Homeless Assistance Act of 1987- the first piece of legislation that concentrated on resolving homelessness in the country through comprehensive national action. The Act led to substantial Federal changes and actions aimed to ameliorating housing exclusion and deprivation in the U.S. Notably, the Act launched the United States Interagency Council on Homelessness (USICH), which adopts a collaborative, intersectoral and comprehensive approach to homelessness. The remit of the USICH is focused on integrated care, facilitation of service entry, capacity building and innovation in service delivery, among others. Some of the most fundamental contributions of the USICH to reimagining homelessness services across the country include its promotion of harm reduction, the humanisation of care, longer-term temporary accommodation for clients with complex needs, the co-location of health and housing services, recovery-focused services, and others (United States Interagency Council on Homelessness, 2015).

In 2017, more than 553 700 individuals were found to be experiencing homelessness on a single night in the U.S., of whom 33% were families with children (U.S. Department of Housing and Urban Development, 2017). Nationwide, men make up 61% of the homeless population, women-39%, and transgender and non-binary persons-less than 1% (U.S. Department of Housing and Urban Development, 2017). Men tend to be significantly overrepresented among the unsheltered homeless population and make up 71% of this group (U.S. Department of Housing and Urban Development, 2017). With regards to the distribution of homelessness by race and ethnicity, 47% tend to be White and 40%-African American (despite the latter group making up only 12% of the total U.S. population), while 78% tend to be non-Hispanic, and 22%-Hispanic (U.S. Department of Housing and Urban Development, 2017).

Chronic homelessness is a persistent challenge in the U.S. The U.S. Department of Housing and Urban Development (2017) defines a chronically homeless person as '*an individual with a disability who has been continuously homeless for one year or more or has experienced at least four episodes of homelessness in the last three years where the combined length of time homeless in those occasions is at least 12 months.*' (p. 2). In the U.S., according to 2017 estimates, 24% of all homeless individuals exhibited patterns of chronic homelessness, with seven out of ten chronically homeless individuals residing in unsheltered locations (on the streets, under bridges, in train stations, etc.; U.S. Department of Housing and Urban Development, 2017).

In the U.S., chronic homelessness is often characterised by disruptive life events such as institutionalisation, incarceration, trauma, interpersonal violence, emergency care admission, symptom relapse and family breakup, all of which can hinder the acquisition and retention of stable housing and the engagement with behavioural health services (United States Interagency Council on Homelessness, 2015). In addition, chronically homeless individuals have been estimated to have a disproportionately high prevalence of a range of adverse outcomes such as mortality, morbidity, disability and joblessness (SAMHSA, 2012; U.S. Department of Housing and

Urban Development, 2017). Relatedly, this subgroup tends to have higher admission rates into emergency services, behavioural health services and correctional facilities than the general homeless population (Culhane et al., 2011). This suggests not only the higher economic and human costs associated with this client group, but also a tendency of those individuals to '*cycle*' through institutional settings. The metaphor of '*cycling*' between institutions refers to the frequent relocations to different service providers or institutions as a result of clients' needs exceeding service capacity, bureaucratic hindrances, the lack of attainment of service goals for those clients, and/or the barriers in accessing permanent housing.

Clients with a history of chronic homelessness are frequently believed to be '[…] *the most challenging to provide cohesive services to and to house successfully and sustainably* […]*'* (Farrell, 2012, p. 338; Farrell, 2010; Olivet et al., 2010). Their notoriety as *'complex'*, *'chaotic'* and *'resistant'* service-users has been partly attributed to their often-compounding health and social needs, transient lifestyles, mistrust in services, among other life experiences that may negatively affect whether and how they get in contact with, engage with, and remain in, services (Farrell, 2012). As a result, those who are chronically homeless have historically been a severely underserved group in the country.

In 2010, the U.S. Federal Government developed its first comprehensive Federal strategy for combating homelessness, *Opening Doors,* which was later updated in 2015. The Strategy prioritises several overarching goals including: (1) Prevent and end homelessness among veterans in 2015; (2) Ending chronic homelessness in 2017; (3) Preventing and ending homelessness for families, youth, and children in 2020; and (4) Setting a path to end all types of homelessness (United States Interagency Council on Homelessness, 2015). Collaborative action by the 19 agencies that comprise the USICH is embedded in the Strategy. The Strategy is underpinned by the assertion that stable housing is an essential prerequisite for not only physical safety and security, but also for achieving dignity, good health and positive educational and vocational outcomes.

Despite this principled commitment to upholding every client’s right to safe and secure housing, the progress towards the goals set by the nationwide *Open Doors* strategy has been mixed (Gillespie et al., 2016). While important milestones have been achieved in areas such as reducing veteran homelessness, progress in other strategic areas-such as youth and family homelessness and chronic homelessness-has been slow and uneven (Gillespie et al., 2016). Persistent challenges to ending homelessness in the country include bureaucratic barriers, policy and service fragmentation, duplication of resources, staff training and commitment at the frontline, the dissemination of evidence-based best practice models, and others (Gillespie et al., 2016). The optimal and efficient use of cross-sectoral resources has been singled out as one of the most pertinent challenges to tackling the ‘wicked’ issue of homelessness (Gillespie et al., 2016).

At a macro-level, some of the critical factors in reducing homelessness in the U.S. remain expanding the availability and access of affordable housing, scaling up evidence-based and cost-effective strategies such as Housing First and rapid rehousing, strengthening the economic support for and reducing inequalities in recently rehoused clients, re-affirming homelessness as a priority concern on the federal policy agenda, and others (Shinn, 2010; Ross, 2013; Fowler et al., 2019).

From the perspective of service-users, critical factors for eliminating homelessness and securing sustainable housing have been the safe, supportive and appropriate transitional housing (Fotheringham et al., 2014); continuing housing, financial and employment assistance; the navigability and alignment of support services and assistance programmes; the inclusive and non-judgemental attitudinal environment of service provision; the availability of tailored, person-centred support; the appropriate training of service-providers, and others (Thurston et al., 2013; Patterson et al., 2015; Hudson et al., 2016). In many jurisdictions at state, regional and city levels, the provision of homeless services does not adequately meet the multifaceted needs of the diverse client populations (Fowler et al., 2019). Furthermore, homelessness prevention interventions that have neglected the wider social determinants of health and housing insecurity have been critiqued for their inefficiency, short-termism and reductionist philosophies (Fowler et al., 2019).

New York City: Service Provision and Strategic Response to the Homelessness Crisis

New York City (NYC) ‘houses’ the biggest number of homeless people in the country. In recent years, the city has faced some of the highest rates of homelessness in its recent history (Coalition for the Homeless, 2018; 2019). According to July 2018 estimates, on a given night, more than 61 000 homeless people were staying in NYC’s shelter system, of whom three-quarters were families (NYC Department of Homeless Services, 2018). In addition, more than 3600 unsheltered (street homeless) persons were recorded in the city on a January night in 2018 (NYC Department of Homeless Services, 2018). Ethnic minorities and those living with serious mental health conditions and/or substance use problems are at a significantly increased risk of being street homeless in NYC (Coalition for the Homeless, 2019; Levitt et al., 2009). The lack of affordable housing, job loss, hazardous or violent living conditions, evictions and overcrowding, in addition to chronic health and mental health conditions, continue to fuel the homelessness crisis in the city (Coalition for the Homeless, 2019).

Temporary shelter-type facilities continue to be the primary strategy for tackling housing crises in NYC and the U.S. However, the shelter provision in the country has long been characterised by inadequacy in living conditions, unsuitability for the needs of many clients, inefficiency, high drop-out rates and human rights violations (Goodman et al., 2016). To many clients, researchers and advocates, shelters are the physical embodiment of the country’s short-termist, reductionist and inefficient response to the homelessness emergency (Goodman et al., 2016).

The average duration of shelter stay has most dramatically increased for single homeless adults over the last eight years-to 397 days in 2018 (Coalition for the Homeless, 2018). Overcrowding, insufficiently distributed resources, poor infrastructure, client transience, high staff turnover and other factors have impeded improvements in the living conditions and the associated quality of life of clients in a considerable proportion of shelters in NYC (Moffa et al., 2019; Coalition for the Homeless, 2018). Due to the extended stays in shelters and to the exposure to a plethora of adverse physical, institutional, psychological and social factors in those settings, temporary accommodation such as shelters can be considered an influential social determinant of clients' holistic well-being and quality of life.

In 2017, NYC launched its comprehensive plan for addressing homelessness, *'Turning the Tide on Homelessness*' (NYC Government, 2017). The plan targets several strategic areas-including the expansion of housing and rental assistance, tackling income inequality and other actions towards homelessness prevention. The plan also continues to expand its investment in supportive housing facilities for clients with complex needs including substance use and mental health difficulties as the more rights-based, evidence-based and cost-effective alternative to institutional care.

In addition, the plan commits itself to improving the capacity and quality of shelters in the city. In the Plan, the NYC Government recognises that the shelter experience can often result in community exclusion and thus present *'a barrier to reestablishing a stable life and finding a path back to more permanent housing.*' (p. x). In its '*Reimagined shelter strategy'*, the NYC Government commits to creating '*new, effective shelters'* (p. x), which are clean, accessible, safe, link clients with social and mental health services, and '[…] *can actually help people maintain stability and find their way back to the lives they had before homelessness.'* (p. x-xi). To fulfil those objectives, the NYC Government (2017) plans to build upon its recent successes in enhancing the quality and accessibility of the shelter provision in its boroughs, particularly increasing the number of safe havens and stabilisation beds available for street homeless persons. Despite innovative initiatives to reduce the rates of street homelessness in NYC such as the HOME-STAT (Homeless Outreach & Mobile Engagement Street Action Teams) city-wide outreach initiative (NYC Government, 2017), the unmet need in unhoused individuals in the city remains high due to persisting bureaucratic barriers, rigid shelter regulations and their complex healthcare needs exceeding the capacities of shelters (Wusinich et al., 2019).

Altogether, the U.S. has made concerted efforts-at federal, state and city levels-to improve the service provision for people who are unaccommodated, including those facing street and chronic homelessness (United States Interagency Council on Homelessness, 2016). The U.S. government has recognised the detrimental effects of shelter stays, including prolonged shelter stays and the unresponsiveness and/or unavailability of appropriate support services, especially for clients with additional and complex support needs (United States Interagency Council on Homelessness, 2016; NYC Government, 2017).

The Complexity of Need in Homelessness in Scotland and the U.S.

The link between homelessness and adverse physical and mental health outcomes has been well-established (Fitzpatrick et al., 2013; Homeless Link, 2014; SAMHSA, 2013; Fazel et al., 2014). Concordance rates between homelessness and SMI vary, with a literature review by Toro (2007, as cited by SAMHSA, 2015), for instance, suggesting that between 20% and 40% of people who are homeless have an SMI, with 20% to 25% having depression, and 5% to 15%-schizophrenia. In the 2016 Homeless Link UK report, Support for Single Homeless People in England: Annual Review 2016, 33% of people in accommodation projects were reported as having complex needs; 32%-mental health problems; 31%-drug issues; 23%-alcohol issues; 23%-history of offending. Notably, 73%

of the audited accommodation projects reported having had to turn people away because their needs were considered to be ‘too high’.

In the U.S., unsheltered homeless individuals (i.e. street homeless or roofless) have a greater prevalence of mental disorders than both the domiciled and the sheltered homeless populations (SAMHSA, 2015). In this most disadvantaged segment of the homeless population, epidemiological estimates of the prevalence of mental disorders have ranged between 25% and 90% in the U.S. (SAMHSA, 2015). Compared with the general population, homeless individuals have been reported to be twice as likely to have a chronic health condition, twice as likely to have a diagnosed mental health condition and six times more likely to have abused drugs and/or alcohol (Homeless Link, 2014; SAMHSA, 2013). The relationship between homelessness and SMI is most likely bi-directional, with poor housing circumstances negatively impacting upon individuals’ health and well-being, and those with pre-existing physical and mental health problems being more prone to losing their tenancies and being made homeless (Fitzpatrick et al., 2013; Somerville, 2013).

The profound health inequalities associated with homelessness and co-occurring mental health problems, in addition to other problematic life experiences, are often exacerbated by (a) histories of trauma (Homeless Link, 2014; SAMHSA, 2013; Fitzpatrick et al., 2013); (b) social and institutional discrimination and stigmatisation (Fazel et al., 2014; Busch-Geertsema et al., 2010; Fitzpatrick et al., 2013); (c) significant barriers to obtaining information and accessing services (Skosireva et a., 2014; Homeless Link, 2014; Bhui et al., 2006); (d) contact with the criminal justice system (Fitzpatrick et al., 2013); and (e) intergenerational poverty (Zlotnick et al., 2013). This constellation of systemic inequalities and injustices and adverse biographical events often engenders a complexity of needs that has been frequently constructed as *multiple or co-occurring disadvantage, multiple exclusion homelessness* and *chronic homelessness* in policy and other public discourses (Fitzpatrick et al., 2013; Padgett, Tiderington, Tran Smith, Derejko, & Henwood, 2016).

It has become increasingly recognised that this complexity of need necessitates better understanding of clients' lives-including their life history and social context, as well as better understanding of the barriers to effective service delivery for those groups (Shelter Scotland, 2016b; Lankelly Chase Foundation, 2015; Public Health England, 2018). In many service and policy contexts, however, the 'complexity' often observed in clients who are homeless tends to be interpreted as chaotic, difficult-to-engage and difficult-to-treat behaviour (Shelter Scotland, 2016b). To effectively respond to the severity and complexity of support needs in homelessness, however, service-providers should embrace complexity such that clients' needs are recognised as unique, holistic and context-specific, and that an understanding of clients as 'whole' persons is a necessary first step to effective service provision (Shelter Scotland, 2016b).

The interprofessional, multi-agency working needed to meet the multifaceted needs of homeless clients, however, poses significant fiscal, staffing and other organisational challenges (Olivet et al., 2010; United States Interagency Council on Homelessness, 2016). Adequate interprofessional and cross-government responses to the complexity of need in homelessness are crucial yet under-performing in the U.K. (Department for Communities and Local Government, 2015). To demonstrate, the most vulnerable clients-those with overlapping mental health, substance use and other difficulties-continue to be the hardest to engage in services and improve outcomes in (Department for Communities and Local Government, 2015). In the U.K., single homeless adults with complex needs continue to be hardest-to-reach client group (Department for Communities and Local Government, 2015). The unavailability of suitable permanent accommodation for those clients, together with austerity measures and funding cuts, has exacerbated the problem (Department for Communities and

Local Government, 2015). Moreover, services too often operate ‘in silos’ making the service provision fragmented and ineffective.

In response to those challenges, the MEAM (Making Every Adult Matter) partnership between the national U.K. charities Clinks, Homeless Link and Mind was founded in 2009 to support the service provision for multiple and complex needs (Public Health England, 2018). MEAM has committed to helping enable a comprehensive system transformation in order to ensure that the needs of people facing multiple exclusions (i.e. homelessness, mental illness, substance abuse, incarceration) are met. Those include, but are not limited to, increased flexibility and responsiveness of services, service user empowerment, better system coordination and lobbying for effective governmental responses. In the ten years since its inception, MEAM has contributed to the expansion of cross-sectoral partnerships, of the visibility of persons with lived experience and to increasing the profile of addressing multiple disadvantage as a government priority (MEAM, 2019).

Innovative, evidence-based and rights-based alternatives to the *‘linear approach’* or staircase model to homelessness assistance have shown promise for reducing the unmet needs of people who are homeless and have complex needs (Public Health England, 2018; Padgett, Henwood, & Tsemberis, 2016). In brief, the linear approach emphasises ‘housing readiness’ by prioritising the placement of individuals into short-term shelter facilities (Williams, 2017). In those facilities, under the close supervision of service-providers and following a prescribed ‘path to housing’, clients are expected to make use of all resources available to them (human resource, treatment options, information, shelter) as they ready themselves for permanent housing. ‘Readiness’, however, often requires achieving a demonstrable level of independence, which can include abstinence from illicit substances and adherence to a psychiatric treatment regimen (i.e. psychiatric stability; Williams, 2017). Clients who are perceived as failing to abide by those procedures are often seen as ‘resistant’ to change and incapable of maintaining their own well-being and their own housing (Williams, 2017; Padgett, Henwood, & Tsemberis, 2016). This approach, however, has frequently been criticised for being anti-therapeutic, ineffective, paternalistic and unsustainable (Padgett, Henwood, & Tsemberis, 2016).

In contrast, Housing First (HF) represents a radical, paradigm-shifting approach to homelessness reduction in which permanent housing is provided to the client without mandates for participation in treatment or meeting treatment targets (Tsemberis et al., 2004; Padgett, Henwood, & Tsemberis, 2016). HF is particularly suited for chronically homeless individuals with co-occurring mental health and/or substance use difficulties (Padgett, Henwood & Tsemberis, 2016; van den Berk-Clark, 2016). HF grants clients with autonomy and control over how and when they engage with support services and allows them to develop a sense of permanence and security-an important precondition for recovery (Padgett, 2007). HF reflects the growing trend of personalisation and humanisation of homeless services, particularly for clients with complex needs (Public Health England, 2018).

Despite successful evaluation studies, including pilot evaluations, of HF in several developed countries, including Scotland, the U.S. and Canada, several persistent barriers to scaling up this intervention have been identified. Those pertain to the need to overcome political resistance and ensure sustainable funding and housing supply, as well as to adapt the HF model to local settings without compromising programme fidelity (Public Health England, 2018; van den Berk-Clark, 2016; Greenwood et al., 2013; Clarke et al., 2019).

Conclusion

This chapter highlighted the socio-political and public health problem of homelessness as the sequela of intersecting axes of inequality. Individuals who are homeless face disproportionately high rates of mortality, morbidity and disability, including mental health problems, problem substance use (PSU), and physical health problems, in addition to other adverse and traumatic life experiences. Furthermore, individuals with co-occurring homelessness and mental health problems are at a higher risk of experiencing the most severe forms of social and housing exclusion such as chronic, repeat and unsheltered homelessness. Although concerted policy actions have been undertaken both in the U.S. and in Scotland, obscenely high numbers of individuals who are homeless continue to experience significant delays in help-seeking and health care, unmet health and social care needs, stigma and discrimination, as well as other human rights violations. The next chapter is dedicated to reviewing and critically appraising the literature on personal recovery and its intersections with the fields of structural disadvantage, homelessness and sociological theory.

Chapter Three

Personal Recovery, Socio-Structural Disadvantage and Homelessness: A Critical Literature Review

Logic of the Chapter

This chapter is dedicated to critically reviewing the theoretical and empirical evidence base for personal recovery. A critical review of the nature and characteristics of, and the socio-structural influences on, the recovery process was conducted. A special emphasis is placed on the offerings and limitations of qualitative, particularly narrative, research into recovery. Then, the chapter proceeds to discuss the evidence for the socio-structural and other contextual influences upon recovery. Following this, the core dimensions of recovery are problematised in relation to homelessness. The gaps in the research and theorising about the relational, contextual and socio-structural embeddedness of recovery are distilled. The structure-agency nexus is drawn upon as a source of sociological critique of personal recovery. The critical review concludes that personal recovery has remained underresearched, underproblematised and undertheorised, especially in the context of homelessness and other forms of socio-structural disadvantage. The theoretical and analytic utility of cross-cultural recovery research is rationalised. Those critical insights inform the research objectives of the current study.

Strategy and Scope of the Critical Literature Review

The critical review approach was deemed fit-for-purpose because of its utility for extracting and synthesising evidence from diverse sources-empirical and theoretical (Grant & Booth, 2009). Critical reviews are also well-suited for the in-depth, critical appraisal of a research field, concept or a problem, with the ultimate goal of helping generate critique, conceptual innovation and testable hypotheses, as well as identify new research directions (Grant & Booth, 2009; Huff, 2008). In addition, critical reviews are apt for gathering evidence and formulating critique to *problematise* a concept or an area of research. *Problematisation* entails '[…] *identifying and challenging assumptions underlying existing literature and, based on that, formulating research questions that are likely to lead to more influential theories.'* (Alvesson & Sandberg, 2011, p. 247). Problematisation is an essentially dialectical process, whereby the governing assumptions, paradigms and concepts in a field are identified, articulated, evaluated and critiqued by offering an alternative assumptive ground (by for instance, drawing on alternative philosophies, paradigms and theories; Alvesson & Sandberg, 2011).

Consistent with its aims and scope, the current critical review used a comprehensive, non-systematic, inclusive and iterative approach to searching the relevant literature. The iterative approach to searching allowed the Researcher to re-engage with key texts, as well as to identify new relevant texts, as the Researcher's knowledge and understanding of the relevant concepts and debates evolved, which facilitated the development of critical insights (Huff, 2008). The search aimed to '[…] *identify most significant items in the field*' (Grant & Booth, 2009, p. 94), without over-privileging certain sources over others based on their underlying paradigms, epistemologies, study designs or reporting quality. Details of the methodology of the critical literature review are available in 'Appendix 1'.

A critical review examining the intersections between personal recovery, socio-structural disadvantage and homelessness was conducted. The critical review is organised in four main parts, with each part reviewing empirical and theoretical research relevant to personal recovery and illuminating its contributions and inadequacies. The first part, '*Evaluating the contributions of qualitative research to understanding personal recovery*', rationalises the importance of qualitative research for understanding personal recovery and evaluates several central contributions of this body of work. The second part, '*Recovery in the context of socio-structural* *disadvantage'*, offers a conceptual critique of personal recovery, together with a critique of the dominant assumptions in the recovery literature. This critique centres upon the inadequate consideration of the socio-structural factors shaping the subjective experiences and outcomes of recovery. The third part, '*Recovery and homelessness: gaps in the knowledge base*', reinforces those critiques by evaluating the research on personal recovery in the context of homelessness. Finally, the fourth part, '*Unpacking the structure-agency nexus and its implications for personal recovery'*, puts forward the sociological theorising about the structure-agency nexus as promising for advancing the theoretical understanding of recovery-in-context. The critical insights and the knowledge gaps distilled from this critical review inform the research questions of the present empirical investigation. Those are concerned with:

- The lived experience of personal recovery in individuals with a history of SMI who have been chronically homeless, including the facilitators and hinderers of their recovery; and
- The socio-structural conditions implicated in their recovery, as well as those individuals' navigation and negotiation of those socio-structural conditions in pursuit of better well-being and recovery.

The Recovery Approach: An Introduction

The deepening of health inequalities in leading developed nations such as the U.K. and the U.S. has been paralleled by the promulgation of the *recovery approach* as a set of guiding principles and as a blueprint for re-envisioning mental health policies and services (Slade et al., 2008; Pilgrim & McCranie, 2013; Le Boutillier et al., 2011; Department of Health, 2001; Scottish Government, 2009). Supporting each client's recovery has been affirmed as a policy objective in the last 15 years in both the U.K. (including Scotland) and the U.S. (McWade, 2016; Department of Health, 2011; Department of Health and Human Services, 2003; Scottish Government, 2017; Slade et al., 2008). Recovery is cited within the '*Transforming Mental Health Care in America, Federal Action Agenda: First Steps'* as the '*single most important goal*' for mental health services (US Department of Health and Human Services, 2003, p. 5). This federal action agenda highlights several of the main components of the recovery-oriented practices-including therapeutic optimism, meaningful choice about treatment options, client participation and building resilience.

Analogically, recovery is embedded in HM Government's '*No Health without Mental Health: A cross-government mental health outcomes strategy for people of all ages'* policy document (Department of Health, 2011). In this document, promoting recovery and inclusion is recognised as '*critical'* to delivering high-quality care across the health and social sectors. This document adopts an expansive definition of recovery: '[…] *greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.*' (p. 6). The strategy thus explicitly addresses some of the social determinants of good mental well-being and recovery, particularly employment, appropriate service provision, education and stigma and discrimination (Department of Health, 2011).

Most recently, the Scottish Mental Health Strategy 2017-2027 set out a 10-year vision for the mental health services in the country (Scottish Government, 2017). In this strategy, enhancing the *recovery orientation* of services by placing clients' '*assets, strengths and self-management*' (p. 35) at the centre of the care is emphasised. Introduced in 2007, the Scottish Recovery Indicator (SRI) has been the embodiment of Scotland's commitment to transforming its mental health services to promote recovery. The revised 2011 SRI 2 contains ten recovery indicators, amongst which are user involvement, social inclusion, basic needs, self-management, a focus on strengths, and several others (Scottish Recovery Network, 2016).

Analogically, in the U.S., the SAMHSA (2012) has identified recovery as a priority within behavioural health services. The SAMHSA and the U.S. Department of Health and Human Services have operationalised recovery into actionable steps aimed at aligning the ethos of service provision with the principles of recovery (SAMHSA, 2012). Critically, personal recovery is seen as the cross-cutting principle that can facilitate cross-governmental and cross-agency actions, with a focus on improving the care for, and recovery of, all service-users, including those with dual diagnosis and complex needs (SAMHSA, 2012).

Across those policy initiatives, personal recovery has been re-affirmed and mobilised as critique and an antipode of the prevailing paternalism, pathologisation and reductionism in mental health services (Bonney & Stickley, 2008). Consensus seems to have been established that recovery is about rebuilding a meaningful, satisfying and valued life (Department of Health, 2005). Furthermore, several policy documents highlight different enablers and hinderers of recovery, both outside and within the care system. Those include previous personal losses, social isolation, lack of individual choice, low expectations from staff, ineffective treatment options and stigmatisation, on the one hand, and self-determination and empowerment, flexibility and responsiveness of care, belief in the unique strengths of service-users, and citizenship, on the other (National Institute for Mental Health in England, 2005; Department of Health, 2005; Bonney & Stickley, 2008).

The process of implementing the recovery vision on the ground is rife with challenges- organisational, political, cultural and conceptual (Hopper, 2007; Farkas, 2007). Smith-Merry and colleagues (2011), for instance, warn about the danger of '[…] *exploiting the diversity of interpretative possibilities permitted by the rather vague definition of recovery itself* […]' (p. 10). The legacies of paternalism, coercion, disease-centrism, intervention rigidity and the lack of service-user involvement in mental health care have frequently been cited as barriers to realising the recovery ideal in practice (Hopper, 2007; Farkas, 2007). Too often, when subjected to the pressures of standardisation, auditability, operational demands and bureaucracy, notions central to recovery such as hope, self-determination, autonomy and empowerment have tended to become obscured and superficially implemented, and even co-opted, within the service provision (Hopper, 2007; Farkas, 2007; Rose, 2014).

Arguably, in order to help bridge the '*translational gap'* (Le Boutillier et al., 2015, p. 430) between the recovery philosophy and values and the mental health and social care systems, service-providers and policy-makers should obtain an in-depth, contextualised understanding of individuals' experiences of recovery (Tiderington, 2017). A greater emphasis is required on authentic and contextualised accounts of what personal recovery is and what it *is not* for diverse populations with diverse life experiences within distinct socio-cultural and organisational settings. Indeed, the comprehensive knowledge about the nature, experience and process of recovery has been discussed as one of the key '*technologies'* that should be used to ensure policies and service models align with the recovery vision (Smith-Merry et al., 2011).

Those conceptual and implementational challenges are especially acute in the homelessness services provision, whereby bureaucratic, organisational and cultural barriers, together with clients' increasing complexity and severity of need, have often impeded the realisation of the principles of recovery on the ground (Cornes et al, 2013; Gillis, 2010; Padgett, Tiderington, Tran Smith, Derejko, & Henwood, 2016). As a result, in many jurisdictions, the recovery approach has not been fully integrated into homelessness services (Gillis et al., 2010). Moreover, certain dominant service models, such as the shelter systems and the 'treatment first' approach, have been associated with numerous *anti-recovery* organisational practices (Cornes et al., 2014; Padgett, Henwood, & Tsemberis, 2016; Hoffman & Coffey, 2008; Jost et al., 2011; Donley & Wright, 2012). Examples of those include institutional practices based on paternalism, infantilisation, rigidity of residential policies, conditionality, the medicalisation of clients' social distress and other systemic antipodes to personal recovery (Hoffman & Coffey, 2008; Jost et al., 2011; Donley & Wright, 2012). Those practices seem diametrically opposed to core tenets of the recovery approach such as the universalist principles of respecting each individual’s rights of autonomy, dignity, respect and self-determination (Shera & Ramon, 2013; Le Boutillier et al., 2011; Pilgrim & McCranie, 2013; Onken et al., 2007).

In many political and organisational contexts, the emancipatory and person-centred values of recovery seem to be subverted by the disempowering, marginalising and anti-therapeutic influences of oppressive structural forces such as psychiatrisation, sanism, and client responsibilisation (Vandekinderen et al., 2014; McWade, 2016). Psychiatrisation and sanism refer to ideologies that perpetuate stereotypes regarding the deviance, helplessness and dependency of mental health service users and therefore perpetuate the discrimination and inequalities experienced by this group (Morrow & Malcoe, 2017). Responsibilisation, on the other hand, relates to the neoliberal governmentality emphasising individual freedoms, duties and autonomy and which may create a political discourse implicitly or explicitly blaming and ‘punishing’ disadvantaged citizens for their own misfortune (Vandekinderen et al., 2014).

According to Vandekinderen and colleagues (2014), those tensions may often render recovery a paradoxical phenomenon in mental health service settings. On the one hand, recovery planning is guided by the principles of hope-building, empowered choice and control by clients, and the restoration of meaningful social roles and personal values. On the other hand, service-users are often denied the social bases for self-respect, dignity and self-determination as a result of oppressive discourses, policies and technologies (Vandekinderen et al., 2014). This necessitates the critical and contextualised consideration of the meaning and implementation of recovery-oriented practice in distinct service-user groups in different jurisdictions (Le Boutillier et al., 2011).

Overview of the Core Tenets of Personal Recovery

As a concept and as critique of services, personal recovery gained its potency from the psychiatric user/survivor movement in the early 1970s (Deegan, 1988; Adame & Knudson, 2007). The movement grew out of groups of service-users' dissatisfaction with the degrading, inhumane, ineffective and disempowering psychiatric treatment. Those groups later merged with other marginalised activist groups and formed grassroots advocacy organisations and peer support networks (Adame & Knudson, 2007). At the heart of the movement were challenging the dominant psychiatric discourses and institutionalised practices through collective action and the construction of emancipatory identities beyond those of the helpless and dependent psychiatric patients. Service-users' rights to self-expression, self-definition, dignity and liberation from the oppressive institutional arrangements underpinned those initiatives (Adame & Knudson, 2007).

This shift of power was the foundational principle of the psychiatric survivor movement, subsequently termed the 'recovery movement' (McLean, 1995). Service-user empowerment was envisioned as an essential pre-requisite for recovery (McLean, 1995). Empowerment was understood in both its psychological and political dimensions (McLean, 1995). *Recovery as empowerment* means promoting service-users' self-efficacy, positive sense of self and human dignity, and expanding their scope for meaningful and impactful decision-making within and outwith the mental health system (McLean, 1995). Those emancipatory and humanistic principles championed by the service user/survivor movement were consolidated in the concept of personal recovery as the vision for mental health system transformation in the following decades (Deegan, 1988; Rose, 2014; Pilgrim & McCranie, 2013). Realising clients' personal recovery requires a shift of the clinical focus away from clients' deficits and towards clients' choice, inner assets and journeys of growth and self-discovery (Slade, 2009). Rather than as *'passive recipients of rehabilitation services'*, Patricia Deegan (1988, p. 1) argues, individuals recovering from mental illness should be treated as self-directed persons who strive to re-build a sense of meaning and purpose and a positive sense of self, despite experiencing occasional setbacks, doubts and vulnerability.

To reaffirm the integrity of the personal recovery concept, it should be distinguished from the concept of clinical recovery (Slade, 2009; Slade et al., 2008). Clinical recovery is largely compatible with the notion of symptom remission, psychiatric rehabilitation and the long-term reduction or elimination of symptoms (Slade et al., 2008). Clinical recovery is typically measured by the reduction in clinical symptomatology and improvements in general functioning and productivity (Slade, 2009). Clinical recovery is also generally believed to be contingent upon treatment adherence, as well as the professional expertise of the mental health practitioner. Clinical recovery purports to be objectively measurable, largely universal in nature, value-free, and induced by clinical (including psychotherapeutic) interventions (Slade et al, 2008).

Arguably, the medical model of mental illness, upon which the notion of clinical recovery is founded, tends to de-contextualise individual suffering by placing an over-emphasis on a narrowly defined list of clinical symptoms (Carpenter, 2002; Bonney & Stickley, 2008). This philosophy of care has also been accused of neglecting individual strengths, values and social ecologies. In addition, historically, the medical model has been associated with numerous human rights violations such as coercive care practices and widespread stigmatization and discrimination (Morrow & Weisser, 2012). Furthermore, the medicalisation of individuals' experiences of mental illness has been linked to the institutional 'silencing' of voices of lived experience in policy-making, service-provision and advocacy (Carpenter, 2002; Karban, 2017).

In contrast, following Anthony's (1993, p. 16) canonical definition, personal recovery reflects:

> '[…] *a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful, and*

> *contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness*'.

The personal recovery notion is imbued with therapeutic optimism, hope and humanism (Slade, 2009). Personal recovery has been characterised by service-users and activists as *'a journey of the heart'* (Deegan, 1996) and *'a self-directed process of healing and transformation'* (Deegan, 2002), which underscores its intimate, unique, growth-oriented and transformational nature. Critically, the personal transformation inherent to recovery cannot be 'programmed'; it is contingent upon the individual's proactive engagement with their own values, beliefs and principles and with the objective conditions of existence (McLean, 1995; Deegan, 1988). Such a conceptualisation of recovery as an intimate transformation opposes mechanistic medical and other institutional 'solutions' or models that homogenise the complex human experience of having mental health difficulties (McLean, 1995).

Personal recovery is a multifaceted and fluid concept, which is often seen as its inherent strength (Hopper, 2007; Pilgrim & McCranie, 2013). This inclusive and holistic nature of recovery is often seen as reflective of its person-centred and emancipatory roots and philosophy (Pilgrim & McCranie, 2013). SAMHSA (2012) provides an inclusive definition of recovery from serious mental illness and/or substance use problems as '[a] *process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.'* (p. 3). This definition seems purposefully broad not only because it aims to capture the recovery process both for persons experiencing mental illness and those experiencing substance use problems, but also because SAMHSA underscores that recovery is holistic and that there are multiple pathways to its realisation. The 'multiple pathways' principle is a reflection of the belief that recovery is shaped by the unique strengths, goals, preferences and needs of each individual and that it can be supported by both formal (e.g.

clinical/medical) and non-formal (e.g. faith- or community-based) approaches (SAMHSA, 2012).

Due to this understanding of personal recovery, clinical and therapeutic models of 'recovery stages' (e.g. Andresen et al., 2006; Leamy et al., 2011) have been subject to continuous debate, especially given the seeming consensus about the non-linear nature of recovery. As Slade and colleagues (2008, p. 130) argue, *'[r]ecovery is not a step-by-step process but one based on continual growth with occasional setbacks'*. Ambiguity also persists as to what those individual recovery stages should be and as to whether they are universally applicable (Leamy et al., 2011). Efforts to measure mental health recovery in clinical settings using standardised instruments have been critiqued based on the argument that such an approach contradicts the processual, holistic, contextual and individualised nature of the recovery process (Weeks et al., 2011). A further criticism of staged models relates to their overly psychologised conception of recovery, which underplays the role of context such as the influence of discrimination and social supports (Davidson et al., 2010).

Evaluating the Contributions of Qualitative Research to Understanding Personal Recovery

Research into the nature of personal recovery, especially individuals' lived experience of it, is instrumental in guiding the principled yet flexible and context-sensitive implementation of the recovery vision in services and policies (Pilgrim & McCranie, 2013). As argued by Olmos-Gallo and DeRoche (2010) in their editorial on outcomes monitoring, '[…] *in order to implement effective and efficient programs and policies that focus on recovery, it is important to understand* ***how recovery happens*** [emphasis added].' (p. 8). Similarly, as cautioned by Drake and Whitley (2014), the expansion of recovery models, programmes, policies and scales should not obscure the primacy of the lived experience of the complex human process of recovery. As noted by Liggins

(2018, p. 666), the crafting of organisational practices and guidelines often entails the '[…] *loss of the heartfelt, subjective qualities of personal recovery'*. Research that is attentive to, and reflective of, individuals' subjective experiences and interpretations of recovery is integral to mitigating the risk of 'co-opting', 'hijacking' or 'abusing' recovery in service provision (Slade et al., 2014). Arguably, eliciting clients' complex, layered personal stories about recovery can yield revealing and potentially transformational insights that could help align '*policies, practices, procedures, services, and supports*' with clients' multifaceted needs (Gillis et al., 2010, p. 78; Smith-Merry et al., 2011).

The diverse corpora of qualitative research-including ethnographic, oral history, narrative and participatory research-have played a central role in foregrounding lived experience knowledges of personal recovery, highlighting its contextual embeddedness, and challenging professionalised, medicalised and other reductionist constructions of recovery (Foster et al., 2006; Davidson, Sells, Songster, & O'Connell, 2005; Topor et al., 2011; Davidson et al., 1997; Borg & Davidson, 2008; Grant, 2014; Rennick-Egglestone et al., 2019).

The Centrality of Narrativity and Subjective Meaning-Making in Recovery

Numerous qualitative investigations have demonstrated the prominent role that individuals' subjective interpretations of their mental illness, relationships, treatment, recovery journey and other life circumstances have in inhibiting or facilitating their recovery (Leonhardt et al., 2017; Sagan, 2015; Connell et al., 2015; Lysaker & Roe, 2012). Autoethnographic and other empirical qualitative research has revealed the varieties of the recovery experience by documenting the vicissitudes and paradoxes that often accompany this process- from revelatory discoveries to feelings of chaos; from positive relationships to social isolation; from perceived failures to successes (Robertson et al., 2017; Drake & Whitley, 2014). Defined as *'coherent, followable accounts of perceived past experience'* (Braid, 1996, p.6), personal narratives have begun revealing how core *recovery processes* (the plural form denoting the multiple components that have been proposed to constitute recovery) develop over time, what potentiates and what stifles them, how the individual's meaning of them evolves, and how the individual's social context shapes their experiences (Higginson & Mansell, 2008; Roe & Davidson, 2005; Farkas, 2007). As such, personal narrative accounts have helped advance the understanding of recovery as '*gradual, multidimensional and unique'* (Temesgen et al., 2019, p. 9; Higginson & Mansell, 2008).

As forms of cultural and socio-political critique, narrative, autobiographical and other critical qualitative recovery research has bridged the gap between the personal and the cultural, social and political (Ellis & Adams, 2014). Such work has foregrounded narrativity, insiderness, cultural critique, personal liberation and transformation, which aligns it with the emancipatory values and commitments of the psychiatric survivor movement (Ellis & Adams, 2014; Adame, 2014; Grant, 2010). In terms of promoting recovery-oriented practice, this research has emphasised the need to give primacy to clients' own definitions of recovery and support them in their reflective engagement with their recovery (Leonhardt et al., 2017). Research into what constitutes '*meaningful recovery'* remains pivotal in informing recovery-oriented care (Lysaker & Roe, 2012, p. 288; Grant et al., 2015).

Adame and Knudson (2007) conceptualise recovery narratives as narratives of opposition towards what they call the master narrative of the medical model of mental illness. Indeed, the authors observe, many such personal narratives are imbued with ideas about political oppression, active citizenship and social justice. In those cases, the personal testimonies of surviving trauma, poverty and marginalisation often assume the function of actual and symbolic resistance towards social and political inequities (Adame & Knudson, 2007; Grant et al., 2015). Such narratives of diversity and difference in individuals' experiences with recovery and experiences with mental health services can make a valuable contribution to the '*stock of available narratives*' that those with lived experience-within or outwith services-can draw upon to re-story their lives in a personally and relationally meaningful way (Grant et al., 2015, p. 285; Fisher & Freshwater, 2014).

This body of research has emphasised the profound impact SMI and co-occurring adverse life events may have on the individual's sense-making so that the individual's internal and external worlds can become '*unpredictable, senseless, frightening, and painful*' (Connell et al., 2015, p. 1). The rebuilding of the sense of control, hope and purpose that characterise recovery, therefore, often requires an intense process of meaning-making as the individual endeavours to '*restructure and reinterpret aspects of one's life narrative in a way that imposes meaning and coherence'* (Connell et al., 2015, p. 1).

For individuals with psychosis, for instance, qualitative research has indicated that the road to recovery tends to involve the creative and strategic reinterpretation of the illness symptoms as non-threatening and controllable, and for some, as even benign and illuminative (Larsen, 2004; Connell et al., 2015). The findings from Connell and colleagues' (2015) phenomenological study with 20 young people who had recently had first-episode psychosis in Brisbane, Australia, are illustrative of the insights from similar studies regarding the importance of sense-making in recovery from psychosis. Particularly, the authors found that the onset of psychosis and institutional care was, for the participants, a period of vulnerability and disorientation-social, psychological and existential. This could result in what Connell and colleagues interpret as '*self-estrangement*', which is illustrated in one participant's testimony: '*I really lost myself…I'm just trying to get back to me…*' (p. 4). This threatening experience, then, seemed to trigger a dialogic process of meaning-making as the participants reflected on the significance of their illness experience within the broader frame of their lives. The participants tended to engage in both intrapersonal (self-reflective) and interpersonal (dialogic) sense-making, which enabled the re-establishment of a continuous sense of self and biography (Connell et al., 2015).

Similarly, in the context of recovery in schizophrenia, Roe and Davidson (2005) comment that the restoration of meaning in life and self-acceptance may require the incorporation of illness symptoms previously perceived as hostile and destructive (e.g. auditory hallucinations in psychosis) into a new meaning system. Interestingly, individuals have been shown to resort to various pre-existing belief systems to inform their own meaning-making (Roe & Davidson, 2005; Mizock et al, 2014). Such belief systems may be organised religion, culturally mediated explanatory models of illness, and others.

Furthermore, autoethnographic work such as Sørly, Karlsson and Grant's (2018) collection of biographical stories and personal reflections has not only conveyed the experience of mental illness and recovery '*as close to life as possible'* (Andersen, 2017) but has also challenged dominant (professional, academic) views on recovery (Robertson et al., 2017; Richards, 2008; Liggins, 2018; Scottish Recovery Network, 2009; Roe & Davidson, 2005). For instance, the British scholar, Alec Grant (Sørly et al., 2018), does not identify with the recovery label and instead embraces the idea of *'becoming-other'* (p. 8) as more reflective of his personal recovery journey. For Grant, 'recovery' is an instrument that he believes health professionals and institutions use for 'fixing' people and 'moulding' them into stereotypical ideas about normality and morality. Instead, he continues, *'[…] the pieces of re-storying a life don't necessarily go back in the same way […] some pieces are thrown away, with newly discovered and unfamiliar pieces crafted into place.'* (p. 8). Those personal reflections underscore the transformational and often-unpredictable nature of recovery, whereby individuals can come to construct their mental illness as an opportunity for personal growth and self-transcendence (Reed, 2009).

In another account of the '*storied complexity*' (Grant et al., 2015, p. 1) of recovery, Liggins (2018) combined one-to-one interviews with ten individuals (eight women and two men) with lived experience with her own autoethnographical account. The findings offer a valuable perspective into the inner workings of healing, and delineate the relationship between healing and feeling ‘*connected’, ‘integrated’* and ‘*transformed*’. The participants used various metaphoric expressions in attempts to capture their experiences-for example, ‘*blooming*’, ‘*piecing myself back together*’ and ‘*a journey towards wholeness’* (p. 4-5). Prior to the achievement of those recovery milestones, however, the author discusses ‘*what it was like to be unwell’* (p. 4). The period of *not* being in recovery was described by the participants, including the author herself, as paralysing emotional and existential pain: *‘…I was struggling with emotions that had no form, no recognition, no meaning. A maelstrom of confusion…’* (p. 4). This sense of loss and loneliness was experienced as cultural, social and spiritual separatedness. The participants describe the recovery journey as an exploration that entails both risks and rewards (Liggins, 2018).

Indeed, within the wider narrative literature on mental illness and personal recovery, two intertwined over-arching themes seem to have most prominently accounted for the dynamic temporal trajectory of recovery. The first one reflects biographical accounts of a *regressive trajectory*, which has been commonly manifested in the narrators’ struggles, hopelessness, loss of meaning, traumatic and other negative life-altering events, powerlessness, a damaged sense of self and others (Llewellyn-Beardsley et al., 2019). The other, antithetical over-arching theme encompasses a *progressive trajectory*, which has typically involved the narrators’ upward spiral towards health and well-being, revelations and epiphanies, positive expectations and hopes, re-connections with oneself and others, among other biographical motifs (Llewellyn-Beardsley et al., 2019). Those interlacing regressive and progressive trajectories have been explored in relation to the core components of personal recovery as identified in the extant empirical literature-including identity, sense of control and empowerment, meaning-making, self-efficacy and self-care, social support and inclusion and others (Leamy et al., 2011; Roe & Davidson, 2005). It appears that the interweaving of those two meta-themes-of disruption, despair and dissonance and of repair, reawakening and resilience-gives the phenomenon of recovery its inherent dynamism, multiplicity and non-linearity (Llewellyn-Beardsley et al., 2019).

Dynamism and narrativity as core characteristics of personal recovery have been instrumental in exploring the *plurality of the self* and the *narrative identity*, which have been central in qualitative investigations of individuals' recovery experiences (Roe & Davidson, 2005; Grant et al., 2015; Bauer et al., 2008). For instance, Wisdom and colleagues (2008) qualitatively analysed identity-related themes within a sample of 45 published narratives of SMI. Several prominent themes were identified-including the fragmentation of the self and the co-existence of the 'ill' and the 'healthy' selves. The findings focus on the tensions between the various 'selves'-for example, the authentic self, the past/unwanted self, and the future/desired self (Wisdom et al., 2008; Roe & Davidson, 2005). Similarly, a recent metasynthesis of 17 qualitative studies of the experience of SMI by Kaite and colleagues (2015) identified several sources of the fragmentation and plurality of one's sense of self as a result of the mental illness. Among those were the social consequences of having the illness (such as isolation, alienation and feeling invisible), the nature of the illness itself (for example, its complexity, unpredictability and uncontrollability), the unwanted physical and social effects of the medical system (particularly pharmacology), in addition to other external factors such as adverse life experiences and economic factors (Kaite et al., 2015). According to the authors' analysis, all those factors shaped the individuals' '*ongoing struggle for reconciliation with the self and illness*' (p. 469). The resolution of such inner conflict seems integral to individuals' sense of coherence and well-being (Wisdom et al., 2008; Mizock et al., 2014).

It appears, therefore, that this inner dialectic between different 'selves' profoundly shapes the recovery experience and outcomes. This idiosyncratic yet culturally embedded process of identity negotiation is one source of diversity in individuals' recovery trajectories and experiences. Altogether, this corpus of qualitative research has yielded compelling evidence that '[…] *identity appears to be a crucial and* *central intersection influencing various domains of recovery* […]' (Yanos et al., 2010, p. 86).

Qualitative recovery research has harnessed the theoretical and methodological offerings of both '*big stories'* and '*small stories*' in order to understand core recovery processes (Bamberg, 2006). Specifically, the autobiographical narratives ('*big stories*') of persons with lived experience have indicated the dynamic nature of personal recovery and its relationship with the experiences of illness and other adverse life experiences. Those narrative data have also provided insights into individuals' changing relationship with their mental illness and their recovery, as well as into the importance of '*turning points*' in stifling or stimulating individuals' recovery efforts (Llewellyn-Beardsley et al., 2019). From an emancipatory standpoint, autobiographical research with psychiatric survivors and those recovering from SMI and other forms of significant mental distress have offered participants the opportunity to re-story their lives in a deeply meaningful and potentially empowering manner (Rennick-Egglestone et al., 2019). Individuals' *narrative identities*, defined as *'interpreting and integrating one's life'* in a way that helps the narrator develop a sense of biographical continuity and coherence (Bauer et al., 2008, p. 84), have been a central empirical 'object' in narrative recovery research (Wisdom et al., 2008; Grant et al., 2015).

Qualitative research on the present-day life narratives of people with lived experience ('*small stories*'), on the other hand, has begun to unravel the significance of the 'insignificant', of the routine and taken-for-granted daily activities and events, for individuals' capacities for recovery (Borg & Davidson, 2008; Sools, 2013). Those 'here-and-now' narrative accounts have shed light onto the ebb and flow and socio-ecological embeddedness of participants' mental well-being and recovery (Borg & Davidson, 2008). Proponents of the integration of 'small stories' into the empirical analysis of narratives tend to theorise 'the everyday' as a reflexive space, where individuals construct their identities, engage in various forms of meaning-making, and perform acts of resistance to power structures (Latham, 2003). Everyday practices and social relations that make up everyday life are infused with power, which is constantly maintained, challenged and/or resisted by individuals in response to the '*gaps, tears, inconsistencies* [and] *ambivalences*' inherent to '*the politics of lived space*' (Latham, 2003, citing Pile, 1997, p. 27). This body of work has shown that the rhythm and triviality of everyday life- its continuity, normality, controllability, stability-are important for understanding such core processes as hope-building, social participation and developing a sense of independence (Borg & Davidson, 2008; Davidson, 2007). Everyday life tends to be organised according to socio-cultural norms and therefore the analysis of everyday life is likely to reveal insights about the socio-cultural context in which one's recovery journey is embedded (Borg & Davidson, 2008). As aptly argued by Derek Summerfield (2002, p. 1107):

> *'Recovery is not a discrete process: it happens in people's lives rather than in their psychologies. It is practice and unspectacular, and it is grounded in the resumption of the ordinary rhythms of everyday life - the familial, sociocultural, religious and economic activities that make the world intelligible.'.*

For instance, in their qualitative investigation of individuals with serious mental illness living in supportive housing, Piat and colleagues (2017; N = 17) foreground the role of *places* and *spaces* in recovery. Piat et al. (2017) were interested in the '*physical, symbolic, and social'* (p. 71) functions that various settings and places had on recovery. To elicit those meanings, the researchers asked the participants to obtain images of the places they visited in their everyday lives, especially those that carried personal significance to them. The analysis of the in-depth interview data revealed that some of the participants derived profound meaning from trivial places, objects and activities. For instance, gardening, for one participant, signified the possibility for change and flourishing despite hardship. Other places such as holy homes, and activities such as cooking, observing and walking, also contributed in unique ways to how the participants perceived themselves and imagined their desired future. Piat et al. (2017) concluded that '*[u]nderstanding these areas […] enables a reconceptualization of* *seemingly banal locales into dynamic sites of recovery, insofar as they foster autonomy and self-efficacy, increased self-care, and meaningful social connection*.' (p. 76). Such research has emphasised the processual and contextual nature of recovery, whereby even the seemingly trivial aspects of everyday life, the '*small bits of life'* (Borg & Davidson, 2008, p. 138), can have a profound influence on individuals' sense of self and recovery.

The evidence from qualitative research pertaining to the vital role of meaning-making in recovery carries important implications for both the scientific enquiry into recovery and the delivery of recovery-oriented care (Leonhardt et al., 2017). This evidence highlights the value of research paradigms such as phenomenological, narrative, participatory and arts-based methodologies that are well-suited to unravel how individuals interpret their illness and life circumstances and how this sense-making affects recovery within the individuals' unique life history and social and cultural milieus (Larsen, 2004). As revealed by narrative and other qualitative research, recovery can be conceptualised as an extraordinarily ordinary phenomenon. Recovery should be understood as emerging from both individuals' 'small' acts of resistance and self-determination, *and* from individuals' 'grand' life stories (Costa et al., 2012).

Recovery as a Multi-Determined Phenomenon

Beyond narrative research, reviews of qualitative and mixed-method studies have also been an influential corpus of literature highlighting the core components and determinants of personal recovery. A steadily increasing number of systematic reviews and narrative syntheses of the '*properties*', *'processes*', '*dimensions*' or *'elements'* of personal recovery have made significant contributions to distilling some of the factors facilitating and hindering recovery. Those facilitators and hinderers refer to both the individuals' internal beliefs, predispositions and practices *and* the individuals' wider context-including relationships, support services, institutions and the wider culture and society (Tew et al., 2012).

To begin with, several reviews have been concerned with identifying core characteristics of personal recovery in the general (or otherwise unspecified) population of mental health service-users or other individuals with mental health problems (e.g. Leamy et al., 2011; Onken et al., 2007; Drake & Whitley, 2014; Stuart et al., 2017; Jacob et al., 2017; Bonney & Stickley, 2008; See 'Appendix 1', for a tabular summary). One of the most influential of those reviews, Leamy and colleagues' (2011) systematic review and narrative synthesis, identified five over-arching recovery processes: **C**onnectedness; **H**ope and optimism about the future; **I**dentity; **M**eaning in life; and **E**mpowerment-captured by the acronym 'CHIME'. The 'connectedness' category encompasses peer and other social support, relationships and community inclusion. 'Hope and optimism about the future' are manifested through belief in the possibility for recovery, 'positive thinking', 'motivation for change', 'hope-inspiring relationships', and 'having dreams and aspirations'. 'Identity' mainly refers to 'self-esteem and acceptance' and overcoming stigma. 'Meaning in life' thrives on a positively constructed meaning of mental illness; good quality of life; spirituality; meaningful social roles; and realisable life goals. And lastly, 'empowerment', according to CHIME, is contingent upon 'personal responsibility', 'control over life', and 'focusing upon strengths'. The 'CHIME' framework is founded on the premise that recovery is a uniquely defined, personal journey that is non-linear, multidimensional, and positively influenced by a supportive and healing environment (Leamy et al., 2011).

According to Leamy and colleagues (2011), the 'CHIME' framework emphasises the need for a greater focus on service-users' strengths and their *'self-narrative development'* (p. 451). The authors also underscore the role of the mental health system in fostering social inclusion, providing physical and psychological refuge, and enabling service-users' '*empowerment and self-management'* through recovery-oriented *'clinical interaction styles'* (p. 451). Importantly, the authors nominate the five

CHIME categories as an alternative set of *'potential clinical end-points for interventions'* (p. 451). The 'CHIME' model has informed the practice of numerous third-sector organisations (such as the Scottish Recovery Network), as well as national and regional mental health policies and guidelines (Slade, 2012; Pincus et al., 2016).

The CHIME framework was validated by Slade and colleagues' (2012) review of the international literature on recovery. Slade et al. (2012) found that while the CHIME components were well-supported by the literature, several evidence gaps persist. According to the authors, those include the need to more substantially integrate non-Western perspectives into popular recovery frameworks as well as to examine more comprehensively and more critically the role of mental health services in supporting recovery. The need for more research into the role of mental health services in recovery is further support by Jacob and colleagues' (2017) review, which identified a range of positive and negative influences on recovery rooted within the mental health system. Importantly, Jacob et al. (2017) synthesised the perspectives of multiple stakeholders- including persons with lived experience, carers and service providers- from a total of 26 studies. They found that supportive relationships, collaboration, mutual trust and respect with service providers, and a range of professional interventions tended to facilitate recovery. In contrast, staff shortages, negative staff attitudes, poor trust, respect and listening practices by staff, indifference and judgemental attitudes by staff, rigid treatment focused primarily on symptoms, inhumane inpatient practices, coercion and paternalism and the side effects of medications tended to hinder recovery.

A conceptually similar but structurally different typology than Leamy et al.'s (2011) was offered by Bonney & Stickley's (2008) review of the British literature on mental health recovery. The authors distil six central interwoven themes: *identity, service provision agenda, the social domain, power and control, hope and optimism* and *risk and responsibility*. Those components were identified by gathering and synthesising the views of three stakeholder groups- individuals with lived experience, practitioners and policy-makers. The authors acknowledge the multi-perspectival, fluid and often-contradictory nature of recovery. Furthermore, the *meanings* attributed to the aforementioned components of recovery appear to be contingent upon clinical, social and political factors (Bonney & Stickley, 2008). The review authors place particular emphasis on the various factors impacting recovery within what they term 'the social domain'- including an individual's reintegration into society, their vocational opportunities, as well as the achievement of equality, full citizenship and overcoming stigma.

A relatively small number of qualitative evidence syntheses have focused on the recovery experiences in specific subpopulations of mental health service-users such as individuals in forensic settings (Shepherd et al., 2016a), individuals with personality disorder (Shepherd et al., 2016b), and individuals with co-occurring mental health and substance use problems (Ness et al., 2014). The two reviews by Shepherd and colleagues highlight the importance of safety and security as pre-requisites for recovery; the dynamics of hope and autonomy; and the role of social networks in constructing a positive self-identity. A distinct contribution of Ness and colleagues' (2014) review, on the other hand, is its emphasis on the barriers to recovery experienced by persons recovering from both mental health and substance use difficulties (a process often termed *dual recovery*). Their review concludes that: '*Persons in dual recovery report inefficiency of complex systems and how problematic this is for their health and health care.'* (p. 114). Ness and colleagues also highlight the need for better coordinated care, a stronger recovery orientation of services, '*a strong focus on humanity and common human life issues'* (p. 114), and the elimination of structural inequalities impinging upon service-users' freedom, autonomy, and ultimately, capacities to recover.

Recovery as a More-than-Personal Experience

Yet another distinct theoretical contribution of qualitative research into recovery pertains to distilling the socio-cultural, socio-political, institutional and discursive contexts shaping individuals' recovery experiences *and* recovery narratives (Onken et al., 2007; Tew et al., 2012).

As highlighted by Ridgway (2001, p. 339), '*recovery is not accomplished alone* [...]'. Indeed, recovery narratives often contain accounts of the crucial role of others-such as peers, family members, significant others and service providers. Reliable social support, empathy, acceptance and emotional intimacy have frequently been found to support recovery (Ridgway, 2001; Tew et al., 2012). The role of service providers has been particularly equivocal in the narrative recovery literature, with some accounts showing the critical recovery-promoting role of appropriate service provision, and others-the negative impact of professional stigma and the resultant internalised stigma (Ridgway, 2001; Onken et al., 2007; Rhodes & De Jager, 2014). Furthermore, certain types of institutional arrangements can entrench service-users' negative sense of self, social isolation and hopelessness (Ridgway, 2001; Onken et al., 2007). Those findings emphasise the contextual nature of recovery in that, as Ridgway (2001) argues, institutional structures can either '*amplify*' or '*suppress*' the processes of recovery and resilience (p. 342).

The role of culture and the community has also been demonstrated in qualitative studies, albeit to varying degrees (Rhodes & De Jager, 2014). For instance, an atmosphere of solidarity, hope and encouragement has been linked to better recovery outcomes, with some marked cross-cultural differences in the community's response to mental health difficulties being associated with recovery (Rhodes & De Jager, 2014; Song & Shih, 2009). For example, a longitudinal qualitative investigation with 15 service-users in Taiwan by Song and Shih (2009) provides evidence of a range of social and cultural factors that, in several cases, had contributed to major positive turning points in participants' recovery trajectories. Among those were parental support, a supportive religious community and marital responsibilities. All of those factors likely aided the participants' social integration and positive self-identities (Song & Shih, 2009).

Onken et al.'s (2007) review represents a multi-level analysis of the factors shaping recovery. The review authors identify a range of 'person-centred' (e.g. hope, agency, self-determination), 're-authoring' (e.g. personal narratives, narrative engagement with dominant discourses), 'exchange-centred' (e.g. social roles, power, choice), and 'community-centred' (e.g. social connectedness/relationships, social circumstances/opportunities including basic needs such as housing, stigma and integration) elements of recovery. The authors foreground the role of person-environment interactions in facilitating or impeding recovery. Onken and colleagues (2007) advocate an ecological framework to help understand how structural barriers impede individuals' health- and recovery-enhancing opportunities.

Another cluster of reviews-Tew et al. (2012) and Topor et al. (2011)-focuses mainly on the social factors in recovery. In Tew et al.'s review, the main themes are *'empowerment and control over one's life; connectedness (including both inter-personal relationships and social inclusion); and rebuilding positive identities (often within the context of stigma and discrimination)'* (p. 443). Within the theme of power relations and empowerment, the review authors discuss the issues of oppressive social situations, injustices, abuse, and equitable and reciprocal social relationships and community participation. Within the theme of identity, stigma and discrimination, the review authors discuss the adverse effects of stigma based on minority status on mental health and recovery. The co-occurrence of housing, occupational exclusion and poor mental health is also briefly highlighted as a significant intersection of disadvantage potentially affecting recovery. The internalisation of stigma is offered as a possible mechanism for the influence of structural discrimination. Finally, Tew and colleagues (2012) elaborate on the importance of social inclusion and social capital as facilitators of recovery, and on the roles of poor income, housing and employment opportunities as potential barriers to social inclusion.

Limitations of, and Tensions within, the Personal Recovery Literature

Despite their seeming breadth and inclusiveness and important contributions made to understanding the nature and dimensions of personal recovery, the qualitative recovery literatures discussed above share several important caveats. Common methodological problems include the small number of included studies in the highlighted reviews (e.g. Ness et al., 2014; Stickley & Wright, 2011a; Shepherd et al., 2016a; 2016b; Stickley & Wright, 2011a); and the inadequate documentation and discussion of participants' socio-demographic characteristics and their relevance for recovery (e.g. Leamy et al., 2011; Stickley & Wright, 2011a; Jacob et al., 2017). The inadequate contextualisation of the included samples-in terms of their socio-economic status, ethnicity, gender, housing status and others-limits the ability to critically examine the extent to which those findings apply to groups experiencing various forms of social disadvantage and inequalities. Accordingly, in the majority of reviewed reviews, there is a lack of detailed critical consideration of how multiple forms of oppression and marginalisation could intersect and interact to influence the experience of recovery. The importance of housing, for instance, is only briefly mentioned in a handful of reviews (e.g. Topor et al., 2011; Drake & Whitley, 2014). In those reviews, however, detailed discussions of what aspects of housing or homelessness may impact on recovery are missing.

A further limitation concerns the inadequate accounts of the role of mental health services in recovery and the mechanisms via which service provision impedes or enables recovery for different service-users groups in different institutional and geographical settings (Slade, 2009). Given the contested and multifaceted nature of recovery, the degree to which it is embodied by the mental health services provision remains a crucial yet complex question. Implementing certain principles of recovery-oriented care such as user involvement and empowerment, positive risk-taking and promoting user autonomy has been a notoriously ambiguous and challenging process in many settings (Slade, 2009; Gilburt et al., 2013). Therefore, there is a need to better understand what aspects, practices and values of service provision impede or facilitate individuals' personal recovery.

Another limitation of the recovery literature concerns the insufficient theoretical engagement with the recovery concept. To demonstrate, Stickley and Wright's (2011b) review explicitly focuses on analysing the theoretical development in the field of recovery and found that '[t]*here is very little theoretical evidence presented for recovery in mental health, which draws together the differing views and discourses.*' (p. 305). Specific areas for theoretical development highlighted in some of the other reviews include the need for better understanding of the link between recovery and social positioning, between recovery and social inequalities, and between recovery and humanism and its values (Stickley & Wright, 2011a). Relatedly, despite the evidence for the impact of a multitude of social and structural factors on recovery, there is a need for more research into *how* experiences of recovery are affected by discrimination and other oppressive social structures and models of service provision (Tew et al., 2012; Topor et al., 2011).

While the majority of qualitative investigations discussed above have provided detailed and insightful idiographic descriptions, representations and interpretations of recovery-relevant phenomena such as identity and sense-making, few of those empirical studies have attempted to construct a theoretically-informed *explanation* linking the social context, identity and meaning-making processes and recovery outcomes and trajectories (Yanos et al., 2010). Such a comprehensive explanation should also incorporate the influences of the individuals' multiple contexts (relational, institutional, socio-cultural) upon the individuals' capacities for recovery (Tew et al., 2012; Onken et al., 2007).

Finally, recovery narratives have been critiqued on the basis of their dubious veracity and reliability (Shapiro, 2011; Woods et al., 2019; Woods, 2011). The authenticity of personal narratives has been questioned due to the assertion that narrators can often conform to dominant political and cultural narratives (sometimes called '*meta-narratives'*; Shapiro, 2011). This can obscure insights about the individual's *true* experience of recovery-for example-one that may challenge or outright reject prevailing notions such as therapeutic optimism, recovery expectancies, or gender-specific stereotypes such as masculinity and resilience. Shapiro (2011) critiques one such meta-narrative- the '*recovery and quest'* narrative-whereby the protagonist's story follows the expected trajectory of a happy life followed by a sudden downfall, which then resolves itself and allows the protagonist to return to their initial happy life. Shapiro (2011) cautions that the powerful 'grip' of such meta-narratives can silence non-conforming stories that '[…] *express anger, despair, suffering, failure or protest, or admit the lack of easy narrative resolution, especially where chronic illness and disability are in play.'* (p. 69). In other words, some critics have suggested that personal narratives can serve to, somewhat paradoxically, stereotype the experiences of health, illness and recovery by disseminating common '*scripts*' for how individuals should '*normally*' experience and story their recovery (Woods, 2011; Woods et al., 2019). This criticism reinforces the importance of eliciting diverse stories of both recovery and non-recovery from individuals with diverse biographies and social positionalities.

A balanced perspective on the trustworthiness of personal narratives is offered by Shapiro (2011), who posits that, driven by the values of narrative humility, researchers and practitioners should treat personal narratives as stories that may serve diverse functions beyond simply reproducing dominant cultural and other societal narratives. Instead, while such meta-narratives may indeed be influential in shaping the personal narrative, the latter should also be seen as an opportunity for a '*personal liberation*' from inauthentic, powerless and/or marginalised existence (Shapiro, 2011, p. 70).

Recovery in the Context of Socio-Structural Disadvantage: Gaps in Theorising

A critical examination of the phenomenon of personal recovery *in the context of socio-structural disadvantage* illuminates crucial theoretical, ethical and methodological inadequacies of the bulk of the personal recovery scholarship (Morrow & Weisser, 2012; Harper & Speed, 2012). Informed by sociological, critical theory, critical psychiatry and health inequalities perspectives, researchers have critiqued some of the fundamental assumptions of both what personal recovery *is* and how personal recovery should be researched (Harper & Speed, 2012; Morrow & Weisser, 2012). Specifically, there has been a tendency of the majority of research into personal recovery to downplay or neglect the complexities of attaining recovery in the context of poverty, homelessness, discrimination and other forms of health and social inequalities. This has led to an underproblematisation of how core recovery processes (such as hope, identity-building and meaning-making) are enabled or constrained as a result of the confluence of individual, biographical, interactional, socio-structural and socio-cultural factors (Pilgrim, 2008).

As Kerr and colleagues (2013, p. 108) posit*: 'Despite the widespread acknowledgment that recovery is a complex phenomenon, it is under-investigated from this perspective.'.* Indeed, as demonstrated by Llewellyn-Beardsley and colleagues' (2019) systematic review and narrative synthesis of common components of mental health recovery narratives, most narrative studies have tended to downplay the importance of socio-cultural and socio-structural factors in recovery. The authors conclude that: '[…] *there was little discussion within analysis of how multiple forms of structural oppression can intersect and be mutually reinforcing* (p. 23).

Woods and colleagues (2019) advance this argument by stating that as a result of '[…] *abstracting the individual from their immediate social network and wider social context'* (p. 170), it has become unclear how mental health is affected by the plethora of social, cultural and affective influences relevant to individuals' lives. This, in turn, has impeded the progress towards understanding how individuals can be optimally supported and empowered in realising their recovery in their communities. Moreover, according to Woods and colleagues (2019), the lack of critical structural analysis of the contexts in which recovery narratives are produced is a barrier to achieving the emancipatory and empowerment goals of the recovery movement. Understanding the intricate ways in which different forms of inequality and discrimination intersect to impact people's experience of recovery is a social justice imperative (Burns, 2009). In addition to examining the pathways that create and perpetuate disadvantage, researchers should unravel how individuals exercise and sustain their autonomy, independence and choice, their full personhood, in the face of adversity, and the implications thereof for achieving good health and well-being (Burns, 2009).

The tendency of recovery research to decontextualise and over-individualise recovery has been accompanied by the common under-representation of individuals experiencing one or more forms of socio-structural disadvantage. To demonstrate, the CHIME framework of personal recovery gives little consideration to the socio-economic status or other pertinent social locations that individuals with lived experience may be occupying and that may be systematically privileging or disadvantaging their abilities to recover (Leamy et al., 2011). For instance, only six of the 87 papers synthesised by Leamy and colleagues (2011) in their development of the CHIME framework were conducted with Black and minority ethnic (BME) participants. The authors recognise the under-representation of minority ethnic groups in the Western recovery literature and highlight examples of themes-particularly spirituality, stigma and culturally specific notions of mental health-that may be more prominent amongst ethnic minority persons (Leamy et al, 2011).

In addition, from 45 narrative studies and 629 first-person accounts reviewed by Llewellyn-Beardsley and colleagues (2019), only 17% represented accounts from BME participants. Moreover, 71% of those studies were conducted in the U.S. or the U.K. (of which only two-in Scotland). This arguably reflects the underrepresentation of diverse geographical and ethnic groups in the recovery literature (Armour et al., 2009). Even scarcer have been empirical studies aiming to analyse how relevant categories of difference (ethnicity, race, gender, health status, socio-economic status) *intersect* to shape the recovery process (Armour et al., 2009; Morrow & Malcoe, 2017). This (implicit) aversion to diversity and intersectionality in much of the recovery literature is also evident in the relatively few qualitative recovery studies adequately addressing the political, institutional, socio-cultural and systemic dimensions of the narrators' experiences (Llewellyn-Beardsley et al., 2019).

Furthermore, socio-structural factors such as financial insecurity, poverty and other forms of social marginalisation have been largely neglected themes in the conceptual development of personal recovery (Stuart et al., 2017; Tew et al., 2012). Relatedly, Rose (2014, p. 218) notes that recovery research has shown a tendency to overrepresent individuals considered '*recovered*' and has therefore neglected the unique experiences of individuals '*who continue to struggle'*. Over-privileging '*mental health success stories*' (Jensen & Wadkins, 2007, p. 325) and narrowly defining service-users as 'successful' and 'unsuccessful' in their recovery may inadvertently contribute to the misrecognition and silencing of those who may face the most severe structural barriers to recovery (Fisher & Freshwater, 2014).

In a recent systematic review and best-fit framework synthesis of qualitative literature on personal recovery, Stuart and colleagues (2017) assessed the extent to which the five core components of CHIME were reflective of the qualitative themes featured in 12 peer-reviewed studies on recovery. The authors found that while CHIME was a generally acceptable model of recovery, it failed to incorporate the themes of financial difficulties, socio-economic disempowerment, and ambiguity and contradiction in the recovery process. Accordingly, the authors conclude that CHIME may have underrepresented people who face considerable life challenges that may prevent them from recovering. Citing Onken et al. (2007), Stuart et al. (2017, p. 11) posit that by focusing exclusively on individuals who self-identify as being ‘in recovery’ or ‘recovered’, researchers may inadvertently reinforce the unsubstantiated claim that ‘[…] *recovery is something achievable by everyone who simply applies themselves.’.* This proposition, in turn, may contribute to the harmful discourse that individuals who may struggle with their recovery are ‘[…] *not trying hard enough’* -eventually leading to the marginalisation of those individuals (Stuart et al., 2017, p. 11).

The extent to which popular conceptual frameworks of personal recovery (such as CHIME; Leamy et al., 2011) are capable of adequately capturing the processual and contextual nature of personal recovery, especially in the context of major life transitions such as homelessness and rehousing, remains contested. While Leamy and colleagues (2011) label the five CHIME components as recovery *processes*, those components reflect abstract, second-order categories that are stripped of their ‘*vital contextual features’* (Hopper, 2007, p. 871). Furthermore, while Leamy and colleagues (2011) propose a transtheoretical model of change adapted to the recovery process, those ‘*recovery stages’* remain glaringly individualistic (cognitive-behavioural) and de-contextualised in nature (e.g. ‘*learning’; ‘determination’; ‘awareness’; ‘efforts’; ‘self-esteem’; ‘believing’*). As a result, Cameron Duff (2016, p. 62) argues, it has been less clear how the five CHIME components are ‘[…] *enabled or inhibited within a broader web of social, political and economic contexts.’.* According to Duff, uncertainty persists as to ‘[…] *what connectedness, hope, and empowerment feel like for individuals living with mental illness; how these qualities are cultivated, nurtured and restored* […]’ (p. 62).

Morrow and Weisser (2012), Pilgrim (2008) and other critics challenge the dominant individualistic and intrapsychic conceptualisation of the recovery phenomenon as one that inadvertently neglects the role of the adverse socio-structural forces, such as the operation of power in society and within the mental health systems, that engender and perpetuate the distress and suffering associated with mental illness. As Bonney and Stickley (2008, p. 149) perceptively note: *‘Whatever the rhetoric* *regarding individualized care, the recovering person continues to find himself or herself cared for within rigid systems*.'. Furthermore, Morrow and Weisser (2012) posit that there has been an inadequate focus on the overlapping and intersectional nature of multiple disadvantage in mental health and on the complex relationship between inequalities and recovery. Morrow and Weisser (2012) argue that, in the recovery literature, social inequalities are rarely mentioned, and where mentioned, race, ethnicity, immigration, and culture have been privileged above other types of inequalities such as those related to disability, age, sexual orientation, housing and poverty.

Proponents of critical social justice theorising of health inequalities argue that empirical inquiries of recovery in individuals with mental illness should be indivisible from the structural analysis of the '*economic, cultural, and political forms of injustices'* that those individuals tend to systematically endure (Morrow & Malcoe, 2017). Such a social justice-oriented research agenda requires theoretical and methodological paradigms that are congruent with the emancipatory and interrogatory functions of critical inequalities research. Specifically, as Harper and Speed (2012) propose, citing Trivedi (2010), there is '[…] *a need for more sophisticated understandings of experience'* (p. 22) that is not only grounded in the language, symbolism and embodied understanding of the people with lived experience, but also (re)contextualised within '*a collective and political and economic'* (p. 22) domains. Recognising the *intersectionalities of influence* upon the recovery process, particularly the influences rooted in institutional and other socio-structural arrangements, is likely to better equip researchers in unravelling how recovery happens, why, for whom and under what conditions.

Socio-Structural and Normative Constraints on Mental Well-being and Recovery

A relatively small corpus of qualitative mental health recovery research *has* indeed attended to, analytically and theoretically, the socio-structural conditions within which individuals exercise their recovery (e.g. Lafrance & Stoppard, 2006; Kidd et al., 2014; Benbow et al. 2011; Padgett, Tiderington, Tran Smith, Derejko, & Henwood, 2016). To varying extents, those studies have attempted to account for how ‘*macro-socio-cultural forces*’ influence what is often constructed as the ‘*subjective, individualized process*’ of recovery (Livingston & Boyd, 2010, p. 2151; Yanos et al., 2007). Among the investigated socio-structural forces shaping recovery have been the normalised, institutionalised discourses of recovery (O’Brien, 2012; Fullagar & O’Brien, 2014); cultural constructions of womanhood and motherhood (Benbow et al., 2011; Lafrance & Stoppard, 2006; O’Brien, 2012); social discrimination on the basis of race (Margolin et al., 2017); poverty, homelessness and adverse life experiences (Kidd et al., 2014; Benbow et al., 2011; Padgett, Tiderington, Tran Smith, Derejko, & Henwood, 2016), and others. Informed by feminist, constructionist, intersectionality and other critical epistemologies, some of those studies have aptly re-conceptualised personal recovery as an *intersectional experience* occurring amidst multiple inequalities, discourses, systems of power, norms and social practices (Lafrance & Stoppard, 2006; O’Brien, 2012).

O’Brien (2012), for instance, interviewed 31 mid-life Australian women who self-identified as ‘recovered’ or ‘in recovery’ in attempts to understand how those individuals understood and negotiated their recovery journeys within neoliberal and largely biomedical institutional discourses. Informed by Foucauldian and feminist perspectives, the author’s qualitative analysis revealed that the women’s narratives indicated an understanding of recovery as the elimination of symptoms and the return to an idealised version of the productive citizen. The author named those personal constructions, *‘a static notion of normalized recovery’* (p. 576). The inability to achieve those normative ‘targets’, a major theme in the participants’ accounts, was associated with fear, distress and a sense of inadequacy. Even participants who had self-reportedly made considerable progress in their recovery journey described their recovery as transient and fragile. To some of the participants, a relapse meant a failure to achieve a state of '*recovered subjectivity'* (p. 576). Those recovery subjectivities denote the participants' internalised discourses regarding what constitutes normality, productivity and a successful treatment outcome.

Those women also expressed concerns about their ability to re-assume control over their lives due to the financial, occupational and marital challenges that they faced. Furthermore, O'Brien (2012) interpreted some of the women's use of various quantifiers (e.g. '*99% fully recovered'; 'eight out of ten'*) to characterise their recovery progress as indicating an internalised view of recovery as a quantifiable, linear progression, therefore reflecting contemporary neoliberal policy discourses. One problematic consequence of such an internalised construction of recovery is the equation of 'being completely in recovery' with being normal, and, respectively, not being fully recovered- with being abnormal, inadequate or flawed. In this qualitative investigation, O'Brien (2012) critiques the so-called recovery imperative as potentially representing a form of governmentality that seeks to impose pre-defined notions of expected recovery to the neglect of individuals' unique biography, values and goals, and social positioning. The author also proposes internalised recovery subjectivities as a potential mechanism mediating between those normative discourses and the participants' self-reported experiences of mental health and recovery.

In a follow-up study, Fullagar and O'Brien (2014) explored how those women negotiated the aforementioned normalised recovery discourses. Fullagar and O'Brien were interested in understanding the *imaginative* and even *transformative* processes of personal agency, especially in relation to recovery. For instance, the authors discuss one participant's obstacles to exploring *'different relations to self'* (p. 120) through, for example, using reflection, introspection and aesthetic enjoyment (e.g. music) in efforts to (re)discover a *'true self'* (p. 120). According to the authors, those obstacles were rooted in a dominant recovery discourse that prioritised self-management, the reduction of symptoms and the return to prescribed social roles (e.g. a dutiful wife and mother), and that neglected alternative pathways to recovery. This series of investigations by O'Brien and Fullagar helps illuminate the intricate relationship between the normative context, including gender relations and mental health discourses, and the intimate processes of self-understanding and self-transformation that characterise recovery.

Informed by intersectionality theory, Kidd et al.'s (2014; N = 6) grounded theory study in the Canadian context revealed that the participants, who simultaneously occupied multiple social locations associated with structural marginalisation (due to their intersecting racialised and gendered identities), faced '*additional layers of complexity and negotiation'* (p. 20) in their efforts to recover. The feelings of cultural entrapment, discrimination and the *'dialectic between multiple and conflicting identities*' (p. 36) compromised the participants' resilience and often made the process of recovery non-linear, difficult and ambiguous. The challenges the participants faced with achieving a coherent identity, rebuilding a sense of self-worth and navigating the power differentials in their lives seemed to erase the boundaries between the personal and the political. Despite its limited sample size, Kidd et al.'s (2014) study illustrates the utility of conducting a structural, intersectionality-informed analysis of qualitative, including visual, data on the lived experience of mental illness.

In another intersectionality-informed qualitative investigation of the experience of mental illness, Benbow and colleagues (2011; N = 67) interviewed homeless mothers with mental illness in a Canadian context. The study was original in its focus on the dialectic between structural oppression and individuals' acts of resilience, and the implications thereof for their mental well-being. As such, this study challenges the individualistic accounts of mental health and recovery that neglect the socio-structural scaffolding of individuals' identities, resilience and coping. While limited methodologically by the lack of detailed demographic information collected, and the reliance on secondary data and focus groups rather than individual interviews, this study yielded valuable insights into the complex social positionalities of homeless mothers with co-occurring health problems and into how they attempted to navigate those. The findings revealed the *'complex and compounding nature of social locations as intersecting sites of discrimination'* (p. 692). Specifically, their participants' accounts uncovered a unique experience of discrimination on the basis of their various social identities related to their status as socially disadvantaged mothers with mental illness. This study therefore provides a compelling testimony to the pervasive effects of racism, poverty, housing instability, interpersonal violence and other forms of oppression upon individuals' abilities to maintain their health, dignity and valued social roles.

Despite their methodological limitations, which compromise the transferability of the findings, the aforementioned studies reaffirm the importance of examining the role of the socio-structural context for unpacking the complexity and dynamism of recovery and coping with SMI in diverse populations. Notably, those studies deploy critical theoretical perspectives such as intersectionality and feminist and critical theories to help trace the multifaceted influences of social structure upon individual agency, identity and mental health outcomes.

Recovery and Homelessness: Gaps in the Knowledge Base

The conceptual, theoretical and methodological critique of the bulk of recovery research presented in the preceding sections is especially pertinent to the research on individuals' experiences of co-occurring SMI and homelessness. Specifically, the experience of personal recovery in the context of homelessness has been both underresearched and undertheorised. Those inadequacies tend to reflect the general under-emphasis in the mental health literature on the role of structural factors such as poverty, housing insecurity and other forms of socio-economic marginality on positive mental health, coping and recovery (Harper & Speed, 2012; Yanos et al., 2007; Karadzhov et al., 2020). The qualitative and mixed-method research into homelessness has tended to focus on either individuals' deficits, vulnerabilities and trauma, *or* on individuals' experiences of recovery *post-rehousing* (Karadzhov et al., 2020; Padgett et al., 2013). This has left a gap in the understanding of how individuals who are *currently* homeless, particularly chronically homeless, conceptualise, navigate and negotiate their recovery amidst the often-chaotic and structurally violent conditions of street life, shelter living and/or the institutional circuit. Those criticisms indicate the need for more empirical qualitative investigations into homeless individuals' lived experience of mental health and recovery, and into the socio-structural context within which they must realise their recovery.

As highlighted in '*Chapter Two*', homelessness often represents a multiplicity of disadvantage, which profoundly influences whether and how individuals can engage in recovery. The burden of chronic homelessness, in conjunction with clients' high support needs (based, for instance, on their SMI, physical health problems, and/or substance use problems), is likely to pose profound, complex and distinct challenges to initiating and sustaining mental health recovery (Padgett, Tiderington, Tran Smith, Derejko, & Henwood, 2016; Kirkpatrick & Byrne, 2009; Busch-Geertsema et al., 2010). The diversity of chronically homeless populations-in terms of demographic and biographical characteristics and support needs-necessitates the contextualised, idiographic understanding of *how* those critical transitions enable or impede clients' prospects of both stable rehousing *and* recovery. Understanding how the homelessness experience impacts recovery from SMI carries significant potential for informing approaches to help those individuals successfully transition out of homelessness, restore their valued capabilities and regain full and active citizenship.

The following sections critically examine the literature on homelessness and SMI and problematise central recovery components in relation to homelessness and co-occurring disadvantage.

Qualitative and Mixed-Method Research with Formerly Homeless Adults with a History of SMI

While qualitative studies into the *substance use* recovery of persons with experiences of homelessness have been numerous (Henwood et al., 2012; Neale & Stevenson, 2015), research into those individuals' *personal* (*mental health*) recovery has been markedly scarcer (Morse, 2000). The comprehensive literature search carried out within the current critical review indicated that virtually all qualitative and mixed-method studies that explicitly address the relationship between homelessness and personal (mental health) recovery had been conducted with *formerly homeless* participants. While this body of work has produced useful findings regarding those individuals' hopes and aspirations, social relationships and integration, struggles, everyday lives and recovery journeys, it does not compensate for the scarcity of qualitative investigations with individuals who are *currently homeless*.

The bulk of qualitative research exploring formerly homeless persons' views and experiences of personal recovery has been conducted with Housing First clients in settings such as New York City and Canada (Padgett et al., 2016; Zerger et al., 2014; Patterson et al., 2013; Kirst et al., 2014). Padgett and colleagues have published a series of qualitative and mixed-method investigations exploring both the biographical narratives and everyday lives of HF clients with SMI diagnoses in New York City (Padgett et al., 2016). The series of qualitative and mixed-method studies by Padgett and colleagues has offered invaluable insights into formerly homeless clients' experiences of ontological security as function of attaining stable and secure housing (Padgett, 2007); experiences with social relationships and their impact on recovery (Padgett et al., 2008); the dynamics of substance use recovery over time following permanent rehousing (Henwood et al., 2012); the identity dynamics following permanent rehousing (Smith et al., 2015); and clients' perceptions of HF services (Padgett et al., 2016).

Highlighting the myriad of structural, institutional and biographical factors that can potentially impinge on homeless or formerly homeless clients' efforts to recover, Padgett and colleagues (2016) proposed the term '*complex recovery'*. As Padgett and colleagues (2016, p. 61) argue, complex recovery should be viewed as the '*dynamic process*' of overcoming the cumulative adversity that prevents one from attaining a '*recovered life'*. Complex recovery is also '[…] *synergistic in nature; it involves more than the additive effects of multiple problems.'* (p.61). Padgett and colleagues (2016) also emphasise the need to investigate how individual factors such as trauma, poor health and homelessness interact with supra-individual factors and contexts such as social networks and service provision to affect complex recovery. While Padgett et al.'s (2016) concerns about the problematisation of the recovery concept by reconsidering the role of a multitude of factors that shape the homelessness experience seem well-justified, the authors offer limited recommendations as to how to utilise appropriate theories and other conceptual tools to expand the notion of recovery. While the authors do mention the potential utility of intersectionality theory for '[…] *framing how individual lives are affected by multiple interacting influences*.' (p. 68), it remains unclear how theories such as intersectionality can adequately incorporate individual-level and contextual and structural influences into a coherent model of personal recovery.

Due to the focus on recovery outcomes in formerly homeless adults, this body of work (e.g. Henwood et al., 2012; Padgett et al., 2013), however, offers limited insights into the processes or mechanisms that govern whether and how recovery-relevant outcomes such as hope, social reintegration, meaningful coherence and a positive self-identity are shaped by individuals' *current* experiences of homelessness.

Understanding the Effects of Homelessness on Personal Recovery

As a multi-pronged ‘assault’ on individuals’ mental, social, psycho-emotional and existential well-being, homelessness, particularly chronic and repeat homelessness, can be suspected to severely undermine individuals’ capacities to engage in recovery (Hsieh, 2016; Karadzhov et al., 2020; Padgett, 2007). The insidious effects of homelessness on mental well-being and recovery warrant the critical reconsideration of how processes central to recovery, such as social connectedness, self-identity, hope and empowerment, are initiated and sustained.

To begin with, according to the CHIME model, being part of the community is one of the prerequisites for establishing ‘connectedness’ (Leamy et al., 2011). Not having a home and struggling with SMI, however, can be extreme forms of ‘dis-connectedness’-physical (material), social, emotional and psychological. The social exclusion that is often synonymous with homelessness tends to be perpetuated by socio-structural factors including dislocation (Piat et al., 2017), socio-spatial exclusion (von Mahs, 2005), and stigmatisation (Horsell, 2006; Padgett et al., 2008). Indeed, homelessness has sometimes been conceptualised as a form of multiple exclusion (Fitzpatrick et al., 2013) and intersectional disadvantage (Zufferey, 2016). The consequences of homelessness for one’s social inclusion and civic participation extend beyond that of housing exclusion (Amore et al., 2011). The multiple, overlapping exclusionary forces that engender and perpetuate many forms of homelessness are directly antithetical to the ‘connectedness’ processes that enable personal recovery (Leamy et al., 2011; Padgett et al., 2008; Irwin et al., 2008; Barker, 2013; Barman-Adhikari et al., 2016; Fitzpatrick et al., 2007). Moreover, the demands for survival and self-preservation in street life and other forms of homelessness often preclude opportunities for meaningful and lasting social connections (Karadzhov et al., 2020).

Furthermore, achieving a positive sense of self in the context of homelessness tends to be impeded by a plethora of biographical and socio-structural factors-including the experience of significant trauma, the commonplace discrimination in service settings, stigmatising attitudes by the general public, and others (Karadzhov et al., 2020; Boydell et al., 2000; Snow & Anderson, 1993). Those factors can often result in self-stigma, moral denigration and a fragmented sense of self (Kidd, 2007; Zufferey & Kerr 2004; Farrugia, 2016). Multiple stigma, and the accompanying social exclusion, discrimination and denied social opportunities have been implicated in the likelihood of engaging in care, among other behavioural, social and health outcomes central to recovery and well-being (Thompson et al., 2004; Lysaker et al., 2008). Given this complexity, the identity work performed by individuals with mental illness and co-existing problems such as homelessness, as well as its relationship with well-being and recovery, warrants further empirical enquiries.

As a core recovery component, *empowerment*, denotes a combination of personal responsibility, control over one's life, autonomy, access to services and interventions, and focusing on one's strengths (Leamy et al., 2011). Many people who are homeless, however, have diminished economic capital (Shinn, 2007) and experience significant administrative hurdles, as well as barriers to care, which cumulatively restrict their personal autonomy (Corrigan et al., 2015; Hamilton et al., 2011; Patterson et al., 2012). Homelessness is often synonymous with a period of powerlessness and is seen as a major obstacle to regaining control over one's life (Kirst et al., 2014).

A small but growing corpus of studies has explicated both the material and non-material dimensions of empowerment in relation to homelessness. To demonstrate, Watson and Cuervo's (2017) qualitative study with 15 young women experiencing homelessness in Melbourne, Australia, highlighted the overlapping effects of material deprivation and social disenfranchisement on the subjectivities of participants. For example, one participant's account revealed a damaged sense of self-the humiliating, degrading and isolating impacts of grappling with homelessness*: 'I felt pretty helpless. I knew that there were services out there but I'd just been there and done that so many* *times that I really didn't have a lot of self-esteem, […] it's pretty degrading actually.'* (p. 467). Beyond the provision of resources, empowerment is contingent upon nurturing a sense of self-efficacy and self-esteem (Watson & Cuervo, 2017).

The idea of empowerment has been particularly contentious in the literature on inequalities (Watts, 2014; McWade, 2016; Harper & Speed, 2012). Several critics have raised concerns about 'reducing' the empowerment concept in relation to persons with mental illness to a *sense* of empowerment, which risks conflating what is essentially a structural issue with a subjective, psychological state (Harper & Speed, 2012; Karban, 2017). Such 'psychologisation' of disadvantage to the neglect of ongoing political struggles and structural violence, those critics argue, reinforces a neoliberal discourse of personal responsibility and self-reliance (McWade, 2016; Rose, 2014; Harper & Speed, 2012; Watts, 2014; Karban, 2017).

Hope, finally, is also problematic in the context of homelessness and co-occurring disadvantage. Leamy and colleagues (2011, p. 450) acknowledge the need for more contextualised, process-oriented understanding of hope: *'There is also a need for future research to increase our understanding of how subtle micro-processes of recovery are operating, such as how hope is reawakened and sustained.'.* Further research is required into the socio-structural enablers and hinderers of hope in individuals with SMI who are homeless (Watson, 2012a; Onken et al., 2007).

Anthropological and sociological research has demonstrated that hope is contingent upon material, political, socio-economic and socio-cultural enablements (Snyder, 2002; Eggerman & Panter-Brick, 2010). Several authors have theorised hope as an inherently political practice; as an act of resistance against oppressive social forces (Snyder, 2002). As Denzin and Giardina (2009, p. 42) argue, citing Paolo Freire (1999), *'Hope is grounded in concrete performative practices […] Hope […] confronts and interrogates cynicism, the belief that change is not possible, or is too costly.'.* This calls for a problematised, contextualised, socio-material understanding of hope in relation to personal recovery and homelessness.

The Role of Temporary Accommodation

Due to multiple systemic factors (including the inadequate supply of appropriate and affordable housing), sustained stays in temporary accommodation are often an inadvertent prerequisite for many persons transitioning out of chronic homelessness (Busch-Geertsema et al., 2010; See '*Chapter Two*'). The safety and mental well-being risks of prolonged stays in temporary accommodation have been long-recognised (Busch-Geertsema et al., 2010). Although temporary accommodation varies in safety, privacy, entry and length of stay requirements, and the provision of co-ordinated professional support, clients' experiences in those settings often tend to be characterised by frustration, distress, precariousness and the sense of social exclusion (Busch-Geertsema et al., 2010; Mayock et al., 2015; Meanwell, 2012).

Uncertainty persists as to the degree to which shelters shape clients' lives- including their sense of self, well-being and social inclusion (Meanwell, 2012). The bulk of research has tended to underscore the constraining effects of homeless shelters on individuals' control, autonomy, positive sense of self and rehousing prospects (Meanwell, 2012). Indeed, ethnographic and other studies examining the institutional dynamics of homeless shelters have argued that the rules, regulations, living conditions and service cultures of shelters tend to hinder clients' self-determination and independence as clients '*become immersed in shelter routines'* (Meanwell, 2012, p.78; Kerman et al., 2019). Other research in those settings has specifically examined the role of staff behaviours, attitudes and discursive practices, and staff-client interactions in co-creating the shelter 'atmosphere' (Meanwell, 2012; Kerman et al., 2019). As negative consequences of such interactions and practices some research has reported residents' experiences of victimisation, humiliation, disempowerment and 'invisibility', which have often been linked to clients' disengagement with services (Meanwell, 2012; Snow & Anderson, 1993; Kerman et al., 2019).

Often such research, however, has neglected the importance of clients' personal agency in shaping their institutional experiences and recovery outcomes (Meanwell, 2012). As aptly pointed out by Meanwell (2012, p. 78), '[r]*esearch on residents' navigation of – and resistance to the control within* […] *shelters highlights the importance of agency.*'. Research has identified diverse manifestations of clients' agency as they navigate institutions such as homeless shelters-including '*submission, adaptation, and resistance'*, as well as challenging and negotiating rules and power (Meanwell, 2012, p. 78; Isaak et al., 2019). Research such as Isaak et al.'s (2019) qualitative study with 45 homeless adults living with mental illness in Canada has distilled a myriad of '*creative and intentional strategies'* (p. 1548) that individuals mobilise to manage the challenges, threats and uncertainties of both street and shelter living. In addition, in their qualitative study with an ethnically diverse sample of 36 homeless adults with mental illness based in Canada, Paul and colleagues (2018) explored the phenomena of coping and resilience. The authors elicited rich accounts of various manifestations of their participants' personal strengths. Those included proactive behaviours and strategies such as engaging in spirituality and in meaningful occupations, actively managing one's mental health difficulties, help-seeking and socialising.

Paul and colleagues' (2018) analysis, however, is markedly stripped of the socio-structural and organisational contexts within which their participants managed to enact and negotiate those self-preserving and health-promoting behaviours. The authors admit that the roles of their participants' cultures and contexts in their coping and resilience *'did not emerge strongly'* (p. 194) from the data. The authors attempt to explain those findings with the rather unsubstantiated proposition that '[…] *extreme poverty, disaffiliation and the long duration of homelessness experienced by study participants led to their identification with a 'street culture' and norms, overshadowing* *their own cultural backgrounds and early experiences*.' (p. 194). Within their study, Paul et al. (2018) offer no evidentiary support for this statement. Two unacknowledged methodological limitations of their study could account for this 'context-stripping' of their participants' experiences of coping and resilience: (a) the use of one-off interviewing, which had precluded opportunities to explore participants' life courses in more depth; and (b) the lack of theoretically-informed analysis of the data, which could have explicated some of those contextual influences and their relationship with the participants' coping and resilience.

Research has begun to shed light onto not only how individuals without a home navigate, and adapt to, the demands of homelessness and institutions but also onto how many of them exhibit resilience, self-management and coping amidst the anti-recovery conditions of homelessness (Isaak et al., 2019; Paul et al., 2018). While qualitative thematic analyses such as Isaak and colleagues' (2019) and Paul and colleagues' (2018) evidence the *existence* of such strategies and practices enacted by homeless clients, they often fail to offer a contextualised and dynamic account of *why* and *how* those practices emerge from within clients' specific biographical, socio-cultural, institutional and relational contexts. This has led to the inadequate understanding of how the socio-structural context facilitates and/or hinders homeless individuals' survival- and recovery-oriented personal agency (Yanos et al., 2007).

Transitioning out of Homelessness: A Critical yet Undertheorised *Process*

For many, the period between the onset of homelessness and gaining permanent rehousing is not simply a transitional stage but often represents a profound, life- and identity-altering and health-disrupting experience that can be perceived as entrapment-financial, social and existential (Chamberlain & Johnson, 2018; Desjarlais-deKlerk, 2018; Mayock et al., 2015). Historically, while much theoretical and empirical work has been dedicated to researching pathways *into* homelessness (Chamberlain &

Johnson, 2013; Fitzpatrick et al., 2013), the determinants and process of transitioning *out of* homelessness have been less well-understood (Lincoln et al., 2009; Chamberlain & Johnson, 2018; Iaquinta, 2016; Busch-Geertsema et al., 2010; Mayock et al., 2015). For individuals who have been *chronically homelessness*, in particular, transitioning out of homelessness is often a precarious, uncertain, arduous and non-linear journey.

Clients of services utilising the '*continuum of care'* (or '*treatment first'*) approach, for instance, would typically have to fulfil a range of rigid service requirements, including total abstinence, in order to be eventually considered for permanent housing (Duncan, Howard, & Streeter, 2019). Such services tend to be underpinned by the assumption that sobriety or abstinence are essential requirements for one to successfully transition into, and maintain, permanent housing in the community (Duncan, Howard, & Streeter, 2019). This '*housing ready*' philosophy , however, is often perceived by clients and service providers alike as ineffective, demeaning, paternalistic and neglectful of the systemic barriers (such as the lack of housing) that impede clients' opportunities for treatment adherence and recovery (Duncan, Howard, & Streeter, 2019). As a result of the rigid conditionalities of the '*continuum of care*' approach, many individuals have tended to drop out of services (Tsemberis et al., 2004). Chronically homeless clients of '*continuum of care*' services have frequently reported professional stigma, mistrust in professionals, frustrations with rehousing procedures, as well as the inability of such services to meet their holistic health and housing needs (Tsemberis et al., 2004).

Henwood and colleagues' (2013) qualitative study explored the experiences, hopes and concerns of 31 predominantly African-American men and women who were beginning to transition into permanent supportive housing (HF) in Los Angeles. The majority of participants had had prior contact with mental health services and self-reported their general health as poor. The study was motivated by the relatively scarce research conducted into individuals' perspectives on health and housing as they wait to imminently transition into permanent accommodation. The authors conceptualise this transitional period as an ambiguous space between what are often dangerous and precarious living circumstances and the promise for stability and control. The results from the thematic analysis showed evidence that the anticipation of moving on from homelessness was a catalyst for stability and recovery. However, the authors caution that their participants' overwhelmingly 'positive thinking' might belie the numerous constraints and challenges that the participants were likely to experience post-rehousing such as social isolation and economic insecurity. Henwood and colleagues conclude that providers should manage clients' expectations in order to optimise their transitional experience and, subsequently, independent living.

In a more recent systematic review of the experience of transitioning out of homelessness, Iaquinta (2016) synthesised the evidence from seven qualitative, five mixed-method and 14 quantitative studies. Iaquinta argues that a '[t]*houghtful exploration of the complexity of transitioning from homelessness to home is warranted.*' (p. 21). The author identified several main themes characterising this critical process- including barriers to rehousing and community reintegration; making adjustment while striving to maintain autonomy; focusing on future prospects; and conceptualising 'home'. While this review highlights the complexity and variation of clients' lived experience of transitioning into permanent housing, neither the review, nor the primary studies (except for Zerger et al. (2014), address how the (prospect of) rehousing affects how those individuals conceptualised and navigated their personal recovery journeys. This exemplifies a current gap in the understanding of the dynamics and dimensions of personal recovery during the period of transitioning out of chronic homelessness.

Data from both the U.K. and the U.S. have indicated varying degrees of resettlement success for formerly homeless individuals, with a considerable proportion tending to lose their tenancies within six months (Warnes et al., 2013). Arguably, in order to help maximise successful rehousing outcomes for clients with a history of chronic homelessness, including clients with high support needs, researchers and practitioners should gain a more complete understanding of how clients make sense of this transitional experience and how it affects their personal recovery. At present, however, the transitioning process for clients with SMI and other complex needs has been underexplored (Warnes et al., 2013).

Unpacking the Agency-Structure Nexus and its Implications for Personal Recovery

As argued in the preceding sections, the bulk of extant recovery research has remained largely ill-equipped to unravel how the socio-structural context shapes individuals' recovery journeys. Arguably, mobilising the sociological concepts of (social) *structure* and (human) *agency* can help address the explanatory (theoretical) deficit that persists in the mental health recovery literature (Noiseux et al. 2009; Stickley & Wright, 2011b). Explanatory models involving the concepts of structure and agency have the potential to advance the theorisation of recovery by providing a more comprehensive and contextualised understanding of (a) how various social structures (including social networks, institutions and policies) impede or facilitate personal recovery, and (b) how individuals enact their own motivations, free will, values and subjective meaning-making to respond to those structures, maintain well-being and promote recovery.

On a theoretical level, the sociologically-informed understanding of recovery in the context of homelessness is likely to advance the knowledge of how individuals exercise their personal agency to navigate, negotiate, reproduce and/or resist health and social inequalities (Parsell et al., 2016; Williams, 2003; Nicholls, 2010). Theorising agency is a treacherous endeavour, however, because the overemphasis on individual agency to the neglect of the influence of wider social structures may succumb to a neoliberal philosophy of individual responsibilisation in relation to recovery and well-being (Hitlin & Johnson, 2015; Loyal & Barnes, 2001; Parsell et al., 2016). Conversely, the under-emphasis of individual agency risks supporting the anti-humanistic view that *'…people [are] cultural dopes, passively progressing along a predetermined path.'*

(Parsell et al., 2016, p. 250, citing Houston, 2010a). Instead, a balanced theoretical position should aim to explicate how social structures, their cascading effects and agential processes interact to shape experiences of multiple disadvantage and recovery, as well as other outcomes relevant to social work and mental health practice (Forbes & Wainwright, 2001; Abel & Frohlich, 2012).

Sociologically-informed recovery research has remained remarkably scarce (Watson, 2012b; Pilgrim & McCranie, 2013; Markowitz, 2015; Clifton et al., 2013; Yanos et al., 2007). In response to this theoretical deficit, Yanos and colleagues (2007) reviewed the available research evidence of the multitude of structural and agential influences in the context of SMI. The authors found substantial evidence of the effects of *both* structure and agency on the everyday realities of persons with SMI. Informed by Giddens's (1984) structuration theory and a variant of symbolic interactionism (Fine, 1993), Yanos and colleagues (2007) developed a multi-level conceptual model that incorporates different types of structural influences, the mechanisms through which they may exert their effects, and different forms of agency. Specifically, the authors review evidence of the roles of codified rules, legislation, and the material environment (*structures*). They also describe processes of internalisation of structural influences leading to diminished coping, low self-efficacy, hopelessness and others (*structural impacts*). Yanos and colleagues (2007, p. 411) posit that because people with SMI tend to face significance marginalisation and stigmatisation, the way they *'negotiate and overcome'* barriers to enable recovery can be aptly conceptualised as a dialectical relationship between social structure and individual agency.

Among the various agential activities discussed are goal-setting, identity negotiation, proactive coping, and collective advocacy (Yanos et al., 2007). The effects of those influences upon recovery are discussed at the micro-level (e.g. developing a new identity a sense of hope), meso-level (community integration and participation), and macro-level (system transformation). Yanos and colleagues' (2007) modelling of the structure-agency interaction and its impact on recovery from SMI seems indeed to be a comprehensive effort to map out the complexity and diversity of structural and agential processes and their effects on recovery-relevant outcomes. In particular, the model recognises both material (e.g. poor housing) and immaterial (e.g. discriminatory practices) structural effects, as well as the effects of both individual and collective agency.

However, two notable inadequacies of their model limiting its explanatory utility are worth noting: (a) the undertheorisation of *how* individuals exercise their agency and (b) the insufficient consideration on the role of social relations on recovery. For one thing, while the model features ‘coping’, ‘goal striving’ and ‘identity transformation’ as manifestations of agency, it provides little elaboration on *how* and *why* individuals actualise those recovery-oriented behaviours. Second, the role of social relations (such as family relationships and the therapeutic alliance) on agency and recovery is not accounted for by their model (Yanos et al., 2007).

Watson’s (2012a; N = 60) study is among the very few empirical investigations of the impact of structure and agency on mental health recovery. He carried out a qualitative study with both staff and consumers at several HF facilities in the U.S. Watson (2012a) was particularly interested in consumers’ experiences with both HF and continuum of care services (the latter referring to a traditional service model that emphasises conditionality and abstinence), and their effect on personal recovery. Overall, Watson (2012a) found that HF was more conducive to the consumers’ sense of security, hopefulness, sense of empowerment, and ultimately, personal recovery. The data demonstrate the role of structural influences (denoted by the structure, organisation and philosophy of the two different models) in enabling or constraining consumer agency. For instance, Watson (2012a) discusses how the rigid conditionality of the continuum-of-care model undermined the consumers’ certainty about the future, which, in turn, precluded them from developing a coherent self-narrative.

Watson’s (2012a) findings illustrate the conceptual potential and analytic feasibility of disentangling the influences of personal agency and social structure upon the recovery process in people who are formerly homeless. His investigation is underpinned by the assumption that recovery is ‘*an interactive process that involves transactions between the person and his or her immediate support system, the treatment system, the community, and sociopolitical and cultural variables.*’ (p. 343, citing Loveland et al., 2005, p. 49-50). This understanding of the multiple social, cultural and systemic influences upon the recovery process, Watson (2012a) posits, is instrumental in generating ‘*a strong process-oriented model of recovery’* (p. 343).

Theoretical and Practical Significance of Understanding Recovery in Individuals who are Homeless

The more in-depth, contextualised understanding of the process of personal recovery in persons who are homeless can instruct approaches to enhancing the citizenship, capabilities and person-centred care in those marginalised individuals (Donley & Wright, 2012; Gillis et al., 2010; Kerman et al., 2019). Citizenship concerns the individual’s reclamation of the complete and equal access to social, economic and political life, which is typically manifested by the individual’s ability to (a) exercise their rights; (b) fulfil both personally valued and socially valued roles and responsibilities; and (c) use public resources to achieve self-betterment, as well as to contribute to the common good (Rowe et al., 2001). Full citizenship also entails having a sense of belonging (Rowe & Davidson, 2016). A citizenship approach embodies therapeutic optimism and a human rights commitment to ensuring the social inclusion of persons with mental health difficulties (Vandekinderen et al., 2012; Clifton et al., 2013).

Homelessness is often synonymous with deprivations in all components of active citizenship (Rowe et al., 2001). The knowledge about how individuals with SMI who are homeless navigate and negotiate the social oppression and marginalisation within institutions, interpersonal relationships and the broader society is likely to help generate a contextualised understanding of what citizenship means to such individuals and what the specific enablers and constraints to attaining full citizenship are. Those enablers and constraints are likely to be rooted in those individuals' *'the material, social, cultural, political, and economic environments'* (Rowe & Davidson, 2016, p. 20).

In addition, such knowledge of the routes into citizenship and recovery may help challenge normative approaches to citizenship as *responsibilisation* (Watts, 2014; Dobson, 2011). Such a neoliberal view tends to rely on a pre-determined, normative image of the 'ideal' citizen-one that is '*self-managing, self-sufficient, and independent'* (Vandekinderen et al., 2012, p. 3). Such a narrow view of recovery and citizenship, respectively, according to Vandekinderen and colleagues (2012), seems to assume that service-users have access to comparable sets of opportunities, resources and relationships necessary for them to embark upon, and achieve, their citizenship projects. As such, it tends to neglect or underplay the fundamental influence of oppressive and marginalising social forces on individuals' capacities for citizenship and recovery (Vervliet et al., 2019; Hamer et al., 2014; Vandekinderen et al., 2012). To achieve a truly critical understanding of those issues, the knowledge from individuals' lived experience should be supplemented with the theoretically-informed knowledge of the '*structure/agency conundrum'* (Clifton et al., 2013, p. 514). This entails understanding how structural constraints affect how agency is exercised, and, conversely, how the exercise of agency can challenge and even transform social structures (Abel & Frohlich, 2012).

The more advanced empirical and theoretical knowledge of recovery amidst homelessness can also inform policy and programmatic interventions that enhance the *capabilities* of those service-users. Capabilities broadly refer to one's practical opportunities to exercise choices, perform socially and personally valued activities and become a productive and content social agent (Nussbaum & Sen, 1993; Hopper, 2007). Capabilities theory encapsulates both material (e.g. resources, income) and non-material (e.g. choice, agency, human potential, subjective quality of life, freedoms) dimensions of disadvantage and marginality (Hopper, 2007; Sen, 1999). The centring of *personal choice* in the capabilities approach resonates with Anthony's (1994, cited in Rapp & Goscha, 2011) assertion that '[c]*ritical to recovery is regaining the belief that there are options from which one can choose-a belief perhaps even more important to recovery than the particular option one initially chooses.'* (p. 565). *Capabilities enhancement*, therefore, could be defined as facilitating individuals' abilities to mobilise possessions, resources, and opportunities to generate socially valued and personally meaningful outcomes (Hopper, 2007). In this sense, removing the barriers to better well-being and housing outcomes for persons with SMI without a home could be conceptualised as '*capabilities-grounded empowerment'*-a political and ethical imperative in a socially just society (Tanekenov, Fitzpatrick, & Johnsen, 2018, p. 138).

In the context of homelessness, the attainment of secure housing has been interpreted as a crucial enabler of many of the vital human capabilities postulated by Nussbaum and Sen (1993)- including physical well-being, control over one's body and one's environment, recreational and reflective activities, and others (Nicholls, 2010). In that sense, an aspect of the personal recovery of a person experiencing homelessness would be gaining stable housing- not only in terms of its physical (material) components but also in terms of its wide range of functions enabling the person's safety, dignity, rationality, meaning and connectedness (Nicholls, 2010; Evangelista, 2010).

To support individuals in activating *'locally-valued-and-relevant-capability-sets'* (Smith & Seward, 2009, p. 229, citing Alkire, 2002, p. 184-185), it must be understood *how* individuals reflect upon, place value on, rationalise, and eventually, choose to activate the available set of capabilities, on the one hand, and *how* they negotiate any unavailability or inadequacy of a set of desired capabilities, on the other (Lavie-Ajayi et al., 2018). Abel and Frohlich (2012) posit that a more comprehensive understanding of '[T]*he interactive processes between structural opportunities and individual agency'* (p.

241) has the potential to enhance the utility of capabilities theory for understanding mental well-being in the context of health inequalities.

Relatedly, the enhanced research focus on recovery in people who are homeless can inform approaches to delivering *person-centred* (or *client-centred*) *care* to clients facing multiple sources of disadvantage. Although universally accepted definitions of person-centred are lacking, common characteristics include attending to the clients' worldviews-'*their whole person, emotional needs, and life issues'* (p. 30); helping them manage the challenges of everyday living; responding to their '*subjective experiences, unique biographies, identities, and life projects'* (p. 35); treating them with respect and humanity, and others (Entwistle & Watt, 2013).

While it has been widely recognised that institutional arrangements and service models should be tailored to the specific needs of different sub-populations of service-users, the implementation of common principles of client-centredness such as participation, inclusion, belonging and empowerment has remained uncertain and inconsistent across health and social services (Gillis et al., 2010; Tiderington, 2017). For instance, the mandate to uphold clients' dignity, worth and self-determination seems incongruous with the realities of the undignifying living conditions and social policies that constrain clients' autonomy in homeless shelters (Mayock et al., 2015). Integrating person-centred care principles within all levels and components of the homeless service provision remains a persistent yet crucial challenge (Gillis et al., 2010).

Utility of Multi-Site, Cross-Cultural Recovery Research

Findings from the global mental health literature have consistently evidenced cross-cultural variations in not only mental health recovery rates but also in how recovery is enabled and constrained in specific socio-cultural contexts (Myers, 2010; Bayetti et al., 2016; Adeponle et al., 2012; Summerfield, 2002). While personal recovery has been described as a locally and culturally situated phenomenon (Leamy et al., 2011; Price-

Robertson et al., 2017a), multi-site, cross-cultural qualitative investigations of personal recovery have been surprisingly scarce (Slade et al., 2012; Brijnath, 2015; Davidson, Borg, Marin, Topor, Mezzina, & Sells, 2005).

Cross-cultural qualitative research offers invaluable opportunities to explore the contextual variation of personal recovery, including the influence of culture, history, polity, the economy and other socio-structural influences. It is important to recognise that personal recovery operates '[…] *in a fluid web of relations constituted by the family, community, and larger socio-political units.'* (Jacobson & Farah, 2012, p. 334). This focus on contextual and cultural variation in personal recovery is likely to protect against 'straight-jacket' approaches to defining and implementing recovery-oriented care across diverse settings (Slade, 2012).

The actual recovery experiences of individuals who are homeless in the U.S. and the U.K. (and Scotland, respectively) likely differ due to the distinct service landscapes, welfare and housing provision and the socio-historical patterning of disadvantage in those countries (highlighted in '*Chapter Two*'). The distinct demographic profiles of homelessness in the U.S. and Scotland discussed in '*Chapter Two*' indicate the possible differential influence of socio-historical, socio-cultural and socio-political processes shaping homelessness in the two countries (Fitzpatrick & Christian, 2006; Shinn, 2007). Also, the different social welfare provisions in the two countries are likely to have differential impacts on clients' capacities to exit homelessness and recover from mental health difficulties (Toro, 2007; Shinn, 2007; Fitzpatrick & Christian, 2006). Differences in health and social care services organisation and intervention strategies in the two countries are also likely to differentially enable or constrain clients' capacities to recover and overcome homelessness (Fitzpatrick & Christian, 2006).

Scotland and the U.S. offer potentially fertile socio-cultural and socio-economic contexts for examining the complexities and contextual embeddedness of personal recovery and homelessness. Scotland and the U.S. have been at the forefront of integrating recovery values and principles into their national mental health policies and strategies (Slade et al., 2012; Perkins & Slade, 2011; U.S. Department of Health and Human Services, 2006). This political commitment has resulted in numerous initiatives to implement the recovery vision in mental health (or behavioural health) services such as the REFOCUS programme in the U.K. (Perkins & Slade, 2011) and the *Federal Action Agenda* and SAMHSA's *Science-to-Services Agenda* in the U.S. (U.S. Department of Health and Human Services, 2006).

Despite their endorsement of recovery, social inclusion and human rights principles, however, both countries have had persistently high rates of income inequality and homelessness-higher than most other developed countries (Shinn, 2010; Wilkinson & Pickett, 2007). The socio-economic, socio-political and socio-cultural contexts in both Scotland and the U.S. have created significant challenges to realising the recovery ideal, as well as to responding to the ever-increasing complexity of need in those facing severe and multiple disadvantage (Gillis et al., 2010; Shinn, 2010; Busch-Geertsema et al., 2010). Cataclysmic macro-economic events such as the Great Recession (2007-2009) and politico-economic projects such as austerity programmes have been argued to have entrenched the inequalities and injustices in the provision of health and social care, especially in marginalised groups in both countries (Lavalette, 2017; Marmot et al., 2013).

Scotland and the U.S. are therefore theoretically important sites for investigating how service-users with multiple and complex needs navigate their recovery in the context of persistent health and social inequalities.

Rationale and Research Questions of the Current Study

Several insights from the present critical literature review informed the present study. Specifically, personal recovery is a complex, multi-faceted phenomenon that encompasses multiple domains of individuals' psycho-emotional, social, existential and cultural lives. Research investigations aiming to interrogate the workings of recovery within specific contexts must be attuned to this complexity. In particular, the qualitative research paradigm-with its focus on the idiosyncratic, processual, dynamic and often-contradictory nature of recovery-has made important contributions to understanding the lived experience of recovery. Researching how individuals make sense of their lives holds promise for developing biographically- and phenomenologically-informed approaches to supporting individuals on their recovery journeys.

Despite the steadily increasing volume of recovery scholarship, several gaps in the knowledge and theorising about personal recovery persist. The present review illuminates two such overarching limitations. The first main caveat refers to the common lack of diversity in the samples of much of the recovery research, particularly the underrepresentation of individuals facing severe and multiple social exclusion and other forms of structural disadvantage. Such critique is especially pertinent to the research on homelessness and co-occurring mental health difficulties (such as SMI). Specific areas of enquiry in urgent need of more research include the relationship between personal recovery and individuals' efforts to transition out of homelessness, as well as theorising the effects of chronic homelessness and temporary accommodation on the recovery process.

The second main caveat pertains to the inadequate use of explanatory sociological theories to account for *how* such marginalised individuals navigate and negotiate constraining social conditions to enable better well-being and recovery. Critical sociological perspectives, especially theories of social structure, human agency and their interplay, should be mobilised to advance personal recovery research in diverse populations.

In an attempt to redress the empirical and theoretical gaps articulated in the present critical review, the current study set out to answer the following research questions:

- **How do individuals who have been chronically homeless and have a history of SMI make sense of, and conceptualise, their personal (mental health) recovery? (RQ1);**
- **What facilitates and what hinders those individuals' personal (mental health) recovery? (RQ2);**
- **What socio-structural conditions and contexts are implicated in those individuals' personal (mental health) recovery, and how? (RQ3);** and
- **How do those individuals navigate and negotiate those socio-structural conditions and contexts to enable better well-being and recovery? (RQ4).**

Informed by the theoretical and practical utility of cross-cultural, multi-site empirical investigations of recovery, the current study endeavoured to answer those questions by targeting two distinct settings-the U.S. and Scotland.

Conclusion

This chapter began by presenting the findings of the critical review conducted by the current author assessing the evidence base for personal recovery. The contributions of key sources of evidence to the understanding of the nature and dynamics of recovery-including autoethnographies, narrative research and other empirical qualitative research-were critically examined. The review demonstrates the under-emphasis and the undertheorisation of the role of socio-structural conditions, including homelessness, on the recovery process. This has impeded the understanding of coping and recovery in individuals experiencing co-occurring homelessness and mental health difficulties. The conceptual bases for the dominant personal recovery paradigm were critiqued from a critical sociological perspective. This illuminated the need for applying theoretical frameworks that can account for the structure-agency interactions within the recovery process. The methodological and conceptual inadequacies that the critical review highlighted informed the present research questions. The next chapter details the philosophical and theoretical underpinnings, as well as the conceptual framework, for the current investigation.

Chapter Four

Philosophical and Conceptual Framework

Logic of the Chapter

This chapter positions the current study philosophically and theoretically. The metatheoretical framework of the current study, critical realism, is introduced. The main tenets of critical realism are presented, together with the rationale for its suitability in qualitative mental health recovery research. The two central concepts in critical realist empirical analyses-social structures and human agency-are operationalised. Finally, the conceptual framework of this study, the morphogenetic model, is outlined.

Critical Realism: An Overview

This study uses (basic) *critical realism* as the underpinning philosophical and theoretical framework (Bhaskar, 1989; Danermark et al., 2005). Critical realism offers an explanatory framework that focuses on the dynamic relationship between social structures and individual agents (also called 'social agents', 'actors' or simply 'agents') in order to account for why and how social phenomena occur (Bhaskar, 1989; Archer, 1995; Sayer, 1992; 2000). Critical realists posit that the knowledge about structure-agency relations in society is critical in guiding social action intended to remove the socio-structural constraints that impede the achievement of valued human functionings and societal flourishing (Bhaskar, 1989; Sayer, 1997). Critical realism is characterised by *ontological realism*, *epistemological relativism* and *judgemental rationality*.

Under critical realism, reality is complex and 'layered' into interrelated yet distinct social strata- *the real* (abstract structures, mechanisms and any other entities with ‘real’ causal powers)*, the actual* (events-both experienced and unexperienced) and *the empirical* (the level of subjective experiences, perceptions, beliefs and knowledge). This stratified notion of reality is termed *depth ontology* (Bhaskar, 1989). The ‘real’ and the ‘actual’ dimensions are called *intransitive* because they exist independently of humans’ knowledge and perceptions of them (*ontological realism;* Bhaskar, 1989; Houston, 2001). Nonetheless, they exhibit *real* effects on human perceptions, behaviours and experiences (i.e. they are causally efficacious). Those dimensions cannot be accessed directly (e.g. through observation or experience); their existence can only be inferred from their effects on the observable realm (i.e. the ‘empirical’). The ‘empirical’ dimension is *transitive* in that it is shaped by our subjective and socially situated beliefs, theories, perceptions, experiences and values (Houston, 2001).

Similar to its social constructionist philosophical rivals, critical realism espouses a position of *epistemological relativism*, whereby all knowledge (including theoretical knowledge) and perceptions are seen as subjective, fallible and culturally and historically situated. It rejects, however, the ‘flat’ ontology inherent in ‘strong’ versions of social constructionism, which tend to reduce reality to experience and discourse and thereby neglect the dimensions of the ‘actual’ and the ‘real’ and their associated causal powers (Archer, 1995; Collier, 1994; Al-Amoudi & Willmott, 2011; Forbes & Wainwright, 2001). This often leads to incomplete, reductionist and radically experience-near accounts of what are complex social phenomena (Al-Amoudi & Willmott, 2011; Wainwright & Forbes, 2001; Bergin et al., 2008).

While critical realism recognises that scientific knowledge can never truly mirror the nature of reality, it allows researchers to assess and compare the explanatory utility of different theoretical explanations based on how well they capture the complexities and contingencies of the social reality (*judgemental rationality*; Hu, 2018). Khazem (2018) argues that this principle allows researchers (and all humans) ‘[…] *to exercise our* *rational judgements and make statements about reality, while allowing for empathy and reconciliation with others.*' (p. 131).

The Critical Realist View of Causality

Under critical realism, causality is seen as non-deterministic (contingent), complex and emergent (Bhaskar, 1989; Sayer, 1992; Collier, 1994; Danermark et al., 2005). Under critical realism, social systems represent open, complex systems that are characterised by '*dynamic processes, unpredictability, novelty, and emergence'* (Kerr et al., 2013, p. 108; Wynn & Williams, 2012). The main constituents of such systems, human agents, tend to act in a non-linear, spontaneous and creative manner, thus constantly changing the composition and properties of the system and causing it to evolve (Kerr et al., 2013). This makes the establishment of law-like, cause-and-effect rules challenging, and the prediction of social phenomena-impossible or dubious at best.

Because of the complexity and stratification of reality, causal tendencies often remain *unactualised* or *unacknowledged* by individuals (Wynn & Williams, 2012). This means that the mechanisms associated with a given social structure may be unperceived or unrecognised by individuals, unobservable and unmeasurable by researchers, or may not be affecting a particular outcome of interest in a direct or straightforward way (Martinez Dy et al., 2014). Nevertheless, such unobservability does not necessarily render the social structure and its associated mechanism(s) non-existent. According to the principle of *transfactuality*, social structures and their generative mechanisms are *'real and external to individuals'* and causally efficacious even though they may be *'actualized or unactualized, perceived or unperceived'* (Martinez Dy et al., 2014, p. 456).

In an 'open' system, the effect of social structures is not deterministic as structures interact with other structures, context and individual agents to generate diverse empirical outcomes. Therefore, structures have the *propensity* (or tendency) to exercise particular generative mechanisms, which, ultimately, may or may not lead to the occurrence of an event (Bhaskar, 1989). The concept of *emergence* describes the principle that, in complex systems, an observed outcome is not merely the summative result of its antecedent factors but tends to possess unique (*emergent*) properties. Due to this complexity, the critical realist analysis shifts the focus away from establishing empirical law-like regularities and towards discovering the causal propensities of social structures and human actors, which, under certain contextual conditions, are likely to produce a given outcome (Sayer, 1992; 2000).

Critical Realist-Informed Qualitative Research

The present study is a critical realist-informed qualitative investigation. Qualitative research methods (also called '*intensive'* by critical realists) are particularly suited to meet both the explanatory and emancipatory goals of critical realism (Sayer, 1992; 2000; Danermark et al., 2005; Bergin et al., 2008). With its idiographic focus, qualitative research is apt for investigating '*distinct events within the context of a specific setting, with each event being investigated individually and temporally to identify the effects of environment, context, structure, and individual influences.*' (Wynn & Williams, 2012, p. 804). As such, qualitative research methods can help expose the causal mechanisms that have generated '*a unique set of events and the specific structural/contextual factors that combined to generate them'* (Wynn & Williams, 2012, p. 804). The aim of *explanatory qualitative research* is not to predict or generalise (in the positivist sense) but to provide a detailed ('thick') and localised examination of how a set of causal mechanisms (and their associated entities) manifests itself within a specific spatio-temporal context to trigger a more or less predictable set of outcomes (Sayer, 1992).

Limiting the qualitative analysis to the inductive analysis of participants' subjective, experiential, self-report accounts is unlikely to help elucidate the abstract causal structures and mechanisms that made those experiences and perceptions possible (Parr, 2015). Indeed, according to critical realists, humans '[…] *can never carry total awareness of the entire set of structural conditions which prompt an action, nor the full set of consequences of that action…'* (Pawson, 1996, p. 302, as cited in Edwards et al., 2014). This is due to the assumption that social structures and cultures 'tint' and shape individuals' experiences, perceptions, emotions and actions (Sayer, 1992; 2000). This necessitates going beyond the empirical data and resorting to theories as catalysts for the explanatory analysis. Under critical realism, every explanatory hypothesis is '*inevitably theory laden'* and mediated by human perception, by the socio-cultural context and by our values and other biases, and is therefore fallible (Houston, 2001, p. 851). Because no theoretical construct can perfectly reflect the domain of the 'real', multiple theoretical perspectives may be applied in order to achieve satisfactory explanatory understanding. Therefore, critical realism is permissive of theoretical pluralism in its pursuit of social explanation.

As argued in the literature review in '*Chapter Three*', evidence has demonstrated that personal recovery is likely shaped by the confluence of individual (psychological, experiential), relational (e.g. social support) and cultural and socio-structural factors (e.g. cultural discourses, housing, poverty, professional support; Tew et al., 2012; Williams et al., 2015). With its stratified notion of reality and causality, critical realism provides a robust theoretical framework for generating a sophisticated explanatory account of recovery that gives consideration to the social, structural, cultural, relational and individual processes shaping recovery (Parr, 2015; Eastwood et al., 2015; Sword et al., 2012).

Conceptual Framework of the Current Study

The conceptual framework of the current study helps achieve the two overarching aims of the study: to *give voice* and *make sense* of participants' lived experience of recovery, homelessness and other significant life experiences; and to *explain* recovery within participants' socio-structural and biographical contexts.

The Primacy of Lived Experience and its Interpretation

To address RQ1 and RQ2 (See '*Rationale and Research Questions of the Current Study*' in '*Chapter Three'*), primacy will be given to the participants' lived experience. The epistemological relativism inherent to critical realism makes critical realism compatible with interpretivist (hermeneutically based) methodologies (Price & Martin, 2018). Hermeneutics is concerned with interpreting language, text and other types of data as a means for understanding them. It requires close, in-depth engagement with the participants' lived experience (Smith et al., 2009). Accordingly, the current study will employ hermeneutically-based methods as a starting point in the analysis (see '*Data Analysis Strategy*' in '*Chapter Five'*; Smith et al., 2009).

Identifying the Agential and Structural Influences upon Personal Recovery

To address RQ3 and RQ4, critical realism was mobilised to conceptualise social structures, human agency and their interplay. This meta-theoretical framework can help produce a balanced, inclusive theoretical account of both the effects of social structures and individual agency on the main empirical object of this study-personal recovery in people who are chronically homeless.

Social Structures

Social structures are sets of internal relations (Sayer, 2000; Danermark et al., 2005). Structures may have multiple constituents (i.e. individual actors and collectives) and substructures (Wynn & Williams, 2012; Elder-Vass, 2007). Individual structures may also be nested within a larger structure. Crucially, each structure has distinct causal powers, which are irreducible to the sum of the causal powers of its constituents (*irreducible wholes*; Collier, 1994). In other words, the causal powers of structures *emerge from* its constituents but are not fully determined by them (Archer, 1995). The value of the concept of *emergence* is that it distinguishes the causal powers of social structures from those of individual human agents (who make up social structures), while reaffirming their interconnectedness (Elder-Vass, 2010).

Although social structures are relatively enduring, they are not immutable (Bhaskar, 1989). In an *'open'* system, composed of reflexive and dynamically acting human agents, structures can be both reproduced and transformed as a result of human activity (Archer, 1995). Conversely, structures are capable of both constraining and enabling human activity (Archer, 1995; Bhaskar, 1989). The construction of an adequate explanation of complex social processes requires understanding both the roles of social structures and individual agency, and of how they interact in a given time and context (Sayer, 1992; Archer, 1995; Parr, 2015).

Human Agency

Under critical realism, humans are active and reflective social agents that are capable of producing real change in the world independent from the influence of social structures-through their subjectively constructed and enacted ideas, beliefs, priorities and aspirations (Archer, 1995). Critical realism also assumes that human motivation to pursue meaningful projects and subjective interests governs most human activity (Smith, 2015). It is the causal force that shapes people's desires, beliefs and emotions and propels them to initiate and persist in actions aimed at realising those life projects (Smith, 2015). Critical realism holds a humanistic and emancipatory view of humans, who are seen as being able to creatively respond to the problematic situations they encounter by resorting to '*imagination, choice, and conscious purpose.*' (Emirbayer & Mische, 1998, p. 973).

The current study conceptualises human agency as a dynamic, temporally embedded, multi-component and relational *process* (Emirbayer & Mische, 1998; Archer, 2003). A comprehensive definition of human agency is offered by Emirbayer and Mische (1998, p. 970), who purport that it is the temporally embedded '*engagement*' of individuals with their structural contexts, whereby individuals can mobilise *'habit, imagination, and judgment'* in response to the problems presented by '*changing historical situation*', which leads to either the reproduction or the transformation of those contexts. Emirbayer and Mische's (1998) distinction between three agency modes-*iteration, projectivity* and *practical evaluation*-will be used in the current study in order to provide a more fine-grained and temporally embedded analysis of human agency in context. According to Emirbayer and Mische (1998), an actor's ability to 'recompose' or re-orientate between different modes of agency is the key mechanism via which actors change their relationship with structure. Iteration refers to the reliance on past practices to inform current courses of action. Projectivity, on the other hand, encompasses *'the imaginative generation by actors of possible future trajectories of action, in which received structures of thought and action may be creatively reconfigured in relation to actors' hopes, fears, and desires for the future.'* (Emirbayer & Mische, 1998, p. 971). Lastly, practical evaluation involves strategic and rational judgements about desirable courses of action in response to '*the demands and contingencies of the present'* (p. 994).

The current study will also utilise Margaret Archer's (1995; 2000; 2003) theorising about *human reflexivity*-the inner force via which human agency is exercised. Archer's modelling of human agency and social transformation (also called *social morphogenesis*) offers a theoretically grounded account of how human agents interact with social structures to either generate change or reproduce the status quo (Archer, 1995; 2003). *Reflexivity* denotes the mental process of identifying, clarifying and ascertaining one's goals, commitments, attitudes, values and beliefs in response to structural enablements or constraints (Archer, 2003).

Archer's theorising about human agency was selected to inform the conceptual framework of the current study for several reasons. To begin with, Archer's elaboration of the concept of the *internal conversation* as the key enabler of human reflexivity allows for the empirical analysis of the inner workings of human reflexivity based on, for instance, individuals' personal narratives (Archer, 2003). The internal conversation is defined as '*a continuous mental deliberation in and for action'* (De Vaujany, 2008, p. 56). It is the catalyst for a range of mental operations aimed at the self- including monitoring, questioning, evaluation, goal (re)definition, commitment negotiation and other agential functions (Archer, 2003). The notions of reflexivity and the internal conversation are essentially *relational* in that they emphasise individuals' continuous and dynamic engagement with, and deliberation and action upon, their context (Archer, 2003).

Furthermore, Archer's three dimensions of reflexivity-*discernment, deliberation* and *dedication*-provide useful concepts for analysing the formation of a person's '*constellation of concerns'* and of individual and social action (Archer, 2007). The process of *discernment* describes how an individual identifies a personal concern or a life project as one of great importance. *Deliberation* refers to planning, prioritisation and a cost-benefit analysis in relation to pursuing this life project. *Dedication* refers to an individual's commitment to realising one's ultimate concern(s) and willingness to persist in the face of obstacles.

Another valuable contribution of Archer's theory is her recognition that, in the presence of certain structural/cultural constraints and enablements, individuals may be differentially able and willing to realise personal projects that transform or reproduce the status quo (Archer, 2003). This theoretical insight is captured by her development of several *reflexivity modes: meta-reflexivity, autonomous reflexivity, communicative reflexivity* and *fractured reflexivity* (Archer, 2003). For instance, autonomous reflexivity entails 'lonesome' deliberation which is goal-oriented and thus carries significant potential for transformative action. For individuals engaging in such a reflexivity mode, context becomes strategic and conducive to action. In contrast, fractured reflexivity refers to disoriented and distressed deliberation. The action potential of this reflexivity mode is highly susceptible to changes in the contextual circumstances, which can lead to further disorientation and ultimately to inaction (Archer, 2003). As noted by Sayer (2009, p. 117), '[…] *our internal conversations may vary from focused and coherent deliberation to fragmented and fleeting musings* […]'. In other words, the activation of one's reflexivity does not necessarily lead to productive action. With regards to fractured reflexivity, Archer (2003, p. 343) clarifies that it is not the case that individuals no longer hold internal conversations but that the internal conversation cannot lead to the realisation of individuals' subjective *'concerns-projects-practices',* which leads to intensified affective distress and to the perceived lack of ability to exercise purposive action. Adverse contextual circumstances can induce fractured reflexivity.

The Morphogenetic Model

Archer's conceptualisation of the structure-agency interplay culminates in her *morphogenetic model of social change* (Archer, 1995). The morphogenetic model serves as the conceptual framework of the current study (See Figure 1). In this model, *morphogenesis* refers to the multiple and complex interactions between different elements within a social system (structures, agents and culture). Those interactions ultimately produce change in the system; this process is called *structural elaboration*. Where no change occurs, the process is called *morphostasis* (Archer, 1982). A key theoretical contribution of Archer's morphogenetic account is its non-deterministic conception of the structure-agency dialectic (Elder-Vass, 2007). According to Archer (1995), social action is '[…] *co-determined by the conditional influence exerted by antecedent structures together with the autonomous causal powers of current agents* […]*'* (p. 75). Those theoretical propositions amount to an *emergenist* view of social change, whereby any event is the product of morphogenetic or morphostatic loops occurring over time (Elder-Vass, 2007).

The analytic value of the morphogenetic sequence for the aims of the current study is that it allows for the empirical ‘decoupling’ of agency and structure within a temporal frame of action (Archer, 2003). It focuses on how structural conditions shape and guide human action, as well as on how human agents respond to, and act upon, their structural conditions in pursuit of their (inherent, intrinsic) interests and thus transform the status quo (Archer, 2010).

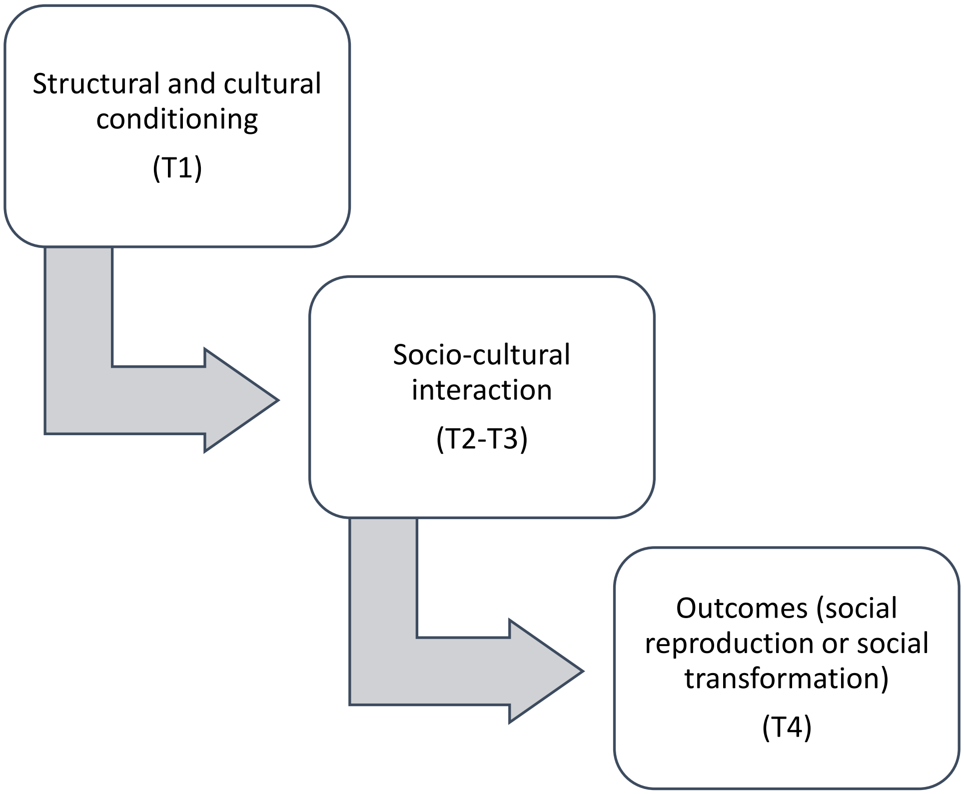


Figure 1. The three stages of Archer’s morphogenetic model (Reproduced from Archer (1995)

The morphogenetic model is comprised of three temporally and analytically distinct stages: *structural and cultural conditioning*, *socio-cultural interaction*, and *outcomes* (Archer, 1995; 2003; See Figure 1). The first stage (T1), structural and cultural conditioning, refers to the influence of pre-existing sets of resources, norms, institutions and other socio-structural entities constraining or enabling individuals' agential capacities (e.g. individuals' concerns, commitments and practices; Archer, 2003). Archer (1995) distinguishes between *material* (human and non-human entities, e.g. resources) and *normative* (ideational, e.g. rules, traditions, discourses) conditioning structures. Furthermore, Bhaskar (1979) defines conditioning structures as systems with a dual influence on actors; they 'instil' a set of (expected/possible/normal) *practices* to be actuated by actors, as well as place actors in particular social *positions* (e.g. duties, roles, relationships, social categories), which necessarily delimits actors' scope of action.

Archer (1995) theorises conditioning structures as having a pluralistic effect upon individual agency. Specifically, she characterises them as: conditioning *'action patterns',* which provide *'strategic directional guidance'* to agents *(p. 196); as 'containing certain limitations and potentialities'* (p. 197); as having effects upon '*the projects to be conceived, entertained and sustained within a given social environment'* (p. 200); as '*shaping processes'* (p. 201); and as having a '*conditional influence'* upon agents (p. 205). Archer goes on to distinguish between two broad types of conditioning effects: (1) social structures that affect agents' *degrees of interpretative freedom*, and (2) social structures that supply agents with *directional guidance*. The former conditioning effect entails modulating agents' preference for certain options above others, as well as supplying actors with reasons that motivate those preferences. This modulation of choice and action, in turn, tends to affect what goals and priorities agents are most likely to identify with and pursue. The latter conditioning effect, *directional guidance*, refers to the situationally supplied *means* (or resources) available for agents to mobilise in the pursuit of their subjectively defined interests and goals.

The second stage of the morphogenetic model (T2-T3), *socio-cultural interaction*, involves the dynamic structure-agency mediation, in which agents exercise their *'most important personal emergent power'* (Archer, 2003, p. 139)-their *reflexivity* in relation to their objective circumstances and as a function of their subjective interests. At this stage, agents deliberate upon, and navigate, the conditioning effects imposed by the socio-cultural context. Their deliberation is mainly governed by agents' subjectively defined life projects, concerns, values and commitments (Archer, 2003), which themselves are shaped by the social relations within which individuals are embedded.

The third and final stage (T4) represents the product of the structure-agency mediation that took place in the previous stage. The *outcome* is the course of action and its associated states of being that occur as the result of agents' reflexive deliberations on their concerns and commitments, within the situational set of objective constraints and enablements. Crucially, this final action may *reproduce or transform* the initial conditioning context and its effects. This result of structure-agency mediation at T4, then, becomes the conditioning context for subsequent cycles of social activity (Archer, 1995; 2003).

Critique and Limitations of Critical Realism

Several pertinent criticisms, particularly to Archer's theorising about human reflexivity and the internal conversation, as well as some more fundamental limitations of critical realism, must be acknowledged. To begin with, Archer's concept of reflexivity has been criticised for its largely individualistic and atomised nature; for being '*nothing more than private internal conversations'*, which seem to insufficiently acknowledge the role of social structures in shaping this process (Farrugia, 2013, p. 288). This, according to Farrugia (2013), equates reflexivity with '*a form of disembodied cognitive rationality'* (p. 288). Critics of Archer tend to argue that one important aspect of human cognition and action her theory seems to miss is the individual's '*capacity for pre-reflexive and* *pre-conscious actions'* (Akram, 2013, p. 45). Indeed, several other theorists have critiqued Archer's models of human reflexivity for neglecting the role of routine or habitual action in shaping society. Proponents of Bourdieusian models of social action, in particular, have accused Archer of over-privileging the role of reflexivity in social change and for her view of the self as '*pre-social and pre-discursive'* (Decoteau, 2016, p. 304; Elder-Vass, 2007; Farrugia & Woodman, 2015). One consequence of such undertheorising, those critics argue, is the failure to account for unintended agency, unconscious, semi-conscious or embodied action, which may be the result of the internalisation of social structures (Decoteau, 2016).

Archer defends her position, however, by arguing that by over-emphasising the role of routine action, one risks committing the error of '*central conflation'*, whereby individual agency and social structure are no longer sufficiently distinguishable causal entities (Archer, 2010). This, then, would make theorists ill-equipped to adequately explain social change (or morphogenesis; Archer, 2010). Archer (2010) clarifies that human action is never completely *'voluntaristic'* (p. 123) because social structures can alter individuals' degrees of interpretative freedom but that nonetheless their actions are non-deterministic, creative and the outcome of individuals' own reflexive practices. Archer (2003, p. 16) positions the internal conversation as the '*missing mediatory mechanism'* between social conditioning and human action.

A related common criticism of Archer's work has been her rather atomised, hyper-individualised conception of the individual, who engages in private, isolated internal conversations (King, 2010). Other authors, however, have defended and re-stated Archer's position that the internal conversation is markedly *relational* in that it represents a continuous process of re-evaluating and re-affirming one's concerns, priorities and actions in relation to the circumstances, including the social relations, within which individuals find themselves (Mutch, 2004).

Furthermore, Archer’s theorising about the role of emotions in reflexivity demonstrates her acknowledgement of the roles of certain forms of *embodied* and *relational* rationality in human reflexivity (Sayer, 2010b). The focus on emotions in Archer’s work partially addresses the criticisms that her model of reflexivity is an overly cognitive one (Sayer, 2010b). Sayer (2010b), for instance, concurs with Archer (2010) that emotions are important in understanding how individuals discern and commit to valued personal projects. In her model of human reflexivity, Archer (2010) emphasises the role of emotions as not merely physiological responses that are somewhat opposed to rational actions, but as evaluative *‘responses to and commentaries on our situations in relation to our concerns*’ (Sayer, 2010b, p. 113). As Sayer (2010b) reminds us, emotions are an essential expression of our shared human vulnerability and interdependence. Emotions-inherently relational entities-have causal powers in that they can reinforce one’s commitments to pursuing one’s life project (Archer, 2010).

In an attempt to mitigate the risk of underplaying the role of social relations by conflating them with structure and culture, the present study will elaborate on the morphogenetic model by delineating social relations as a distinct causal entity shaping recovery. This is visualised in ‘*Chapter Seven*’ (Figure 22).

Researcher subjectivity is another inherent aspect of critical realism, which could undermine the credibility of the analysis. Consistent with critical realism, the researcher’ knowledge, interpretations, analysis and theories remain subjective, incomplete and fallible (Wynn & Williams, 2012). Moreover, analytic approaches central to critical realist analysis-such as *abduction* and *retroduction*-are creative, selective and arbitrary thought operations, which aim to discern the causal entities that presumably have the strongest explanatory potential (Danermark et al., 2005). Also, while critical realists reject the strong interpretivist-constructivist claim that the social reality is determined by humans’ perceptions, language and discourse, they acknowledge that scientific knowledge of this social reality is *context-dependent* (Sousa, 2010). All knowledge is situated and value-laden, which should be taken into consideration when assessing the scientific and practical merits of research (Sousa, 2010).

Researcher reflexivity is therefore important in a critical realist study (Sousa, 2010). The concept-dependence of our knowledge of the world *as we experience it*, and the context-dependence of the knowledge produced by research necessitate that researchers be critically (self-)aware of the cultural, institutional and socio-historic situatedness of their research findings (Sousa, 2010). In particular, the individual and social identities of the researcher (e.g. on the basis of age, gender, sexual orientation, disability status, ethnicity, race and so forth), as well as their membership to scientific communities and educational organisations, likely shape the production of knowledge, and therefore need careful examination as part of the research effort (Sayer, 2000; Sousa, 2010). Furthermore, the researcher's repertoire of theoretical knowledge also heavily influences a critical realist analysis and determines its essentially subjective, fallible and selective nature.

Conclusion

This chapter was dedicated to presenting and rationalising the philosophical and theoretical influences that underpin the current empirical investigation. Critical realism was discussed as an appropriate metatheoretical alternative for achieving contextualised understanding and explanation of personal recovery in the context of structural disadvantage. Emirbayer and Mische's (1998) and Archer's (2003) conceptualisations of personal agency and human reflexivity were also utilised in the current study. Archer's morphogenetic model was selected as a conceptual framework to account for the interaction between social structures and individual agency in recovery.

Chapter Five

Methodology

Logic of the Chapter

This chapter begins by detailing the design components of the current study-including data collection locales, sampling strategy, participant recruitment, data collection methods, transcription of the interview and mobile phone diary material, and data analysis strategy. The theoretical and practical rationales for the research design are presented. The demographic characteristics of the 18 study participants recruited from Scotland and the U.S. are presented, together with an account of their engagement with the mobile phone diary. Ethical considerations are discussed and the strategies for methodological and ethical rigour undertaken-outlined. The chapter concludes by outlining the methodological strengths and originality of the study.

Study Design

This study is a *multi-site participatory qualitative* investigation into the experiences of mental health recovery in persons transitioning out of chronic homelessness. The philosophical framework underpinning this study is critical realism (See '*Chapter Four*'). This is an interview-based study that integrates a range of data gathering and elicitation approaches such as the *life story interview*, a *mobile phone diary* and *visual elicitation*. The Consolidated criteria for reporting qualitative research (COREQ; Tong, Sainsbury, & Craig, 2007) guided the reporting and strategies for rigour of the study.

The study was conducted in several homeless services settings in Glasgow (Scotland), and New York City (U.S.). This study was granted ethics approval by the University of Strathclyde University Ethics Committee on July 28, 2017 (UEC17/42

Weaver/Karadzhov/Quinn). This study adhered to the data protection guidelines and principles contained in the EU Data Protection Directive, the Data Protection Act (1998) and, after May 25, 2018, the General Data Protection Regulation (GDPR). Because the Scottish data collection arm took place shortly after the GDPR was enforced, minor corrections were made to the Participant Information Sheet (See 'Appendix 10'). In addition, a standard Privacy Notice (see 'Appendix 12') was also enclosed with the Consent Form and handed out to the Scottish participants.

Utility of Interview-Based Methods

The flexibility and participatory nature of semi-structured and minimally structured in-depth qualitative interviews provide valuable opportunities to explore participants' subjective perceptions, attitudes and experiences in a sensitive, naturalistic (conversation-like) and participant-centred manner (Pope et al., 2002). This allows researchers to examine the complexities and subtleties of participants' idiosyncratic meaning-making and thus understand what really matters to them (Pope et al., 2002). The idiographic focus of the in-depth qualitative interview method makes it well-equipped for studies of personal, sensitive and/or complex experiences and other phenomena, including SMI and homelessness (Packard, 2008; Pain, 2012; Catalani & Minkler, 2010; Magnusson & Marecek, 2015). Within a hermeneutically-based methodology, the qualitative interview method offers a wide range of analytic possibilities such as the analysis of meaning-making in everyday life contexts, of stories, of language and discourse, of identity, of implicit cultural meanings, and many others (Magnusson & Marecek, 2015; King et al., 2018).

The qualitative interview method has also demonstrated theoretical and practical utility in both phenomenological (Smith, 2011; King et al., 2018) and realist (Maxwell, 2012a; Danermark et al., 2005) empirical investigations. In particular, the qualitative interview method has been demonstrated to be apposite for helping generate both empathetic understanding of the participants' lived experience *and* causal explanations of individual and collective phenomena (Maxwell, 2012a; 2012b).

In a life story interview, participants are typically asked to narrate about the most significant events in their lives, particularly any critical moments, turning points, challenges, revelations and other themes of personal significance (Gubrium & Holstein, 2001). From an ethical standpoint, the life story interview offers the narrator the opportunity to share, reflect upon, and validate, their life experiences in a supportive and empathetic environment (Atkinson, 2012). Those relational processes can help the narrator gain greater self-knowledge, insight, goal-directedness and even self-confidence (Atkinson, 2012). In addition, because life story interviews are relatively unstructured and participatory, the participants are encouraged to create their narratives authentically and at their own pace, which could be an empowering and a cathartic experience (Atkinson, 2012; Phoenix & Sparkes, 2009). Furthermore, although each life story is unique, life stories tend to share common human experiences of joy, hope, anguish, vulnerability and courage. Sharing those experiences can bring the narrator 'closer' to a sense of a shared humanity and help destigmatise their experiences (Atkinson, 2012).

As highlighted in '*Chapter Three*', life story interviewing ('big stories') is uniquely suited to the empirical investigation of personal recovery (Bamberg, 2006; Popay et al., 2003; Patterson et al., 2012; Llewellyn-Beardsley et al., 2019). The extant research literature has conceptualised individuals' experiences of recovery as 'paths', 'pathways', 'roads', 'journeys' and 'projects'-all in the pursuit of a more satisfying, productive, meaningful and liberating life (Deegan, 1996; Leamy et al., 2011; Topor et al., 2011). Those metaphors denote that personal recovery tends to unfold within the individual's life course and ultimately should reflect the individual's own beliefs, values, commitments and ideals. Examining the life story allows the researcher to analyse how those concerns, commitments and values have evolved over time, and how this has influenced the individual's subjective construction of their recovery projects. Analysing the biographical narrative allows the researcher to not only identify those reflexive processes, but also discern how the individual's concerns, projects and practices are constrained or enabled by the various social structures and contexts featured in the individual's life story (Archer, 2003; Caetano, 2015; Weaver & McNeill, 2015).

Ethical and Practical Concerns in Interview-Based Qualitative Studies

Although notions of vulnerability in research are highly contested, individuals who may have co-occurring SMI, PSU and experiences of homelessness may be considered doubly or even triply vulnerable research participants (Packard, 2008; Aldridge, 2014). This may be due to a number of potential vulnerability-inducing situational and structural factors such as institutionalisation, structural violence and inequities, being overresearched, precarious living conditions, increased vulnerability to distress or discomfort, and others (Bracken-Roche et al., 2017; Rogers & Lange, 2013; Packard, 2008). Such multiple and co-occurring disadvantage is likely to create overlapping vulnerabilities in those participant groups. As such, the research encounter could not only exacerbate pre-existing vulnerability but also create new, situational vulnerabilities in the participants (Bracken-Roche et al., 2017). This necessitates a special consideration of the ethics of such research with potentially vulnerable individuals (Shaw, 2005; Aldridge, 2014).

Methods such as in-depth interviewing, life story interviews and visual elicitation have been recognised as providing a greater degree of sensitivity, inclusivity and attentiveness to participants' voices than, for instance, other methods such as structured interviews and questionnaires (Aldridge, 2014). Those methodological advantages are especially pertinent to research with groups that are traditionally excluded from research, that are otherwise marginalised or that might have diverse verbal and reflective abilities (Aldridge, 2014). The flexibility of such participatory, interview-based methods also maximises the opportunities of the research to generate authentic, empathetic and democratic accounts of participants' experiences (Aldridge, 2014).

Establishing rapport with participants and maximising their engagement with the research are other important ethical challenges. In interview-based studies, the researcher's positioning, competencies and attitudes are often considered key 'instruments' for ensuring the ethical, inclusive and empowering conduct of the research (Taylor, 2009). Taylor (2009, p. 395), for example, highlights the researcher's *'use of self'* as essential for addressing the power imbalance between the researcher and vulnerable participants, and for increasing the trustworthiness of the research process. In this process, the researcher's self-awareness, genuineness, positioning and narrative and cultural humility are of crucial importance (Taylor, 2009). Researchers should also recognise that interpersonal and contextual factors such as class, culture, age, gender, socio-economic status, the interview environment, participants' perceptions of the researcher and others are likely to shape the interview encounter and the research findings (Hewitt, 2007). Those practices help ensure an inclusive, respectful, honest and egalitarian research encounter, in which participants are not 'othered' but instead recognised as having unique voices, life histories and concerns that should be heard and acknowledged.

Establishing and maintaining boundaries, preventing participant exploitation and coercion, preventing participant labelling and the reinforcement of stereotypes are other ethical imperatives in qualitative research with vulnerable groups (Ensign, 2003). Those considerations informed the participant recruitment and interviewing procedures (See *'Data Collection Methods and Procedure'*).

Utility of Visual Elicitation Approaches

Visual or photo elicitation generally refers to integrating visual imagery into the qualitative interview in order to stimulate recall, reflections and discussions (Padgett et al., 2013). In elicitation interviews, participants are usually presented with images or other visual artefacts, including ones they have generated as part of the research, and asked to reflect on their meaning and significance (Guillemin & Drew, 2010). Elicitation interviews aim to augment the analytical, theoretical and emancipatory capabilities of the traditional qualitative interview (Guillemin & Drew, 2010; Pain, 2012).

From a critical social science perspective, visual imagery has been shown to have distinct communicative, performative and socially reflexive functions (Han & Oliffe, 2016; Seitz & Strack, 2016). When conducted ethically and rigorously, the elicitation interview approach can facilitate participants' self-expression, stimulate their tacit knowledge and understanding of the phenomenon under enquiry, enhance the richness of the data and redress, in part, at least, some of the power imbalance between participants and researchers (Pain, 2012). Such methods tend to position participants as experts, as insiders, who control what is being recorded and partner with the researcher on its interpretation and/or dissemination (Clements, 2012, as cited by Morrow & Malcoe, 2017; Han & Oliffe, 2016). In addition, visual imagery can help participants articulate painful, sensitive, and/or ambivalent feelings and experiences (Clements, 2012, as cited in Morrow & Malcoe, 2017). Furthermore, visual elicitation interviews are suited for generating accounts of 'invisible', routine phenomena within the daily lives of participants, which may carry important theoretical insights (Gubrium & Harper, 2013). Last but not least, inviting participants to actively deconstruct the meanings behind the images they have obtained also reduces the likelihood of misinterpreting the data and can therefore increase the authenticity and credibility of the findings.

Research has consistently demonstrated that using participant-generated images as interview probes can help stimulate recall, enhance collaborative analysis and aid participant reflection (Padgett et al., 2008; Padgett et al., 2013; Han & Oliffe, 2016). Such data gathering methods have been successfully utilised in research with a range of vulnerable groups-including those who are homeless and those with mental illness (Padgett et al., 2013; Copes et al., 2018).

The Mobile Phone Diary

The methodological strengths of visual elicitation motivated the incorporation of the mobile phone diary in the current study. With their image- and video-generating capabilities, mobile phone diaries share many of the theoretical, methodological and ethical strengths of participatory visual methodologies. The mobile phone diary is a hybrid data collection tool that combines the traditional diary method with visual methodologies (Palen & Salzman, 2002; Murray, 2009). The mobile phone diary is a naturalistic, in-situ data collection method that captures participants' dynamic day-to-day experiences in a contextualised and accessible manner (Bagnoli, 2004). Mobile phone diaries are contextual and dynamic self-documenting tools for studying participants' actions in mobile contexts (Büscher & Urry, 2009). Diary entries can be textual or digital (audio, visual and audio-visual) allowing for the multimodal capturing of actions, thoughts and emotions in real time (Büscher & Urry, 2009). Thus, the mobile phone diary allows the researcher to gain an in-depth insight into participants' personal lives and daily practices while avoiding the safety and other ethical hazards associated with conventional ethnographic work (Murray, 2009). Researchers have argued that mobile phone diaries have the potential to yield a *'provocative, experiential and sensorial insight into participants' lives'* (Hagen & Rowland, 2010, para. 12).

A distinct set of ethical principles relating to the generation of visual images and other identifiable data was applied to protect participants' safety, confidentiality and respect and dignity (See '*Mobile Phone Diary Logging Period*' and '*Elicitation Interview*' in this chapter). Those include minimising the burden of participation; preventing feelings of inadequacy or embarrassment in the participants as a result of introducing a novel piece of technology; and providing adequate training and ongoing support

(Packard, 2008; Padgett et al., 2013). In addition, efforts were made to foster trust between the Researcher and the participants, as well as a sense of ownership in the participants (Pain, 2012).

Data Collection Settings

Data were collected from four residential facilities and one drop-in centre for homeless persons between February 2018 and September 2018. Two of the residential facilities and the drop-in centre were located in New York City (U.S.). The other two residential facilities were located in Glasgow (Scotland). Those locales were targeted due to the high percentage of clients with complex needs they catered for.

U.S. (New York City)

The three U.S. data collection sites consisted of two safe haven shelter facilities and one drop-in centre for street homeless adults located in an NYC borough. The U.S. data were collected between February 2018 and June 2018. The safe havens had a capacity of between 50-75 beds (the *exact number of beds was purposefully omitted for anonymity purposes)*. Those shelters offered a range of in-house services such as housing placement and benefits assistance, medical and psychiatric care, medication management support and substance use counselling, as well as external referrals for substance use and psychiatric and medical treatment. The drop-in centre offered 24/7 crisis prevention and outreach services, in addition to housing and benefits assistance, referrals to treatment centres, counselling, transportation, and other services. The safe havens personnel included programme directors, clinical coordinators, case managers, activity specialists, a visiting medical doctor and a visiting psychiatrist, and other administrative and security staff. In-house psychiatric care was provided via a psychiatric consultant who attended the site between 1-2 days per week. Both safe havens also offered in-house wellness groups, group counselling, arts & crafts, and other leisure activities such as outdoor trips.

The safe havens and the drop-in centre represent low-barrier programmes for clients with complex healthcare needs, particularly those with histories of street and chronic homelessness (NYC Mayor's Office of Operations, 2017). Those facilities provide opportunities for clients to establish successful working relationships with support workers as they work towards eligibility for permanent housing. Safe havens represent an innovative service delivery model for homeless persons with complex needs who are often seen as 'hard-to-serve', 'service resistant' or difficult to engage in traditional, high-threshold homeless services (Bridgman, 2002; Lincoln et al., 2009). Placement in the safe haven programmes typically required a referral by an outreach team and verification of a history of chronic homelessness (as defined by the U.S. Department of Housing and Urban Development). Compared to the traditional shelter model, safe havens provide lower-threshold, more accessible, localised, comprehensive and tailored support. Distinct features of those homeless services include the lessened, or the lack of, curfew restrictions, the less strict sobriety policy, its lower admission threshold, and others. Rapid rehousing is often an explicit goal of safe haven programmes although clients are often allowed unlimited stays depending on the availability and suitability of the permanent housing options and on the clients' support needs and other circumstances.

Scotland (Glasgow)

Between June 2018 and September 2018, participants were also recruited from two residential facilities in Glasgow (Scotland)-one emergency access service for women affected by homelessness, which had a capacity of between 10-30 beds, and one temporary accommodation service for homeless men (called an assessment centre), which had a capacity of between 40-70 beds (the *exact number of beds was* *purposefully omitted for anonymity purposes).* Those facilities offered a range of support services including 24/7 staff presence, case management, in-house counselling and support groups, referrals to specialist services, housing assistance, in-house doctor visits, communal recreational activities, and others.

The women's emergency access service offered residential accommodation to single homeless women with low to medium support needs, including those with substance misuse and mental health problems. Residents were typically accepted after a referral from emergency services, emergency homeless services or housing authorities. The average length of stay was approximately six months; however, in some cases, it was up to two years. Residents were not imposed limits on their maximum allowed length of stay. The staff provided clients with practical and emotional support, including helping clients access primary care and pharmacy services. The staff had a minimum of SVQ (Scottish Vocational Qualifications) Level 3 in Social Care but could come from a range of academic and professional backgrounds. The staff were trained in trauma-informed care and psychologically-informed environments. Group social activities were regularly organised such a movie nights, games and gardening.

The temporary accommodation service for homeless men provided housing and other practical support to help clients resettle into the community. To be eligible for this service, clients had to be assessed as homeless and usually referred from emergency services or housing authorities. Many of the clients of this service tended to have complex needs and were considered vulnerable. Tailored support plans were made for clients considered to be particularly vulnerable to self-harm. The service liaised with a range of housing and health professionals to help deliver holistic support to the clients. The service connected clients with addiction and mental health services, criminal justice services, social work services, welfare services, and education and employment support. The staff included social workers, as well as less qualified personnel, some of whom were working towards SVQ qualification.

Sampling Strategy

The sampling strategy combined *purposive* (*maximum variation*), *convenience* and *intensity sampling* approaches (Patton, 1990; 2002; Emmel, 2013; Robinson, 2014). The maximum variation sampling aimed to ensure diverse characteristics of the population of interest were represented. This approach aimed to help illuminate diverse aspects of the phenomenon under empirical investigation (i.e. personal recovery). The aim of this sampling strategy was to capture the '*complexity, nuance, and the dynamics of the lived experience*.' (Emmel, 2013, p.138). This was achieved by recruiting participants from different geographical settings (Scotland and the U.S.), with various current housing arrangements (street homeless and temporary housing), mental health diagnoses and demographic characteristics (e.g. ethnicity, gender, age).

Intensity sampling was also used to maximise the theoretical insights generated from the data by targeting participants representing '*information-rich case*[s]*'* (Robinson, 2014, p. 35, citing Miles & Huberman, 1994). Patton (1990, p. 171) defines intensity sampling as collecting *'information-rich cases that manifest the phenomenon intensely'.* Because the overarching aim of the present study was to examine the experiences of personal recovery in the context of homelessness, the recruitment focused on participants with SMI (i.e. at the extreme end of the mental health difficulties spectrum) who had been chronically homeless (i.e. at the extreme end of the housing exclusion spectrum). It was hoped that this strategy would help generate useful insights into the relationship between mental health, recovery and homelessness.

The *convenience* approach to sampling was necessitated by the pragmatic (time, financial and logistical) constraints of the research. It meant that only a small number of potential data collection sites could be targeted and that a relatively small but manageable number of research participants could be recruited while ensuring *data adequacy* (see the next section).

This sampling strategy, while tailored to the objectives of the current study, meant that the present findings would not be generalisable to the wider population of interest (See '*Limitations of the Study*' in '*Chapter Eight*').

Data Adequacy and Saturation

In a critical realist-informed qualitative study, a relatively small number of participants allows for the detailed examination of causal mechanisms and the specific contexts that impede or facilitate their activation (George et al., 2005; Wynn & Williams, 2012; Sayer, 1992). In this sense, each participant's account can be conceptualised as a *'case'*, which illustrates a unique configuration of contexts, mechanisms, actions and outcomes (Emmel, 2013). This commitment to idiographic analysis and theory-building justifies a relatively small sample size and prioritises the depth, nuance and explanatory utility of the data. This affinity towards small sample sizes is shared by some hermeneutically-based methodologies (such as IPA), according to which the appropriateness of the sample size is judged according to the depth, nuance and insightfulness of the data (Morrow, 2007; Smith et al., 2009).

Critical realism is philosophically opposed to deterministic approaches to sample size and data saturation estimations (Emmel, 2013; Pawson & Tilley, 1997). The utility of the sampling approach cannot be judged until after the data analysis has been completed, whereby each participant (or each 'case'), is re-interpreted as a unique manifestation of the emergent causal properties of social structures, human agents and their interactions within a set of contexts (Emmel, 2013). It is only after the data analysis has been completed that theoretically significant '*absences*' in terms of potentially causally efficacious social structures, mechanisms and contexts could be attributed to the under-representativeness of the sample. This position resonates with more recent guidance on justifying sample size sufficiency in interview-based studies, in which the authors advise that '[…] *data adequacy is best appraised with reference to features that are intrinsic to the study at hand*.' (Vasileiou et al., 2018, p. 1). In the present study, it was the metatheoretical positioning (i.e. critical realism) that guided the approach to ensuring data adequacy or sufficiency.

Eligibility Criteria

To be eligible for participation in the study, individuals needed to:

(1) Be of 18 years of age or older;

(2) Be able to speak English fluently;

(3) Have the decisional capacity to provide informed consent;

(4) Have a history of an SMI diagnosis (such as depression, schizophrenia, bipolar disorder and others);

(5) Meet the local statutory criteria for homelessness; and

(6) Exhibit a pattern of *chronic homelessness.* Chronic or long-term homelessness was defined as having been *'continuously homeless for one year or more or* [having experienced] *at least four episodes of homelessness in the last three years where the combined length of time homeless in those occasions is at least 12 months.'* (U.S. Department of Housing and Urban Development, 2017, p. 2).

Fulfilment of all study eligibility criteria was verified by the staff at the data collection sites who assisted with the recruitment.

Participant Recruitment

In New York City, initially, two homeless services providers were contacted by email introducing the purpose of the study and requesting access to their clients (See 'Appendix 2'). One of those providers agreed to serve as the gatekeeper for the current study and allowed the Researcher access to several of its facilities. In Glasgow, potentially eligible facilities were identified through networking and contacted via email introducing the study and requesting field access. Both service providers contacted in Glasgow agreed to act as gatekeepers and provided the Researcher with field access.

A staff member (a service manager, a programme director or a case manager) from each facility acted as a link person that liaised with the Researcher on recruiting prospective participants. At one-to-one meetings, the Researcher explained to the link staff member the aims and remit of the current study, as well as the eligibility criteria. The Researcher emphasised the importance of confidentiality, anonymity, non-coerciveness and inclusivity in the recruitment process. For example, the Researcher insisted that no client be disregarded for potential participation on the basis of their presumed reflective capacity or verbal or other cognitive abilities as long as they demonstrated the capacity to provide informed consent.

The link staff in each facility were then tasked with identifying clients meeting the study eligibility criteria, introducing those clients to the nature of the study using the Study leaflet and the Participant Information Sheet (See 'Appendix 8' and 'Appendix 10'), and arranging initial meetings between interested and eligible clients and the Researcher on the premises of the respective facility. Where required by their organisation, the staff obtained internal informed consent from their clients, which allowed the staff to introduce those clients to the Researcher as meeting the study eligibility criteria. The staff did *not* disclose specific information to the Researcher regarding the clients' specific diagnostic history or other confidential personal circumstances. The staff approached clients about potential participation based on the eligibility criteria and also on the clients' availability during the Researcher's regular site visits during the research period. The Researcher was not provided with information regarding how many of the clients approached by the link personnel refused to participate in the study.

Upon meeting with the prospective participants for the first time, the Researcher introduced himself and re-acquainted them with the Participant Information Sheet and the Consent Form. After that, the prospective participants were encouraged to ask any questions and could then opt in to take part in the study.

Demographic Characteristics of the Sample

18 participants (14-self-identifying as male and 4-self-identifying as female) were recruited in total. Ten participants resided in a safe haven facility or attended a drop-in centre in New York City (U.S.), and eight resided in temporary housing facilities in Glasgow, Scotland (U.K.). The sample had a diverse ethnic composition-with nine (50%) participants self-identifying as White/Caucasian, four (22%)-as African-American, three (17%)-as Hispanic, and two (11%)-as Asian. The participants' mean age was 48. The youngest participant was 29 years old, and the oldest-66 years old (See Table 1).

16 participants' native language was English; one participant was bilingual (Spanish and English); and one participant's native language was Spanish. All participants interviewed in Scotland had been born in the U.K. From the American sample, only one participant was not born in the U.S. but in Mexico. Seven participants reported having at least a high school degree, while the rest had less than high school degree. Only one participant was currently employed; four were 'disabled, not able to work'; eight were 'unemployed, not looking for work; four-'unemployed but looking for work'; and one was 'retired'. The majority of participants (eleven) were never married;

three were divorced; three were separated; one was married. Only two participants reported living in a marriage-like relationship. Ten of the participants reported having children.

The majority of participants (ten) rated their current *physical health* as ‘fair’; four-as ‘good’; two-as ‘poor’; one-as ‘very good’; and one-as ‘excellent’. Compared to a year ago, six reported that their physical health was ‘same’; seven-that it was ‘better’; and four ‘worse’ (One participant did not answer this question.). When asked to self-evaluate their current *mental health*, eight reported that it was ‘fair’; six-‘poor’; three-‘good’; and one-‘excellent’. Compared to a year ago, eight rated their mental health as ‘same’; five-as ‘better’; and five-as ‘worse’.

The participants’ mean total length of time homeless in lifetime was 11 years (with a median of six years) and ranged between two and 30 years (See Table 1). Six of the participants had first experienced homelessness before the age of 18, while seven-after the age of 30. For seven participants, the longest uninterrupted period of homelessness had been less than two years; for six-between two and five years; and for the remaining five-more than five years. The participants had been clients of their current accommodation provider for between three years and two weeks, with a mean of nine months.

On the background questionnaire (See ‘Appendix 3’), the participants cited a range of reasons for their first episode of homelessness-including PSU, family conflict/breakdown, loss of job, unemployment or financial difficulties, and mental health issues. In almost all cases, more than one factor was cited as precipitating homelessness. During the interviews, 13 participants disclosed their mental health diagnoses. Their mental health problems included depression, anxiety, bipolar disorder, and psychosis/schizophrenia. The remaining five participants did not disclose their specific SMI diagnosis during the interviews. Finally, 12 (or 67%) of the participants also revealed they had a history of PSU (alcohol and/or illicit substances; See Table 1).

Table 1: *Demographic and Housing History Characteristics of the Sample*

Setting	New York City, U.S. (10); Glasgow, Scotland (8)
Gender	Male (14); Female (4)
Ethnicity	White/Caucasian (9); African-American (4); Hispanic (3); Asian (2)
Age	Mean = 48; Median = 49; Range = 29-66; (*Note: 1 undisclosed*)
Housing arrangements at time of interview	Temporary accommodation (15); Street homeless (3)
Age at first episode of homelessness	Less than 18 years of age (6); Between 18 and 30 years of age (5); More than 30 years of age (7)
Length of time homeless in lifetime	Mean = 11 years; Median = 6 years; Range = 2-30 years
Longest uninterrupted period of homelessness	Less than 2 years (7); Between 2 and 5 years (6); More than 5 years (5)
Main reason for first episode of homelessness	Problem substance use (6); Family conflict/breakdown (5); Loss of job/unemployment/financial difficulties (4); Mental health issues (1) *Note: In most cases, multiple reasons were cited.*
History of SMI diagnosis (Note: In some cases, multiple diagnoses applied.)	Depression (8); anxiety (7); schizophrenia/psychosis (4); bipolar (1); undisclosed (5)
History of PSU	Yes (12); No or unknown (6)

Table 2: *Participant Profiles (N = 18)*

Participant Pseudonym (N = 18)	**Setting**	**Gender**	**Age**	**Ethnicity**	**Length of Time Homeless in Lifetime**	**Number of Interviews (N = 45)**	**Mobile Diary (N = 9)**
Liam	U.S.	Male	45-50	Hispanic	3 years	2	No
Scott	U.S.	Male	50-55	Caucasian	5 years	3	Yes
Matthew	U.S.	Male	55-60	Asian	7 years	4	Yes
George	U.S.	Male	65-70	Hispanic	>20 years	2	No
Joshua	U.S.	Male	55-60	African-American	30 years	1	No
Benjamin	U.S.	Male	55-60	African-American	30 years	4	Yes
Oliver	U.S.	Male	50-55	African-American	4 years	3	Yes
Susan	U.S.	Female	Undisclosed	Asian	6 years	2	No
Kelly	U.S.	Female	35-40	African-American	5 years	3	Yes
Edward	U.S.	Male	55-60	Hispanic	5 years	3	Yes
Neil	Scotland	Male	50-55	Caucasian	6 years	3	Yes
Craig	Scotland	Male	45-50	Caucasian	2 years	3	Yes
Ashton	Scotland	Male	40-45	Caucasian	27 years	2	No
Simon	Scotland	Male	45-50	Caucasian	10 years	2	No
Claire	Scotland	Female	35-40	Caucasian	5 years	3	Yes
Henry	Scotland	Male	45-50	Caucasian	5 years	1	No
Mary	Scotland	Female	30-35	Caucasian	17 years	2	No
Conor	Scotland	Male	25-30	Caucasian	3 years	2	No

Note. The participants' exact age has been concealed for anonymity purposes. All participant names reported are pseudonyms to protect their anonymity.

In total, 45 one-to-one interviews were conducted. The interviews lasted between 20 minutes and 90 minutes, with an average interview duration of 45 minutes (See Table 2). Half (or nine) of the participants took part in at least three interviews. Seven participants (or 39%) completed only two interviews, and two participants (or 11%)-only one interview (See Table 2). Reasons for attrition from the study included relocation to another facility, medical emergencies, personal crises, lack of interest in, or time for, completing the mobile phone diary, loss of contact with the Researcher, and physical disabilities (For example, poor eyesight prevented one participant from using the mobile phone diary.). Only three participants (Liam, Simon and Henry) explicitly refused to complete the second or the third phases of the study due to lack of interest or without sharing a specific reason. Attrition due to loss of contact with the Researcher occurred when the participant failed to show up for two consecutive interview appointments, or when the Researcher could not reach the participant after two attempts to contact them via the shelter staff.

Data Collection Methods and Procedure

Individual in-depth interviews were used, in combination with the mobile phone diary and a demographic information questionnaire. The study involved four data collection phases: an initial interview, a second interview, a mobile phone diary logging period, and, finally, an elicitation interview (See Figure 2).

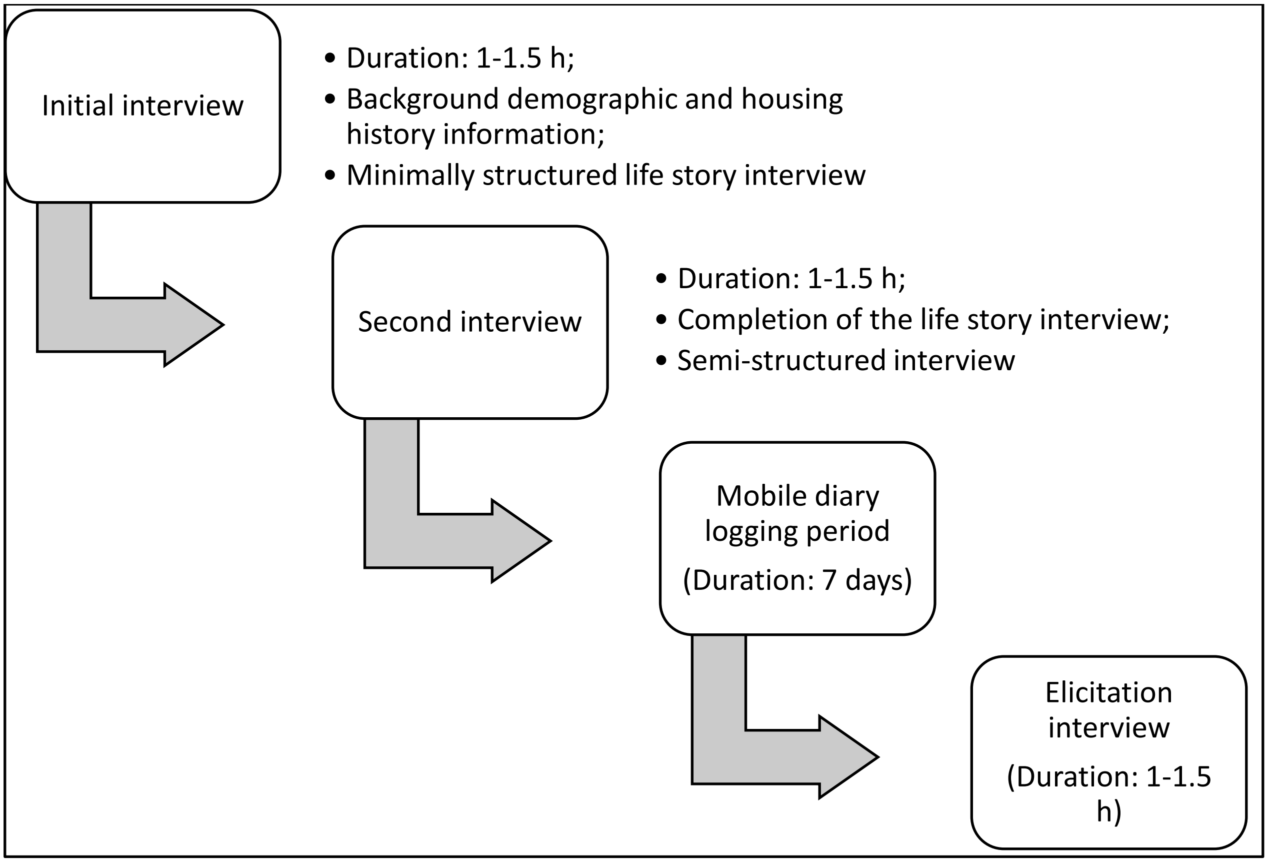


Figure 2. Data collection sequence

Ethical Considerations and Researcher Reflexivity and Positionality

The Researcher recognised the vulnerable status of the participants, as well as the potential for multiple overlapping vulnerabilities. This awareness and sensitivity were reflected in both the research design and planning (procedural ethics) and the Researcher's conduct in the field, including his responses to any exigencies (situational ethics; Guillemin & Gillam, 2004). Heightened ethical sensitivity was also warranted due to the current study's focus on personal and potentially sensitive experiences such as the life story, losing one's home and one's experiences of well-being and recovery.

In the field, the Researcher conducted himself in an *ethically relational* manner (Tracy, 2010). This entailed being mindful of how his actions, appearance, language and demeanour might impact the participants and also recognising the importance of establishing mutual trust, respect and solidarity with the participants (Guillemin & Gillam, 2004). To demonstrate, the Researcher developed rapport with the participants by conducting the interview in an informal, conversational and approachable manner, minimising the use of scientific jargon, using participants' own preferred language, and conducting the interview at a familiar location and offering refreshments. He also self-disclosed his lack of professional experience in a social work or mental health context and lack of lived experience of either homelessness or SMI. This helped the Researcher emphasise his outsider status, his minimal prejudice and professional biases, as well as his openness to learn *from* the participants. This helped position the participants as experts on their own life story and therefore challenge the traditional research dynamics, whereby the researcher is seen as the expert on the research topic (Dickson-Swift et al., 2007). Moreover, despite being a cultural outsider (especially in the U.S.), the Researcher attempted to increase the degree of reciprocity with the participants by briefly introducing himself and his experience of living and studying in a foreign country and being far away from home. It was hoped that this demeanour and those concrete practices helped overcome the participants' possible suspicion, shame or fear in relation to disclosing their thoughts and experiences (Shaw, 2005; Dickson-Swift et al., 2007).

The Researcher also demonstrated heightened ethical sensitivity in the process of the interview. This was partly motivated by the recognition that, in qualitative research, participants often open up about emotional, intimate and sometimes painful experiences, which can put them at an increased risk of discomfort, shame or distress (Dickson-Swift et al., 2007; Tracy, 2010). From the research literature, the Researcher was aware of the high prevalence of adverse life experiences in individuals with lived experience of homelessness, substance use and SMI. Therefore, the Researcher was prepared to offer empathetic listening, encouragement and emotional support, especially in cases when the participants disclosed painful, including traumatic, life experiences. On multiple occasions during the interviews, he encouraged the participants' autonomy by emphasising that they were in control of what they wished to disclose. Furthermore, in efforts to uphold the participants' autonomy and avoid exploitation, the Researcher checked in with them that they still felt positively about their participation at multiple times during the study (Hewitt, 2007). The Researcher also reminded the participants that their voice mattered and that their experiences were valid-even when the participants shared they felt discouraged, unheard and invisible in society.

The Researcher is a Caucasian man from Eastern Europe in his late 20s. He has an academic background in psychology and global mental health. The Researcher had no practical social work or homeless care experience. Prior to data collection, he had not visited a homeless shelter or any other service facility for people who were homeless. In the U.S., the Researcher was also a complete cultural outsider in that he had never visited or spent longer time in the U.S. prior to the data collection in NYC.

During the entire research lifecycle, the Researcher maintained awareness of how his social position, personal and academic views and experiences might be biasing the research, including his conduct in the field. During data collection and transcription of the interviews, the Researcher constantly examined how any emerging understanding of the phenomena of interest was influenced by the accumulating data and by the Researcher's own biases and identities (Jootun et al., 2009; Tracy, 2010). The Researcher discussed any potential influences of his prior assumptions on the data collection and analysis processes with his academic supervisors and his academic mentor as a form of peer debriefing (Padgett, 2016). In addition, the Researcher kept a decision trail outlining the evolution of the research questions, interview questions and approaches to sampling (Jootun et al., 2009). The Researcher also kept post-interview memos containing both descriptive and interpretive sequences, and both theoretical and methodological notes (Somekh & Lewin, 2005). This helped track and '*bracket*' (acknowledge and minimise) the potential inadvertent influences of prior biases on the research process.

Informed Written Consent

Prior to commencing the initial interview, the Researcher presented participants with the PIS, a Privacy Notice and a Consent Form (See ‘Appendix 9’, ‘Appendix 10’ and ‘Appendix 12’). Both the PIS and the Consent Form explained the voluntary nature of participation in the study, the participants’ right of withdrawal at any time without penalty, the participants’ right to refuse to answer any question, as well as the data recording, anonymisation, storage and re-use procedures. The PIS also detailed the potential risks of participation such as the possible emotional discomfort. Finally, participants were encouraged to ask any questions that they might have. Participants were then asked to sign two copies of the Consent Form and retained one of the copies, as well as a copy of the PIS and the Privacy Notice, for future reference. The PIS contained affiliation and contact details for the Researcher and for his academic supervisors. The Researcher retained the second copy of the Consent Form, which was safely stored in a locked office cabinet.

Initial Interview

All interviews were conducted during normal working hours in a private office space located in the temporary accommodation facility in which the participants resided. Site staff were easily accessible to provide any support should any of the participants become extremely distressed. Such situations, however, did not occur during the study.

During the initial interview, after obtaining informed written consent, participants were asked to complete a short pen-and-paper background information questionnaire, which was followed by a 15-min structured residential history interview (See ‘Appendix 3’ and ‘Appendix 4’). The questionnaire gathered information about the participants' age, gender, country of origin, native language, ethnicity, marital status, number of children, educational history, and employment status. This information was obtained to enable meaningful comparisons between the demographic profiles of the current sample and those of the wider homeless populations in Scotland and the U.S. This helped assess the representativeness of the current sample and contextualise the findings.

The final four questionnaire items elicited participants' subjective ratings of their current physical health and mental health. This set of multiple-choice (Likert-type) questions was included to help probe into participants' reflections about their health, well-being and recovery in the subsequent interviews (Adamson et al., 2004). A typical follow-up question based on the questionnaire was: *'You indicated that your current mental health was 'good'. I am curious to know, what is 'good mental health' to you*?'. Participants were reminded they could refuse to answer any question. Most questions had a '*Prefer not to answer'* option. The questionnaire took approximately five minutes to complete.

Then, participants were asked a series of brief housing history questions. This interview component was based on the Homeless Supplement to the Diagnostic Interview Schedule (HS/DIS; North et al., 2004). Participants were asked about their current housing status, homelessness history and chronicity, shelter use, transience of housing (housing stability), reasons for the first and for the current homeless episodes. The purpose of this interview segment was to validate the participants' pattern of chronic homelessness (an eligibility criterion), contextualise the participants' experiences, and draw meaningful comparisons between the participants and the general homeless populations.

Following this, the main component of the interview, the minimally structured *life story interview*, commenced (Gubrium & Holstein, 2001; Holstein & Gubrium, 1997). This interview component was minimally structured in that the Researcher followed a broad interview schedule (See ‘Appendix 5’) using probes when necessary while aiming to elicit participants’ actively constructed personal narratives and preserving their unique flow, pattern and direction (Gubrium & Holstein, 2001). The following themes were explored: most significant/defining life events, episodes or ‘chapters’ (including onset and precipitants of homelessness, onset and precipitants of mental illness, and others); early life experiences and childhood; family and family dynamics; neighbourhood and schooling; experiences of housing and homelessness; memorable acquaintances; moments of hardship and moments of strength and joy; contact with support services; present-day life, and others.

The interview schedule also aimed to elicit information about temporal sequences of events, about participants’ rationale behind life choices made, deliberations about their life paths, as well as about the specific contexts within which such deliberations had occurred (Hall & Powell, 2011; Riessman, 2003; Fraser, 2004). The Researcher also probed into participants’ explanations about their life circumstances and significant life events, as well as into their self-evaluations and meta-statements (e.g. ‘*To what extent do you think poverty impacted your life?’; ‘How did you manage to keep going?’*). Carefully placed evaluative outcome questions (*e.g. ‘How did this affect you?’; ‘What do you hope will change about this story/situation?’;* Hall & Powell, 2011) aimed to further encourage the participants to reflect on the wider social and structural context.

At the end of each interview, the participants were offered a £15/$20 shopping voucher in recognition of their time. The type and amount of the incentive were decided after discussions with the site staff and after consulting with the available literature of research with similar participant groups (Seitz & Strack, 2016). Each interview was audio-recorded using an unobtrusive portable voice recorder. Following each interview, the recordings were transferred onto the University’s password-protected cloud data storage, Strathcloud, and permanently deleted from the voice recorder.

Second Interview

The second interview typically took place a day after the initial interview. At the start of this interview session, the participants were queried about their experiences during and following the initial interview. The Researcher aimed to probe into any significant adverse emotional and psychological impact of the initial interview. The Researcher was aware of the potentially (re)traumatising impact of discussing sensitive personal experiences. Therefore, the Researcher remained vigilant of any verbal and non-verbal cues of discomfort or distress in the participants.

The overwhelming majority of participants shared positive experiences during the initial interview. Only one participant, Ashton, shared he had had an '*emotional*' night the night before because he had been thinking about the experiences he had discussed during the initial interview but that, after that, he was *'alright'*. The Researcher validated Ashton's experiences, reiterated the voluntary nature of the study and confirmed whether Ashton wished to continue his participation. The Researcher then decided not to ask any more questions about Ashton's past and to instead focus on his present-day life while remaining attentive to any visible signs of distress that he displayed.

For the rest of the participants, the second interview was dedicated to eliciting the rest of their life stories, after which they were queried about their present-day lives, daily routines, occupations and sources of joy and sources of hardship. In addition, the participants were asked about their personal constructions of well-being, mental health recovery and the 'good life', as well as about their personal values, priorities and commitments (e.g. *'What does recovery mean to you, if anything?';*

‘What does it mean to have a good life?’; ‘What hinders or helps your recovery?’). Furthermore, they were asked about their imagined future, their hopes and goals.

The Researcher also encouraged the participants to define recovery in their own words (e.g. *‘I wonder if you have heard about the term ‘recovery’ as applied to your mental health. If yes, what does recovery mean to you?’*). In cases when the participants were unclear about the term or perceived the term as applying to their substance use, the Researcher offered an accessible working definition of recovery in order to gauge the participants’ views on recovery. The Researcher utilised the definition offered by the Mental Health Commission of Canada (2012, p. 15), because of its lack of academic jargon, simplicity and openness to interpretation: *‘Living a satisfying, hopeful, and contributing life, even when there are on-going limitations caused by mental health problems and illnesses’.*

Following the completion of this interview, the Researcher discussed the mobile phone diary component with the participants and asked them whether they wished to participate. Participants who agreed to take part in the mobile phone diary phase were trained in using the mobile phone diary. The participants could decide whether they wished to use their own mobile phone devices (after installing the mobile phone diary application) or borrow a mobile phone device provided by the Researcher.

Mobile Phone Diary Logging Period

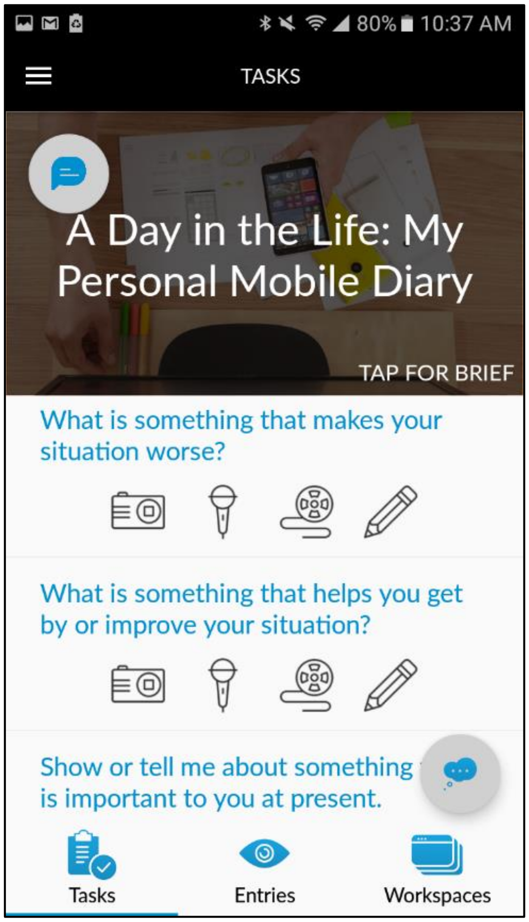
The *Ethnographic Observation System* (EthOS; Everydaylives Ltd; https://www.ethosapp.com/) online platform and its mobile phone application, *ethos,* were selected to host the mobile phone diary (See Figure 3). *ethos* was chosen following a careful search and evaluation of alternative hand-held and web-based mobile research applications based on its feasibility, including usability in both the U.K. and the U.S., cost-effectiveness, user-friendliness and capabilities of capturing data multimodally-via text, image, video and audio.

Participants that opted to complete the mobile phone diary phase were asked to engage with the diary for a period of seven days, during which they had to respond to seven daily questions (also called prompts) set in advance by the Researcher via the mobile phone diary interface. The questions concerned the participants’ daily routines and movements, their perceptions of their days, their perceptions of their lives ‘now’, their personal priorities, as well as aspects of their current lives that made it easier/harder for them to get by. For each mobile phone diary prompt, the participants could respond with a text note, an audio recording, a photograph or a video recording (See Table 3 and Figure 3). The use of mobile phone diary questions reflected the desire to ensure flexibility of expression and participant autonomy while also keeping participants engaged (Crozier & Cassell, 2016).

A few of the questions explicitly asked the participants to obtain a photograph as a response. The participants were advised, however, to only take photographs if it was convenient, safe and respectful to do so. Participants were explained they did not have to answer every single question each day but only when convenient or feasible. They were also explained that text and audio responses did not have to be long; instead, participants could make very short entries (or ‘snippets’), which could be later expanded upon during the final (elicitation) interview.

Table 3: *List of the Mobile Phone Diary Questions and the Modalities of Response Enabled*

Mobile Diary Question:	**Modality of Response Enabled:**
Tell me about your day. What did you do? Where did you go?	📷 🎤 🎞 ✏
Was today a good, bad, or an 'OK' day for you?	📷 🎤 🎞 ✏
Show me where you spend most of your time these days.	📷
Take a photo of something that best captures your life now.	📷
Show me or tell me about something that is important for you at present.	📷 🎤 🎞 ✏
What is something that helps you get by or improve your situation?	📷 🎤 🎞 ✏
What is something that makes your situation worse?	📷 🎤 🎞 ✏



A Day in the Life: My Personal Mobile Diary

What is something that makes your situation worse?

What is something that helps you get by or improve your situation?

Show or tell me about something is important to you at present.

Figure 3. Mobile diary interface (*ethos*)

During the diary logging period, the Researcher monitored the diary entries made in real time via the EthOS web platform (https://www.ethosapp.com/). The Researcher was available for interim support through the site staff. In cases when the participants did not make new entries for a period of two consecutive days, they were sent a reminder via email or communicated with in person during one of the Researcher's routine site visits in order to confirm they wished to continue their participation and to check whether they experienced any technical difficulties.

Accessing, Storing and Using the Diary-Generated Data

The secure storage of data on the *ethos* platform was ensured by the platform's up-to-date and audited security measures such as SSL encryption and database back-up solutions (Full technical details are available at https://ethosapp.com/site/security-policy). During the logging period, the Researcher regularly accessed the platform and downloaded any new diary entries and stored them onto the University's cloud-type storage system, Strathcloud. At the end of the logging period, the Researcher liaised with the *ethos*'s moderators to ensure all participant data were irrevocably deleted. Mobile phone diary images that contained identifiable people were immediately deleted after a note was taken of their contents.

In addition, at the end of the logging period for each participant, any mobile devices provided by the Researcher were wiped clean of any participant-generated data. Immediately following the end of the elicitation interviews, all printed photographs were destroyed using an office document shredder.

Elicitation Interview

After the seven-day logging period had ended, the participants were invited to a final, elicitation interview (Padgett et al., 2008). The purpose of the elicitation interview was to give participants the opportunity to discuss their mobile phone diary entries. In preparation of this interview, the Researcher had printed out any images generated via the diary (unless they contained images of identifiable people), as well as a written overview of any text diary entries. The diary entries served as probes to stimulate discussion, including the clarification of the meaning behind the entries made, and to invite participants' reflections (Padgett et al., 2013; Packard, 2008; Guillemin & Drew, 2010; Drew & Guillemin, 2014).

The interview began by asking participants about their overall experience with the mobile phone diary (*methodological reflections*; Riach, 2009; Crozier & Cassell, 2016). Mobile phone diary feedback was obtained using the following questions: ‘*Can you tell me about your experiences of completing the mobile phone diary?’ Which part did you enjoy the most and which-the least?*; *Did you encounter any difficulties?*; *Was the mobile phone diary helpful for communicating different aspects of your life*? (Riach, 2009; Crozier & Cassell, 2016). Following this, the participants were asked to discuss each of their diary entries. For image diary entries, the Researcher used the PHOTO questioning technique as a guide (Hussey, 2001, as cited by Horwitz, 2012; Andonian & MacRae, 2011; See Table 4). The Researcher also asked questions about ‘non-data’ to stimulate further discussion (e.g. *‘Why did you decide not to use the mobile phone diary on that day?’*; ‘*Is there an image that you wish you had taken but you did not?’*; Hodgetts et al., 2007). A full list of elicitation interview questions can be found in ‘Appendix 6’.

Table 4: *Mobile Elicitation Interview Protocol (Hussey, 2001; Andonian & MacRae, 2011)*

***PHOTO* Items:**
Describe Your Picture; *What is Happening in your picture?;* *Why did you take a picture Of this?;* *What does this picture Tell us about your life?;* *How can this picture provide Opportunities to improve your life?*
Additional Items:
Do you remember what you were thinking or doing when taking this image?
What does this photo mean to you?
How does this photo relate to your recovery (if applicable)?
Anything else you would like to add…?

Finally, the participants were asked to review and sign an additional consent form, the Release of Materials Consent Form (See ‘Appendix 11’). This consent form requested permission from the participants to use the participant-generated images and interview and diary quotes in academic publications, teaching activities and other research dissemination activities. Participants were explained they retained the copyright of the images and that any disseminated materials would be anonymised.

Mobile Phone Diary Participation Data

Nine (50%) participants opted to complete the mobile phone diary and elicitation interview. The total number of diary entries was 202 (130 images, 40 text entries, 28 audio recordings and 4 video recordings). Across participants, the number of diary entries varied dramatically-from three to 97 entries, with a mean of 23 entries and a median of seven entries (See Table 5).

Table 5: *Mobile Phone Diary Output Overview (N = 9)*

Participant:	**Entry Types:**	**Output:**
Scott	Text and images	1 image, 3 text entries
Matthew	Audio, text and images	21 images, 11 audio, 1 text entry
Benjamin	Audio, images and video	8 images, 17 audio, 3 video entries
Oliver	Text and images	1 image, 2 text entries
Kelly	Text, images and video	2 images, 4 text entries, 1 video entries
Edward	Images	7 images
Neil	Text and images	8 images, 10 text entries
Craig	Text and images	79 images, 18 text entries
Claire	Text and images	3 images, 2 text entries

Transcription of the Interviews and the Audio and Video Diary Entries

All interviews were audiotaped with the non-intrusive *Evistr™* digital voice recorder and later transcribed by the Researcher. Any audio recordings generated via the mobile phone diary were transcribed, as well, and integrated with the rest of the textual data and treated as primary data. All interviews were transcribed verbatim. The transcription was facilitated by the transcription web-based application, *Transcribe*™ (https://transcribe.wreally.com). The use of this software made the transcription process more time-efficient through the use of keyboard configurations for pausing the audio, among several other features. Several technical features of *Transcribe*™ ensured the security and privacy of the audio recordings and the transcripts. The audio recordings were played directly from the Researcher's university desktop computer and deleted after use. No audio data were uploaded onto the web platform. Any text typed into the web editor was only stored within the browser in use and deleted before exiting the browser. No text was stored onto the web platform.

Only certain types of non-verbal data were transcribed. The transcription symbols that were utilised were selected from the Jefferson Transcription System (Jefferson, 2004; See 'Appendix 7'). The current study acknowledges that transcription is an interpretive act (Bailey, 2008). Decisions regarding what non-verbal data (e.g. intonation, length of pauses, emotionality, etc.) to record were made based on the aims and methodological approach of the current study (Bailey, 2008).

To preserve the anonymity of the participants and of any individuals and institutions mentioned in the interviews, all names of people and places mentioned within the interviews were omitted during transcription. Each participant was assigned a participant number and a pseudonym. Those numbers were used to annotate the questionnaires, the interview recordings and the transcript files. A single copy of the 'Key' document linking the numbers and pseudonyms to the participants' identities was stored in Strathcloud and only accessed by the Researcher.

Data Analysis Strategy

The analysis of the qualitative interview and mobile phone diary data proceeded in two phases (See Table 6).

An ***inductive*** analysis was carried out using *interpretative phenomenological analysis (IPA)*. This analytic phase aimed to understand the participants' lived experience by generating a '*thick description*' of the phenomena under enquiry (i.e. personal recovery and the barriers and facilitators thereof; Smith et al., 2009). This analysis addresses RQ1 and RQ2 regarding participants' sense-making about, and conceptualisations of, recovery, and their perceived barriers and facilitators of recovery:

> (RQ1) How do participants make sense of, and conceptualise, their recovery?;
>
> (RQ2) What facilitates and what hinders their recovery?

An ***abductive-retroductive***, critical realist analysis of the data was also conducted, which aimed to identify the social structures, enabling conditions and mechanisms (including participants' individual (human) agency) that made possible, or *explained*, the phenomena under enquiry (i.e. the emergence or non-emergence of personal recovery in the context of chronic homelessness). This analysis addresses RQ3 and RQ4 regarding the socio-structural contexts implicated in recovery and participants' navigation and negotiation of those contexts:

> (RQ3) What socio-structural conditions and contexts are implicated participants' recovery, and how?;
>
> (RQ4) How do participants navigate and negotiate those socio-structural conditions and contexts to enable better well-being and recovery?

This sequence from inductive (bottom-up, experience-near) to abductive-retroductive (theory-driven) analysis was based on Danermark et al.'s (2005) stages in critical realist explanatory research (See Table 6). Danermark et al.'s explanatory model proceeds according to several analytic steps: (1) description; (2) analytic resolution; (3) theoretical redescription; (4) retroduction; (5) comparison between theories and (6) concretisation and contextualisation. Because the morphogenetic model was the pre-conceived theoretical framework of choice for this study, step (5) was not implemented. Step (6), concretisation, was infused throughout all steps as the analysis was continuously grounded in the data. Hence, step (6) was not a distinct analytic step in this study.

Table 6: *The Analytic Sequence Applied in the Current Study (Danermark et al., 2005; Smith et al., 2009)*

Analytic Method in Current Study	**Danermark et al.'s (2005) Model for Explanatory Social Science**	**Procedure**
Phase One: Inductive Analysis		
Interpretative phenomenological analysis (IPA)	*Description* *(Stage 1)*	'*Thick description'* of the phenomenon; line-by-line coding; *'double hermeneutic'*; identifying themes capturing the 'essence' of the phenomenon ('*reduction*')
Phase Two: Abductive-Retroductive Analysis		
Theoretical coding	*Analytic resolution* *(Stage 2)*	Resolving the phenomenon into its main constituents in order to facilitate theoretical explanation using the pre-defined categories of *'agency'*, '*social structures and cultures*', '*social relations'* and *'outcomes'*
Abductive-retroductive analysis	*Abduction/Theoretical redescription* *(Stage 3);* *Retroduction* *(Stage 4)*	Applying the morphogenetic model, in addition to other relevant concepts; identifying the structures, mechanisms and social relations that, *if they existed*, could explain the emergence of recovery

Analytic Phase One: Inductive Analysis

The '*description*' step of the analysis was carried out using IPA (Stage 1; Smith et al., 2009; See Table 6).

Overview of IPA

IPA is an inductive and interpretive approach to understanding individuals' lived experience of a phenomenon (Smith et al. 2009). IPA is underpinned by phenomenology and hermeneutics (Larkin et al., 2006). Central to phenomenological enquiries is the study of the lifeworld- *'[t]he total sphere of experiences of an individual which is circumscribed by the objects, persons, and events encountered in the pursuit of the pragmatic objectives of living.'* (Schutz, 1970, p. 320, as cited in Atkinson, 2010, p. 7). The goal of phenomenology is to discern the essence of the phenomenon as it manifests itself in the individuals' experiences and as situated within their cultural and socio-historical context (van Manen, 1997; Smith et al., 2009). Phenomenology is essentially humanistic in its philosophical orientation in that it conceptualises the act of understanding another individual's inner world as an act of caring (van Manen, 1997).

IPA is well-suited for generating rich, empathetic accounts of complex and/or sensitive phenomena (Smith et al., 2009). IPA was selected for its attentiveness to the complexities, nuances and ambiguities that often characterise individuals' experiences of multifaceted phenomena such as personal recovery. IPA centres upon the individual's lived experience as an '*interpretive feat'* (Eatough & Smith, 2008). On the one hand, the participant recounts their experience by 'binding' and 'integrating' the various elements of the experience such as memories, emotions, beliefs, intuition, perceptions and judgements (Eatough & Smith, 2008). On the other hand, the researcher attempts to make sense of the participant's own sense-making. This duality is called a *double hermeneutic* and is seen as the main means of knowing in IPA (Eatough & Smith, 2008). The IPA is never fully complete because multiple interpretations are possible as participants re-engage with the phenomenon and as the researcher attempts to interpret participants' meaning-making. The researcher's understanding of the phenomenon is constantly evolving. IPA requires constant reflexive 'dialoguing' between different interpretive layers (Smith et al., 2009).

As highlighted in ‘Chapter Four’, hermeneutically-based methodologies such as IPA are compatible with the epistemological relativism inherent to critical realism (Roberts, 2014; Price & Martin, 2018; Sayer, 2000). Under critical realism, because our knowledge of the world is necessarily *mediated*, understanding how individuals make sense of their lives is instrumental in discerning how social entities exercise their effects to help generate the outcomes of interest (Sayer, 2000). In a critical realist-informed empirical analysis, understanding individuals’ subjective meaning-making, intentionality and interpretations of events within the individuals’ social context is an essential first step in the development of a causal explanation (Wynn & Williams, 2012).

Coding and Theme Development

The current study followed Smith, Larkin and Flower’s (2009) six-step procedure for conducting an IPA:

(1) Reading and re-reading of each interview transcript;

(2) Exploratory commenting and identifying codes at linguistic, descriptive and conceptual (latent) levels;

(3) Developing emergent (provisional) themes;

(4) Refining themes, searching for connections across themes and developing super-ordinate themes;

(5) Repeating steps (1)-(4) for the other participants and transcripts;

(6) Identifying patterns across data sets and participants.

Throughout this process, the Researcher remained reflexive about how his own biases, preconceptions, stock of knowledge and increasing familiarity with the empirical material might be influencing the analysis (Smith et al., 2009).

After the Researcher had immersed himself into the transcript by reading, re-reading and establishing an empathetic relationship with the data in their entirety (**Step One**), the line-by-line coding (**Step Two**) was carried out using NVivo 11 (QRS International, 2015). The use of qualitative data analysis software facilitated the coding, storage and comparison of the large amounts of data and also increased the procedural rigour, efficiency and transparency of the analysis. Also, it allowed for all interview and mobile phone diary data (including images and transcripts of audio and text entries) to be imported into each participant's file.

The audio and text entries from the mobile phone diary were transcribed and coded directly and treated as primary data. Visual images, in contrast, were *not* coded. Instead, the Researcher relied on participants' interpretations of the images during the elicitation interviews (Clark & Morriss, 2017).

Overall, three types of codes were used: descriptive codes for manifest (surface-level) content; linguistic codes for particularities in participants' verbal and non-verbal communication (for instance, metaphoric language, use of colloquialisms and pauses); and conceptual codes for latent, more abstract meanings (Smith et al., 2009; See Table 7). Descriptive coding ensured closeness to the data although it was recognised that even descriptive analysis involves at least a minimal degree of interpretation. Conceptual coding helped unearth 'hidden' layers of meanings in the data. This type of coding exemplified the reflexive, interrogative stance of the Researcher, whereby the Researcher was constantly '*dialoguing*' with the data and his own interpretations of the data (Smith et al., 2009). On occasion, multiple codes were assigned to the same data unit to allow for a multiplicity of meanings (See Table 7). Recoding, when necessary, also occurred during the later stages of the analysis. This reflected the Researcher's openness to multiple interpretations and his evolving hermeneutic understanding of the phenomenon.

Table 7: *Examples of the Types of Coding Used in the IPA*

Interview Excerpt (Data Unit)	**Code(s) Assigned**	**Type of Coding**
'And if you're strong enough, you can deal with it. For what I went through, when I was a child, I'm strong.'	Being strong	Descriptive code
'Cause I think we all suffer from mental health problems. […] We just don't know it.'	Use of the collective pronoun 'we'-possible normalisation of illness	Linguistic code
'[…] *I was a very needy person and I always wanted to have...some kind of...something that I never had and that's erm someone to care for me...and to love me...and I wanted to feel wanted* […]'	Emotional connectedness; Vulnerability; 'Unhomelikeness'	Conceptual code

Step Two resulted in the generation of a long list of codes for each participant that comprehensively captured the entirety of their accounts.

In **Step Three**, the codes were tentatively grouped together into provisional themes based on their conceptual proximity. This helped manage the large number of codes by organising them into provisional clusters (into 'parent nodes' and 'child nodes' in NVivo 11).

Step Four involved developing emergent themes (subthemes and super-ordinate themes) for each participant. Theme development aimed to preserve the particularity and context-boundedness of the original data while also achieving a level of saturation and abstraction to allow the Researcher to capture the '*psychological essence'* of the phenomenon (Smith et al., 2009, p. 92). 'Closeness' to the participants' lived experience was maintained by using participants' own language whenever appropriate and by auditing each newly derived theme based on its groundedness in the verbatim data.

A theme represents an abstract category of conceptually similar data units (codes) that captures significant and idiosyncratic aspects of the participants' accounts (Smith et al., 2009; See Figure 4). For each participant, the codes were developed into minor themes (or subthemes), which were then developed into a smaller number of super-ordinate themes (See Figure 4, for an example). This necessarily involved a process of *data reduction*, whereby the complex phenomenon was saturated to its main, essential constituents (Danermark et al., 2005; Smith et al., 2009).

Super-ordinate themes were selected based on the prevalence of their supporting codes and subthemes; based on the '*the manner in which the theme assists in the explanation of other aspects of the account […]'* (Brocki & Wearden, 2006, p. 97, citing Smith et al., 1999); and based on their relevance to the research questions at hand. Some super-ordinate themes were generated using *subsumption*, whereby a subtheme or a code itself becomes a super-ordinate theme as it draws other related themes and codes towards itself (Smith et al., 2009). An example of subsumption is the super-ordinate theme, *'feeling 'wanted, accepted and needed'*, which originated from a participant's verbatim account. In other cases, *abstraction* was used, whereby similar codes and subthemes were clustered together and a new name was given to the emerging super-ordinate theme (Smith et al., 2009). An example is the super-ordinate theme, *'the need for safety, security and constancy'*. Finally, *polarisation* was also used, whereby the clustering of opposing codes generated a new theme (Smith et al., 2009).

An example is the super-ordinate theme, *'dilemmas of meaning'*, which incorporates the themes relating to loss of meaning in life and to sources of meaning.

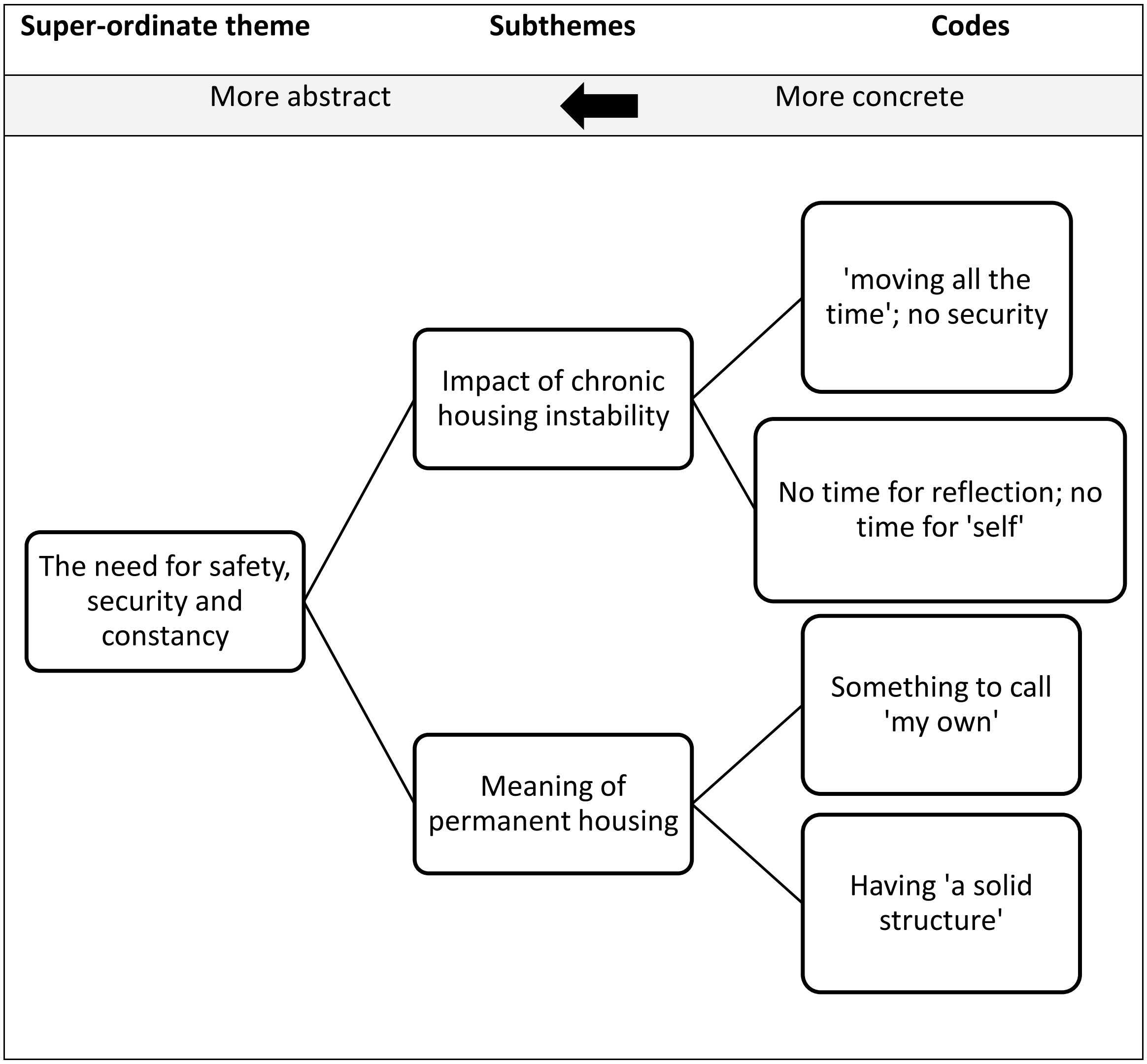


Figure 4. An example of developing a super-ordinate theme from subthemes and codes

Step One to Step Four were repeated for all participants. The Researcher maintained attentiveness to each participant's idiosyncrasies by 'bracketing' any insights gained from the previous participants (Smith et al., 2009). This was achieved by psychological ‘distancing’ from the previously coded transcript before immersion into the next transcript, as well as by not relying on pre-existing codes to code the new transcripts. Eventually, an exhaustive list of themes was derived for each participant.

A final step (**Step Six**) involved identifying patterns across all data sets and participants and developing super-ordinate and higher-order themes. The Researcher identified relationships between emerging themes across participants by looking out for ‘*convergence and divergence, commonality and individuality’* (Smith et al., 2009, p. 107). This process involved moving the analysis to a ‘deeper’, more abstract level in order to help generate a holistic interpretation of the phenomenon while retaining the particularities and complexities of individual themes and accounts. The final set of super-ordinate themes (seven) aimed to capture the ‘wholeness’ of the experience of recovery and the barriers and facilitators thereof, while preserving a sensitivity to the uniqueness of each participant’s lived experience and context. As a final main step in the theme development and refinement, two *over-arching themes* were generated from the super-ordinate themes. This final theme *saturation* was carried out to create a *‘story line’ that gives a holistic view on the study phenomenon’* (Vaismoradi et al., 2016, p. 107).

To ensure the final thematic structure authentically reflected the original data, each transcript was revisited with the super-ordinate themes in mind to ascertain whether they faithfully and insightfully conveyed the participants’ lived experience. The Researcher also reviewed his memo notes and theoretical notes, which helped ensure his prior theoretical knowledge and other preconceptions had not significantly influenced the IPA (Somekh & Lewin, 2005; Smith et al., 2009).

Analytic Phase Two: Abductive-Retroductive Analysis

The second analytic phase was the theory-driven, critical realist analysis. It maps onto the analytic resolution, theoretical redescription (abduction) and retroduction stages in Danermark et al.'s (2005) analytic model (See Table 6).

This phase began with theoretical coding as a form of analytic resolution (See Table 8), which was aimed at resolving the phenomenon of recovery into its main constituents in order to facilitate theoretical explanation (Danermark et al., 2005). Theoretical codes specify '[…] *the possible relationships between categories and move[s] the analytic story in a theoretical direction.'* (Saldaña, 2009, p. 252). Guided by critical realism and in response to the research questions, the pre-defined categories of '*agency*', '*social structures and cultures'*, '*social relations'* and *'outcomes'* were deployed to re-code the qualitative data (Fletcher, 2017). As discussed in *'Chapter Four'*, identifying elements of personal agency, social structures and social relations is essential to developing critical realist-informed explanations (Sayer, 1992; Archer, 1995). This was necessarily a selective process, however, as it is never possible to identify all components, aspects and dimensions of phenomena (Danermark et al., 2005).

Within each IPA super-ordinate theme, agential, interactional, structural and outcome components were identified. Questions that guided the theoretical coding included '*What did the participants do/think?'* (agential components); '*What interactional and structural circumstances appeared to be relevant to the participants' acting/feeling/thinking in that way?*'; (structural, contextual and relational components); and '*What were the reported/apparent/intended/unintended consequences of the individuals' actions and/or the interactional and structural contexts?'* (outcome components; Wynn & Williams, 2012). For instance, the following components were identified for the theme, '*the need for safety, security and constancy'* (See Table 8):

Table 8*: An Example of Theoretical Coding*

	IPA Theme: The need for safety, security and constancy
Structural, contextual and relational components	Lack of a safe and stable family environment; Chronic homelessness and housing instability; Street life and the shelter system; Relational trauma
Agential components	Resolution to ‘break away’ from a ‘negative’ lifestyle; Help-seeking; ‘Focusing’ on what is ahead; Using substances as a ‘crotch’
Outcomes	‘Had to’ grow up ‘fast’; ‘no time’ for self; ‘no childhood’; Alienation from family and mainstream society; Lack of control over life

The possible structures, cultures, relations and agential activities derived from the analytic resolution of the entire data set were then grouped together to come up with a final list of plausible causal entities that were deemed most relevant to participants’ self-reported recovery experiences in the IPA phase.

Following this, the ***abductive-retroductive analysis*** took place (See Table 6). In this phase, the processes of abduction and retroduction were carried out simultaneously (Danermark et al., 2005). Bergene (2007, p. 19) defines abduction as ‘[…] *reinterpretation and recontextualisation, as researchers take their starting-point in a theoretical framework and thereby interpret and assign new meaning to the phenomenon under study or develop theory by applying it in new contexts.’.* Timmermans and Tavory (2012) call the analytic operation of abduction a *‘creative* *inferential process'* (p. 167), in which the choice of theory depends on the researcher's interpretative repertoire (Alvesson & Sköldberg, 2017).

At this stage, the Researcher engaged with the wider literature on homelessness, health inequalities, emotions, capabilities, stigma and other relevant research areas. This involved '*confronting*' data with existent theory and identifying '[…] *areas of the literature and theoretical knowledge that are significant to emerging data, concepts and categories*' (Hoddy, 2019, p. 115). The aim of this pluralistic abductive approach was to maximise the explanatory utility of the analysis.

Retroduction is the thought operation of postulating the existence of *transfactual* (unobservable; located in the realm of the 'real'; Bhaskar, 1989; See '*Chapter Four*') causal entities, conditions and mechanisms, which, *if they existed*, could explain the phenomenon of interest (Danermark et al., 2005). It involves *'working back'* from the observable manifestations of the phenomenon (in this case, the IPA findings) to a theoretical model of the causal entities that, if triggered, possibly generated the observable empirical 'events' (Sayer, 1992). In this study, the empirical events of interest were participants' capacities to envision and enact recovery. Retroduction attempts to answer the questions: '*How did the phenomenon come about?*'; *'What must the world be like for the phenomenon to exist?'; 'What causal mechanisms are related to the phenomenon?';* Danermark et al., 2005; Bhaskar, 1989). In the current study, the analysis was concerned with discerning the social structures and contexts implicated in participants' recovery, as well as with how participants navigated those conditions to enable recovery (RQ3 and RQ4).

The abductive-retroductive analysis was carried out using Archer's morphogenetic model (See '*Conceptual Framework of the Current Study'* in '*Chapter Four'*), together with a range of ancillary theoretical concepts such as Emirbayer and Mische's (1998) agency types and Archer's (2003) reflexivity modes. Archer's morphogenetic model and her theorising about personal reflexivity and the internal conversation were used as a theoretical framework to help discern (or *retroduce*) the interplay between social structures, social relations and individual agency. The set of causal entities derived from the analytic resolution step was transmuted into the morphogenetic model. The analysis was deemed finished when an adequate degree of causal depth was achieved that allowed for the meaningful integration of the various components of the morphogenetic model and other existent theory with relevant recovery outcomes observed in the data (Hoddy, 2019). This resulted in a 'layered' explanatory model of personal recovery in the context of homelessness (See Figure 22 in '*Chapter Seven*').

Rigour and Trustworthiness

Several approaches were utilised to increase the rigour and trustworthiness of the current study (Tong et al., 2007; Tracy, 2010; Shenton, 2004; Willig, 2017). Credibility is achieved by ensuring the findings from the study accurately represent the phenomenon of interest (Shenton, 2004). The credibility of the current study was enhanced by using data elicitation methods (such as the life story interview) that allow for generating rich, contextualised and authentic accounts of recovery in the context of structural disadvantage. As discussed above, the interview strategy aimed to elicit the participants' active, authentic narratives and conceptualisations of mental health recovery in the context of their life stories. The Researcher encouraged the participants to self-define and to construct their own ideas about recovery.

Furthermore, the creative but pragmatic mix of data gathering techniques used in the current study, including life story interviews, semi-structured interviews, mobile phone diary and elicitation interviews, enabled the gathering of rich data that could capture the nuance and complexity of the phenomena under investigation (Tracy, 2010). This pluralistic approach to data collection not only allowed for data triangulation (Tong et al., 2007) but also arguably enhanced the richness and depth, evidentiary adequacy and explanatory potential of the analysis (Tracy, 2010). The use of multiple types of analysis on the same data set (i.e. inductive and abductive-retroductive analyses) is a form of analytic pluralism, which increased the capability of the current research design to examine the complex and multidimensional nature of recovery.

In addition, the use of repeat interviewing and iterative questioning allowed for greater rapport with the participants, the more tactful and gradual questioning into sensitive topics, and the clarification of any ambiguities or contradictions in the participants' accounts. This further strengthened the trustworthiness and authenticity of the findings (Shenton, 2004; Willig, 2017).

The systematic procedural detail offered in this chapter allows for the rigour of the current study to be independently assessed. The details offered regarding the research design and data analysis also increase the dependability of this study (Shenton, 2004). The account of thematic development provided and the interweaving of verbatim quotes and interpretations further enhance the rigour and transparency of the data analysis.

From a critical realist perspective, investigating recovery in different geographical and socio-political settings (Scotland and the U.S.) allowed for capturing and corroborating the plausible existence of a range of social structures, cultures and other contexts, all of which had had significant effects on participants' capacities to recover. In other words, this multi-site, transatlantic data collection strategy increased the causal depth of the current analysis (Wynn & Williams, 2012). From a methodological perspective, the multi-site data collection allowed for data source triangulation (Patton, 1990) as a form of empirical corroboration (Wynn & Williams, 2012)-therefore increasing the credibility and transferability of the findings.

Methodological Strengths and Originality

The present study's target sample-individuals with a history of SMI and chronic homelessness-offers the opportunity to examine the dynamics and contextual embeddedness of personal recovery in individuals facing severe and multiple disadvantage. As argued in '*Chapter Three*', the focus on the experiences of this underresearched and socially marginalised group carries significant potential for a critical theoretical engagement with the personal recovery concept, as well as for informing the recovery-oriented and person-centred care for clients who are homeless and have complex needs. The multi-site, transatlantic data collection strategy allows for capturing data from participants with diverse ethnic, socio-economic, demographic and geographical backgrounds-thus increasing the diversity and representativeness of the sample. It also augments the capability of the present study to recontextualise recovery in relation to a wide range of socio-structural arrangements such as different welfare systems, housing sectors and mental health systems.

The life story approach to the qualitative interviews allowed for a high degree of participant autonomy in the process of data elicitation, while also revealing their sense-making, significant life events and the synergy of socio-structural contexts that shaped their experiences of mental health, homelessness and recovery (Mooney, 2016; Paat et al., 2019). In addition, the innovative use of a mobile phone diary and photo-elicitation expanded the possibilities for collecting contextualised, multi-modal data. The mobile phone diary facilitated the elicitation of situated accounts of participants' present-day realities, as well as enhancing participants' reflections upon their own lives (Bartlett & Milligan, 2015). To the author's knowledge, this was the only qualitative study to date to have used a mobile phone diary approach in the study of persons who were homeless and had SMI.

Despite the theoretical and methodological utility of critical realism in understanding mental health-related phenomena outlined in '*Chapter Four*', critical realism has remained severely underused in both mental health and social work research (Pilgrim, 2014; Bergin et al., 2008; Houston, 2001; Craig & Bigby, 2015; Anastas, 2014). The few published critical realist-informed empirical investigations into the experience of mental illness, including mental health recovery, have largely failed to apply critical realist concepts and models to generate a sophisticated understanding of the causal effects of personal agency, social structure and their interplay (for example, Kartalova-O'Doherty & Doherty (2011) and Sword et al. (2012). Such superficial applications of critical realism represent missed opportunities for advancing the understanding of the causal complexity underpinning personal recovery. To the author's knowledge, the current study was the only empirical investigation that had applied critical realism to the study of mental health recovery in the context of homelessness. The adaptation of Archer's (1995) morphogenetic model allows for the examination of how observed recovery-relevant outcomes could be accounted for by the dynamic interplay between socio-structural enablements and constraints and individuals' own agential powers. The morphogenetic model allowed for the 'translation' of the critical realist philosophy and its principles into a concrete analytic strategy.

The innovative combination of IPA and critical realism creates a pluralistic methodological design that is well-suited for generating a non-reductionist, multi-layered understanding of personal recovery in the context of multiple disadvantage (Pilgrim & McCranie, 2013; Angus & Clark, 2012). This methodological pluralism offers fertile opportunities to combine a '*meaning-focused*' (i.e. hermeneutic) approach with the analysis of '*distal and supra-personal*' influences shaping recovery (Pilgrim, 2014, p. 9; Hood, 2016).

Altogether, the research design of choice is well-suited for unpacking both the phenomenological complexity *and* the multiplicity of causal influences upon the recovery process. By integrating participatory research design elements and an explanatory philosophical framework (critical realism), the present study preserved its emancipatory commitment while also maximising its theoretical sophistication and generativity.

Conclusion

This chapter detailed the study context, research design, participant characteristics and the associated ethical considerations. In this multi-site participatory qualitative study, 18 adults with lived experience of chronic homelessness and SMI were recruited from Glasgow and New York City and asked to take part in a series of in-depth interviews, as well as in a mobile phone diary and an elicitation interview. In recognition of participants' vulnerability and the sensitive topics of the research, a range of arrangements were put in place to ensure the ethical rigour of this investigation. An innovative, two-pronged approach to the data analysis was used, which aimed to generate a nuanced, multi-level explanatory analysis. A series of methodological strategies were used to increase the trustworthiness and rigour of the findings. This study employed an innovative multi-method data collection strategy to elicit the responses from an underresearched participant group pertaining to an understudied phenomenon-personal recovery in the context of chronic homelessness.

The next two chapters report the findings of this study.

Chapter Six

Findings from the Interpretative Phenomenological Analysis (IPA)

Logic of the Chapter

This chapter is dedicated to the findings from the inductive, IPA phase. Two over-arching themes were generated: (a) *contemplating and envisioning recovery*, and (b) *enacting and sustaining recovery*. Collectively, those two themes reflect the participants' lived experience of recovery as revealed in their biographical accounts. Verbatim quotes, as well as participant-generated images, are used throughout the analysis in support of the seven super-ordinate themes. Case summaries are also included to preserve the entirety of the participants' life stories. This chapter then proceeds to discuss the thematic similarities and discrepancies between the American and the Scottish data sets. Finally, the participants' reflections on the study are presented.

Interpretative Phenomenological Analysis (IPA) Themes

The aim of the IPA was to uncover how the participants conceptualised, made sense of, and experienced personal recovery, as well as to illuminate what enabled and impeded their recovery journeys. The analysis resulted in seven super-ordinate themes, which were organised around two over-arching themes: (a) ***contemplating and envisioning recovery***, and (b) ***enacting and sustaining recovery*** (See Table 9). Those two higher-order themes capture the dynamic nature of recovery in the context of homelessness and co-occurring disadvantage *as felt and lived by the participants*. They also reflect the multidimensional and processual nature of recovery.

The first higher-order theme is concerned with whether and how the participants related to, identified with, and conceived the recovery idea, as well as what they believed the pre-conditions for their abilities to contemplate and envision recovery were. The analysis of their reflections upon what recovery means to them, was recovery a possibility in their life and what enabled them to authentically reflect upon those matters is presented under this theme.

The second higher-order theme pertains to what enabled and constrained individuals in their *enactment* and *maintenance* of their recovery-oriented ideas, goals and practices. Here, the analysis of their reflections upon *how to make recovery happen in their lives*; *who they needed to be or become to realise their recovery*; and *what facilitated and impeded those processes* is detailed.

The IPA phase aimed to address the following research questions:

- How do individuals who have been chronically homeless and have a history of SMI make sense of, and conceptualise, their personal (mental health) recovery? (RQ1);
- What facilitates and what hinders those individuals' personal (mental health) recovery? (RQ2).

Table 9 illustrates the thematic structure generated by the IPA. Each of the seven super-ordinate themes contains several subthemes. The boundaries between those themes are tentative, however, as the recovery aspects they signify appear to be tightly interwoven.

Table 9: *Thematic Structure Generated by the IPA*

Super-ordinate Themes:	**Subthemes:**
1. Contemplating and envisioning recovery (over-arching theme)	
1.1. Participants' conceptualisations of mental health recovery	a. Recovery as something vague, ambiguous and elusive; b. Recovery as achieving stability, control and self-direction; c. Dual recovery
1.2. The need for safety, security and constancy	a. Impact of chronic housing instability: Lack of security, constancy and '*homelikeness*'; b. Functions and meanings of transitional and permanent housing
1.3. Achieving insight	a. A '*wake-up call*'; b. Enablers of insight
2. Enacting and sustaining recovery (over-arching theme)	
2.1. '*It's a daily process*': Positive coping and self-management	a. Strategies of, and barriers to, effective coping with SMI; b. Mental illness as borne out of the volatile living environment; c. The intrinsic value of '*doing things*' and the perils of boredom; d. Formal support services as key enablers of positive coping and self-management
2.2. Nurturing a strong and positive sense of self	a. Rediscovering one's '*strong*' self; b. Impaired sense of self-worth; c. Sources of positive self-identity
2.3. Dilemmas of meaning	a. '*Trials and tribulations';* b. Loss of meaning and hopelessness; c. Faith in God and spirituality; d. Routes to wisdom and personal growth

2.4. Feeling *'wanted, accepted and needed'*	a. Family experiences, vulnerability and deprived socio-emotional needs; b. The value of social and emotional connectedness

1. Contemplating and Envisioning Mental Health Recovery

The first cluster of super-ordinate themes, (1.1.) *participants' conceptualisations of mental health recovery*, (1.2.) *the need for safety, security and constancy*, and (1.3.) *achieving insight*, captures the participants' lived experience of engaging with, and contemplating, the recovery idea (See Table 9). It also reflects the multitude of facilitators and hinderers that they believed impacted on their abilities to envision and initiate their authentic recovery journeys. Collectively, those themes reveal the vicissitudes and potentialities associated with (a) recognising recovery as a viable alternative life project; (b) establishing the physical, psychological and ontological preconditions to engage in authentic reflections about recovery; and (c) gaining self-knowledge and self-acceptance. The findings also unravel some participants' ambiguous relationships with the recovery idea. For many, discovering that change, including recovery, was desirable and possible was an effortful and uncertain process. It was contingent upon their reconciliation with their past, navigation of the contingencies of the present, and abilities to transcend their current hardship and envision a desired future. Temporary accommodation (e.g. the shelter) both enabled and constrained their capacities to contemplate and envision recovery.

1.1. Participants’ Conceptualisations of Mental Health Recovery

Table 10*: Overview of the Subthemes for the Super-ordinate Theme, Participants’ Conceptualisations of Mental Health Recovery*

a.	Recovery as something vague, ambiguous and elusive;
b.	Recovery as achieving stability, control and self-direction;
c.	Dual recovery

Recovery as Something Vague, Ambiguous and Elusive

The narratives of nine participants revealed how their overwhelming daily struggles for survival and self-preservation, together with the cumulative psychological impact of past adverse and traumatic events, seemed to impede their abilities to engage with the idea of recovery. They tended to address recovery (usually when questioned directly) in negative, implicit and ambiguous terms. Some of them explicitly questioned the possibility of recovery in their lives. This use of *apophatic* (implicit, negatory; Slee, 2001) language revealed their uneasy relationship with recovery.

For many of those participants, the term ‘mental health recovery’ was unfamiliar and ambiguous (See Table 10). Only a small minority of them had encountered the concept of recovery as applied to their mental health. And even those participants who were somewhat familiar with the notion tended to struggle to conceive and articulate what recovery meant in their own unique circumstances and life history. For example, while Susan (an Asian woman living in NYC who had been homeless for six years and was currently attending the drop-in centre) showed an implicit understanding that recovery was of ‘*essential*’ importance to her, she could not define it in concrete terms. She rationalised this by explaining that this had been the first time she had been receiving the appropriate professional support that would hopefully enable her to embark on her recovery journey. This journey, for her, started with ‘*speaking up about it’* and formulating her ‘*own idea’* about her recovery:

> *‘But again this is the first time so I don't know what it's gonna entail. So I don't even have my own idea of what the recovery stage is gonna be like.’* (Susan).

Those statements seem to convey this participant’s (implicit) belief that her ability to conceive her recovery was the crucial initial step towards attaining recovery. Her use of possessive pronouns (‘*my own idea’*) seems to underscore her perceived importance of achieving an understanding of recovery that was authentic and resonated with her life history, beliefs, personal strengths and values. It seemed that for several participants, including Susan, *owning* their recovery was a vital catalyst for creating more concrete recovery-oriented goals and consciously engaging in recovery-relevant actions.

When queried about the extent to which they considered themselves to be ‘*in recovery’* with regards to their mental health, several participants resorted to metaphors and other indirect linguistic expressions to convey their states of uncertainty and ambivalence towards their recovery. Kelly (NYC safe haven resident), for instance, described herself as being *‘in and out of’* recovery; Edward (NYC drop-in centre client)-as *‘just hanging in there’*; and Susan-as being at the *'one day at a time'* stage. This frequent use of metaphoric language appears to betray those participants’ difficulties (and possibly their reluctance) with directly engaging with the recovery idea. Indeed, the majority of participants tended to avoid addressing recovery explicitly when queried about it during the interviews. Instead, they frequently shifted the discussion topic towards their present-day struggles (economic, psychological, socio-emotional, existential), which, for many of them, were so overwhelming that they ultimately impeded their capacities to contemplate and envision recovery.

Furthermore, two participants (Scott and Neil) seemed to associate recovery with complete symptom remission or illness disappearance, which seemed to trigger apprehension because they perceived such outcomes to be unrealistic:

> '*You say 'in recovery'-I'm never gonna get better from it. I know I'll always have it forever. I know I'll have it. I'm stuck with it.'* (Neil).

The repetition, *'I know I'll have it forever.',* and the metaphoric expression, *'I'm stuck with it.',* signify Neil's uneasiness and sense of inevitability regarding his chronic mental illness. When the Researcher offered Neil a definition of personal recovery as '*the idea of being in control of one's life and being able to have a fulfilling life despite the illness'*, however, this participant seemed to identify with the notion to a much higher degree *('That helps.'*). Yet, he admitted he had not encountered 'recovery' as defined in such terms.

Furthermore, George, a Hispanic safe haven client in his late 60s, who had been homeless for more than 20 years in his lifetime (See Figure 5), shared:

> *'…recovery is fearful to me. Because it's the other side of life that I never experienced.'*

George is a Hispanic participant, who had been a safe haven client for several years. He was born abroad but had spent most of his life in New York City. He had first lost his home due to financial hardship and unemployment. Since then, he had had multiple episodes of housing instability, including long periods of homelessness. Due to ‘peer pressure’ and a lack of fatherly ‘guidance’, he had begun engaging in socially deviant street culture activities, which had lasted for many years. During those years, he led a nomadic life and began suffering from substance use problems. He had also been struggling to escape his social circle of ‘drug addicts and alcoholics’.

At present, he was separated from his family and struggled with physical health problems and substance use problems. He was actively working on his substance use recovery and was readying himself for the imminent transition to permanent housing. He planned to be in recovery, finally ‘settle down’, enter the workforce, work for a year and pay taxes.

Figure 5. Case summary: George (65-70 years of age; safe haven client in NYC)

George emphasised the importance of engaging in introspective activities in order to design and define his recovery. George characterised this process of intensive self-searching, self-analysis and ‘finding’ himself as ambiguous and frightening and yet as integral to his recovery:

> *‘See, right now, I'm analysing myself because I'm trying to figure out the same thing you're trying to figure out-what is it that I'm searching for. I mean...Am I searching for gold, am I searching for family, am I searching for happiness? […] I'm trying to figure out the same thing you're trying to figure out-what is it that I'm searching for […] ‘I plan on staying (there) for as long as it takes me to finally erm...find myself. What I mean by 'find*

> *myself' is figure out exactly what it is that I wanna do and what it is that I am* <u>*capable*</u> *of doing…[…]'.*

This statement by George seems to poignantly capture the essence of recovery to this participant- its potentialities but also its complexity and ambiguity. *'Finding'* himself was highlighted as vital for enabling him to '*commit*' to fulfilling his recovery within his physical and other practical limitations. George emphasised this process of self-analysis and self-searching as an essentially human struggle.

Another participant, Matthew, shared his overwhelming distress and hopelessness, which had rendered the recovery idea distant and unintelligible. Matthew was a safe haven client in his late 50s in NYC. He had been homeless for a total of seven years, which included periods of street homelessness and squatting. His account of his present-day life and well-being was dominated by feelings of loss, isolation, disappointment, and existential suffering. When asked whether he had ever thought about his mental health recovery, after pausing for several seconds, he replied:

> *'Honestly, no because nobody has shown it* [hope] *to me. No one has taken the time to erm...give me an inkling of hope. No [stutters] one here. No one (here would?) give me erm...a light at the end of the tunnel-no one here. […] I don't hold (up) any hope for my recovery'.*

The repetitive '*no one'* and the paralinguistic cues (e.g. the stuttering) reveal a limbo-like experiential state, in which Matthew could identify no viable routes to recovery. For Matthew, the '*inkling of hope'* seemed to be the elusive catalyst for recovery. His account seems to indicate that the experience of hope (and hopelessness, respectively) was a relational phenomenon (e.g. *'I don't have anybody…'; 'No one has taken the time to give me…'*). This participant situated his diminishing hope and disbelief in the possibility of recovery within his cumulative experience of disappointments in others, including service-providers, and his inability to fully communicate the complexity of his struggles to others. For Matthew, not being believed, listened to and validated impeded his capacities to contemplate and envision recovery.

Nevertheless, several participants seemed to possess an implicit, embodied understanding of what recovery should *feel like*. Ashton imagined his recovery as *'a sense of well-being'*, *'a sense of completion'* and *'not being consumed by your mental health'* , Simon-as *'moving in the right direction for better mental health',* and Scott-as *'self-comfort'* and as *'being comfortable in my own skin*.' Scott (a safe haven client in NYC in his late 50s, who had been homeless for five years in his lifetime) also addressed recovery as a holistic, *'unpieceable'* phenomenon: '*It's not just one aspect. It's a few aspects. It's a few different things that make it whole.'.*

Those accounts seem to reveal that those participants perceived recovery as a global, multidimensional experience, which encompassed some state of well-being, expansion of the self, self-acceptance and being 'in tune' with oneself and with others, among other facets. And as a complex global experience, recovery often eluded words.

Recovery as Achieving Stability, Control and Self-Direction

A minority of participants (seven) articulated their conception of recovery in concrete terms. Those participants situated recovery within their unique circumstances, hopes, goals and daily lives. Most of them also shared concrete practices they employed on a daily basis in attempts to facilitate the attainment of their recovery goals, however small those might be. Notably, all those participants did experience frequent disruptions in their sense of stability, control and well-being due to, for example, having active symptoms and/or reacting negatively to the chaotic and precarious environment of the shelter.

Those participants envisioned their recovery as *achieving stability and control,* and as *being active and self-directed*. The experience of *stability* seems to have a dual connotation. On the one hand, stability was experienced as symptomatic remission, which was most commonly achieved through following a psychiatric medication regimen, and/or through spending time in inpatient care to treat the acute phases of mental illness. Stability, however, was also referred to as exiting homelessness and securing permanent housing.

For Mary (a Scottish woman in her late 30s who had been homeless for a total of 17 years in her lifetime), for example, recovery meant both better crisis management (in terms of her mental health) *and* exiting homelessness. For Neil (an assessment centre client in Scotland in his late 50s who had been homeless for six years in lifetime), recovery meant '*being in charge of'* his life, including being stably housed and financially independent. Neil expressed his desire to enter the workforce again as that would give him a sense of normality, purpose and control. For Neil, crucial to achieving recovery was restoring his financial autonomy-an antipode to what he described as being '*powerless*' and dependent on the State.

Notably, participants placed emphasis on recovery as both a set of desirable outcomes, *and* as a process that had to be instantiated daily. Indeed, several participants described recovery as synonymous with daily labour. To Ashton, Claire and Conor, recovery manifested itself in small, daily accomplishments. Formulating and pursuing daily goals was the cornerstone of recovery for Claire. Claire is a Scottish woman who was a client at the emergency shelter for women in Glasgow and who had been homeless for a total of five years in her lifetime. Her narrative was markedly future-oriented and conveyed her commitment to securing the things that she valued the most-her children, her housing, a stable job and coming off medication, which would ultimately enable her to lead a '*normal*' life. For Claire, recovery was the process of transmuting her idea of the 'good life' into manageable steps that she could pursue and ‘*fight for*’ every day. Similarly, for Scott, recovery was *‘a chance (...) for a quote-unquote somewhat normal life.’* To help him secure a life in recovery, Scott highlighted the role of consistent, positive daily behaviours such as engaging with his treatment and making rational, reflective choices.

Those accounts reveal that several participants were indeed capable of articulating their ideas about recovery in concrete, positive and future-oriented terms. To them, recovery was characterised by the alleviation from the often-crippling symptoms of mental illness *and* by the thrill and anticipation at their starting to regain control over their lives. Recovery was conceptualised as the synergy of both tangible (housing, financial resources, employment) and intangible (well-being, self-direction, comfort) assets.

Dual Recovery

On many occasions during the interviews, establishing a shared understanding with the participants about the meaning of mental health recovery was challenging. This was possibly due to several participants’ discussions of *substance use recovery*-a term they sometimes seemed to use interchangeably with *mental health recovery*. Those participants often perceived their mental health recovery and their substance use recovery as being tightly interconnected. Indeed, 12 or 67% of the participants disclosed a history of alcohol or other form of PSU (See Table 1 in ‘Chapter Five’). Many of them believed that the aetiologies of their mental illness and PSU were interlinked. In some biographical narratives, engaging in PSU had begun as a means of alleviating pre-existing mental illness symptoms. Conversely, other participants believed their mental illness had been caused or severely exacerbated by the long-term PSU.

Unsurprisingly, therefore, several participants believed their mental health recovery and their substance use recovery were interdependent. Conor’s narrative illustrates the complex interaction between mental illness symptoms and PSU during significant points throughout his life:

> *'In my case, I think it's all together-through my past, through my present, do you know what I mean like...I think it's all interlinked with each other.'*

Conor was an assessment centre client in Scotland in his late 20s who had been homeless for three years in his lifetime. For participants such as Conor, *dual recovery* seems to be the experiential category that more adequately captured their recovery experiences. Dual recovery, in this context, seemed to refer to participants' recovery trajectories as they coped with both mental illness and PSU.

George's narrative also seemed to exemplify the experience of mental health and substance use recovery as a holistic process. For George, recovery meant much more than merely the cessation of substance use or merely the management of mental illness symptoms. Instead, it meant *'envisioning*' a desired self and designing a life that could be productive and meaningful:

> *'…that's what recovery is about-what do you do with yourself after recovery... You follow what I mean? You can stop drinking, or you can stop getting high or both, you know...() You can stop. But what happens when you stop? What are you gonna do with yourself? (…) That's what hope is all about. Envisioning yourself. When you envision yourself-that's what hope is all about. You know what I mean? And that's the image you want to bring out, and that's what recovery does.'.*

The verb *'envision'* captures this participant's efforts to transcend his current, unsatisfactory circumstances by projecting a desired future in which he was a productive citizen who paid bills. This contrasted with much of his past life, which had included involvement in the drug scene, a nomadic lifestyle and *'falling victim'* to addiction. The repetition, *'That's what hope is all about.'*, acts to reinstate the processual and future-oriented (transcendental) nature of recovery. To this participant, recovery and hope entailed expanding one's inner boundaries towards a more contemplative and self-directed self.

Altogether, the idea of dual recovery seemed to resonate with several participants as it captured the multiple interlacing dimensions of substance use and mental health difficulties-their perceived aetiology, impact on the self, effective treatment and the meaning of recovery as liberation and self-transformation.

1.2. The Need for Safety, Security and Constancy

Table 11*:* Overview of Subthemes for the Super-ordinate Theme, the Need for Safety, Security and Constancy

a.	Impact of chronic housing instability: Lack of security, constancy and '*homelikeness'*
b.	Functions and meanings of transitional and permanent housing

Virtually all participants emphasised safety, security and the sense of constancy as preconditions for recovery and well-being (See Table 11). Overall, their narratives revealed the importance of security and constancy not only in terms of physical survival and self-preservation, but also in terms of the availability of the physical, emotional and psychological 'space' that allowed them to engage in introspective activities, which were perceived as instrumental in the recovery process.

Impact of Chronic Housing Instability: Lack of Security, Constancy and 'Homelikeness'

Virtually all participants shared that they felt safer and more secure in their current temporary accommodation (e.g. the safe haven). To them, temporary housing was the crucial transitional space between what life used to be (e.g. chronic homelessness) and what life could be (e.g. permanent housing and recovery). The overwhelming majority of the participants (15 out of 18) described their lives 'before' as pervaded by *the lack of security and constancy*-demarcated by chronic housing instability, alienation from the mainstream society, unstable social relationships, and, for some, the lack of long-term life commitments. Indeed, the participants' mean length of time homeless in lifetime was 11 years (See Table 1 in 'Chapter Five'). They often described their lives 'before' as a seemingly endless cycle of instability, precariousness and, for some, a chronic sense of purposelessness and lack of control.

Benjamin (an African-American safe haven client in his late 50s) and Ashton (a Caucasian assessment centre client in Scotland in his late 40s), for example, shared they had never had housing stability. Both participants had spent significant periods of their lives (more than 25 years) without own, permanent housing and shared they had become entrenched in a street culture lifestyle.

The analysis reveals that, ironically, insecurity was among the few *'*constants' throughout many participants' lives. Even though most participants had had intermittent periods of housing stability, their life stories conveyed an enduring state of *'unhomelikeness'* (Svenaeus, 2000). As a state of being-in-the-world, unhomelikeness is synonymous with the existence in a world that has become hostile, fractured and unnavigable (Svenaeus, 2000). To demonstrate, Neil distinguished between having physical shelter and feeling truly 'at home': *'Yeah, I have a roof over my head but I was still homeless.'.* Neil described this lack of 'homelikeness' as feeling insecure and vulnerable. His life story narrative was imbued with feelings of powerlessness and the lack of direction in life:

> *‘Moving all the time, not knowing the future or anything. You've not security wherever you are.* […] *I'd wake up in the morning and I saw myself just...going nowhere* […]*’* (Neil)

Similarly, Kelly described her cumulative hardship with the metaphor *‘going through war’*, which included her care leaver experience and experience as a single mother in the shelter system. She described her stay in the shelter system as unsafe, violent and demeaning. The concept of ‘*war*’ is diametrically opposed to that of ‘*home*’. Residing in the shelter system had entrenched her chaotic, fragmented and vulnerable state of being-in-the-world:

> ‘*From now it's all building down on me-from childhood to now-what I'm going through and it's just hell.’* (Kelly)

Kelly described her current circumstances as having *‘one foot in the hot plate and one foot out the hot plate’.* This idiom seems to reflect her current struggles to regain autonomy and control. Kelly expressed her desire to ‘*focus on herself’* by dedicating time to reflect and re-affirm who she was. Kelly’s current complex predicament-including food insecurity, financial difficulties, as well as her dissatisfaction with the effectiveness of the housing, social care and mental health services, hindered her capacities for introspection, self-reflection and self-care. Kelly also felt judged and not listened to by the social work staff, which made it even harder to navigate her living conditions.

The cumulative psychological impact of chronic disadvantage, especially housing instability and intimate partner violence, is starkly exemplified in Craig’s account:

> *‘And if you are in that negative situation all the time, which I was, it's...that has a big impact. I know there is a chance to get a total life turnout for myself and I know I can get away from how I am feeling all the time but...I mean, you gotta understand, this is long-term for me and it has had a big impact, even right now...’.*

Craig was an assessment centre client in Glasgow in his late 50s, who had experienced a series of adverse life events such as unemployment, separation and substance use problems, which had perpetuated his chronic homelessness and internal state of ‘unhomelikeness’ (See Figure 6).

Craig had been a resident at his current temporary accommodation facility for more than six months. He had first become homeless after deciding to leave his family home and travel. He was later hindered by joblessness and financial problems. He had grown up in a deprived area and had been involved with the ‘wrong mob’. Craig had eventually ended up without a place to stay multiple times, including once for a period of two years. Separation, substance use problems, housing sector inefficiency and the Recession had all contributed to his prolonged unemployment and homelessness. He had subsequently managed to ‘break away’ from his socially deviant lifestyle. However, his relationship difficulties, ongoing substance use, low self-esteem and financial pressures had significantly exacerbated his mental health and caused him to lose his stable housing. As a single homeless man, Craig felt depression, fear and loneliness. At present, he received professional support for his problems. He led a hermit-like lifestyle but was eager to resume work and return to ‘normality’. He was struggling with managing his mental health and often resorted to drinking. The lack of occupational opportunities also impaired his well-being.

Figure 6. Case summary: Craig (50-55 years of age; shelter resident in Glasgow)

Altogether, the enduring state of 'unhomelikeness' as a result of complex and chronic life adversity was a significant barrier to recovery.

Functions and Meanings of Transitional and Permanent Housing

For many participants, entering their current temporary accommodation signified a crucial *'turning point'* and the emergence of the possibility for a better life (*'My life changed for the better straightaway.'* (Neil). Several participants experienced this transition from chronic homelessness as an opportunity to get *'a total turnout'* (Craig) by orienting themselves towards longer-term goals, which related to housing, health, occupation, personal development and reconnecting with significant others. Scott, for instance, discussed how the structured substance use and mental health support, as well as the safe housing itself, had enabled him to acquire stability and security, which, in turn, facilitated his contemplative, self-management and goal-setting practices, all of which were integral to his recovery:

> *'I started to feel more secure with where I was and what was going on around me.'*

Other participants (e.g. Benjamin; Neil; Liam) also shared that they felt a sense of relief, gratitude, peace, and 'easing' of the mind in their current temporary accommodation. For instance, in an audio mobile phone diary entry, Benjamin highlighted having secure housing as a crucial enabler of his sense of well-being and autonomy:

> *'Well, I'm here in this shelter right now. The shelter is called 'a safe haven'. You've got your own room. And by me having my own room-that gives me peace of mind […] you're safe. I can read, watch television, or whatever I choose to do.'.*

Benjamin also took a photograph of a plastic bag hanging on his room door (See Figure 7). A seemingly mundane object, the bag symbolised Benjamin's gradual restoration of 'homelikeness'. The photograph was taken in response to the diary question: '*What is something that best captures your life now?'*:

> *'I'm in the shelter, I'm in the room. I mean it's better than where I was at anyway. Because once upon a time, I didn't have no door to hang no bag on-you see what I'm saying? I didn't have no door to close. I'm saying it's the little things you gotta be grateful for.'*

Figure 7. A plastic bag hanging on Benjamin's room door, which symbolised having a roof over his head

Benjamin’s account shows his increased mindfulness and control over his environment, which were instrumental for his regaining his state of ‘*homelikeness’* and sense of ownership-signalled by the repetitive, ‘*own room’*, and the verb phrases, ‘*can read’* and *‘choose to do’*.

The importance of permanent housing and the security and the sense of constancy it would avail is further emphasised by Craig’s reflections on how obtaining his own tenancy would affect his mental well-being:

> *‘Security. The reason I feel and I've got all those emotions and everything with me just now is because I've no security. I've lost that family circle. I've lost that circle of friends that I used to have. I've lost the very roof I stay under. I know that at some point, I am going to get my own place and when I do that, that's gonna give me a lift. […] It gives me a high thinking about it.’.*

This excerpt demonstrates the multiple functions and meanings of permanent housing and its potential effects on this participant’s socio-emotional well-being and recovery. Beyond satisfying his chronically deprived need for security and constancy, housing, for Craig, would act as a ‘bridge’ connecting him with valued social roles and relationships (as a father, as a friend, as a business owner). This would, therefore, enable him to become the person he ‘*used to be’*. Craig’s use of the metaphors, *‘high’*, *‘buzz’* and *‘lift’*, signifies his renewed sense of hope and self-efficacy.

Overall, both the safety and security afforded by the temporary (transitional) accommodation *and* the imminent prospect of permanent housing acted as enablers of most participants’ sense of ‘homelikeness’ and recovery. Housing was seen as necessary for interrupting the vicious cycle of insecurity and deprivation.

1.3. Achieving Insight

Table 12*: Overview of the Subthemes for the Super-ordinate Theme, Achieving Insight*

a.	A ‘wake-up call’
b.	Enablers of insight

For many participants, having safety, security and a sense of constancy facilitated opportunities for gaining self-knowledge and insight. Most participants discussed the achievement of better insight into their illness, their lives and themselves as a critical enabler of recovery. *Insight*, including the lack thereof, emerged as a major theme in several participants’ life story narratives (See Table 12).

A ‘Wake-up’ Call

For Scott and Neil, for instance, gaining a better understanding of their mental illness was instrumental in adhering to treatment and learning effective coping strategies. Despite having grown up in different countries, both participants (whose age was similar) recounted first experiencing mental health problems in their childhood and adolescence-at a time when there had been widespread mental health stigma and a lack of mental health literacy in their communities. Their early symptoms of mental illness had often been met with a lack of understanding, even among their families. This, in turn, had led to delayed help-seeking of professional support and had also impeded their own understanding of their illness:

> *‘And they just didn't realise about my mental disability. And it was very hard to convince them, you know: ‘’Look. I have a problem. And it's not drugs.’’ […] They just blamed it all on drugs... They just, they didn't*

> *understand I had learning disability, emotional disorders...I didn't fully understand it…’* (Scott).

Scott had been a client of his current temporary accommodation facility for several months. He had experienced mental health difficulties from an early age. He had first started to use illicit substances to ‘self-medicate’ his depression and anxiety. His family had generally been supportive until a family bereavement had led to a family breakdown. This, together with his mental health problems and financial difficulties, had led to his first episode of homelessness. Scott had spent a total of five years without a home, which had included couch surfing, squatting, contact with the criminal justice system and other temporary shelter. Scott had also been involved in the drug scene, during which time he had lived ‘recklessly’ and led a ‘negative lifestyle’. Despite having attended substance use support groups, he would ‘always’ go back to using drugs.

At present, Scott was pursuing recovery, taking it 'one step at a time', 'making progress' and 'living', not just 'surviving’.

Figure 8. Case summary: Scott (50-55 years of age; safe haven client in NYC)

For Scott, using substances had begun as a means of self-managing his symptoms at a time when no professional support was available or sought after: *‘I didn't realise...about the depression and the anxieties. So right away, you know, self-medication.’.* Over time, however, using substances had become ‘*self-defeating’*, and had contributed to him becoming entrenched in the *‘negative lifestyle’* of drug culture and street life (See Figure 8).

For Scott, self-awareness, self-knowledge and self-acceptance were difficult processes. They required the unlearning of maladaptive coping behaviours (for example, *‘looking for the quick fix’*). Among the ‘positive’ behaviours that he had adopted were adhering to, and trusting, the medication and psychotherapy, and re-evaluating his past in order to gain a better understanding of how his lifestyle had affected his mental well-being: *‘I first had to understand why I was feeling the way I was feeling...*[…]’.

This introspective analysis brought Scott a sense of insight, clarity and commitment to achieving a better life:

> *‘I have a lot of good and bad experiences. I had to go to jail. I had to be out there on drugs. And then, and then, I had to also give myself the chance at certain periods of life to get well, to see what it was.../A lot of it was maturity. I had to grow up. And I really had to take a look at, you know, what did I want for my life. And I knew that I didn't want a dysfunctional life. I knew that I didn't want a reckless life.’.*

The repetitive, *‘I had to…’,* conveys his efforts to meaningfully interpret his *‘negative’* past and harness this newly acquired knowledge to catalyse his personal transformation, which he described as *‘growth’* and ‘*maturity*’.

Similarly, Conor discussed having experienced a dramatic shift in his self-awareness and self-directedness as a result of the safety, security and support he had received in his current temporary accommodation:

> *‘The last couple of months have been a hell of a wake-up call* […] *I thought that everything was just starting to fall into place.’*

Conor experienced his renewed insight as the resolution to never ‘*go back to’* his hurtful past circumstances and as the renewed sense of control and autonomy over his life.

Enablers of Insight

The participants also offered detailed examples of what had enabled and constrained their insight. The lack of mental health literacy in society, together with the widespread mental health stigma, had prevented Neil from fully acknowledging his mental health problems and from receiving adequate professional support until many years after their onset. Neil's narrative revealed his painful attempts to manage his mental illness symptoms through self-isolation and excessive drinking for long periods of time:

> *'I cut myself off […] It was a relief from everything else around me […] I was just drinking heavily-every day as soon as I got up just to block it out.'*

When, many years later, Neil received his mental health diagnosis, he felt relief and a sense of validation of his struggles: '*And to me, that* [diagnosis] *was like...'I actually got a name on it...!'.* This participant also emphasised the importance of mental health literacy, and that he found reading and researching about his illness immensely helpful. For Neil, achieving such insight was both therapeutic and empowering.

For several other participants, receiving a mental illness diagnosis had facilitated their insight into their illness. Susan, in particular, discussed her experience of being diagnosed with a mental health condition after several years of struggling with severe mental health problems without receiving appropriate care:

> *'Great! I finally have someone who understands it and who knows that...It was a validation. And a relief that I now have someone who I can talk to about it.'*

However, Susan shared she still had not fully made sense of her illness. Susan expressed her intense struggle to maintain control over her mental health with the metaphor of the jigsaw puzzle:

> *‘My anxiety is such that I erm… […] my brain/I totally felt that it went completely fuzzy-is the best way to describe it/ […] All of my thoughts were...you know...it's like a jigsaw puzzle that you've made before-you know what the picture looks like but all the pieces just went to hell...Just you're like: 'Wow, hold on, wait a minute! I had it all together just a moment ago...!'*

The metaphor of the jigsaw puzzle captures this participant’s strenuous efforts to achieve insight into the workings of her anxiety. The lack of complete understanding of, and control over, the anxiety symptoms was a significant barrier to her rehousing and recovery efforts as it often impeded her ability to attend medical and housing appointments and to follow up with her housing application.

Insight, therefore, was often experienced as the catalyst for recovery. Self-knowledge and the knowledge of mental illness were common precursors of insight. For many, the achievement of insight was a liberating and transformational experience.

Summary of Super-Ordinate Themes (1.1)- (1.3): Contemplating and Envisioning Mental Health Recovery

For the participants, all of whom hoped to break the cycle of chronic housing instability, *imagining* their recovery was an effortful, ambiguous and even frightening process. For many, the years of chronic homelessness, victimisation and negative institutional encounters seemed to have impeded their imaginative and reflective capacities necessary for them to recontextualise their past, transcend their unsatisfactory present and project a future life *in recovery*. Yet, many participants shared that entering their current temporary accommodation had marked the beginning of an upward spiral in relation to their symptom management and recovery. Others, however, experienced their current circumstances as a daily struggle for survival and the preservation of hope, which was often emotionally painful and existentially threatening. (Re)Gaining one's state of '*homelikeness*' and achieving better insight into oneself and one's mental illness were found to be crucial preconditions for recovery.

2. Enacting and Sustaining Mental Health Recovery

As demonstrated in the analysis so far, for the participants, cultivating the capacity to *envision* recovery was the crucial initial step towards attaining a better life. However, security and safety, reflection and insight were necessary but insufficient for the participants to *enact* and *sustain* their recovery. Recovery was also contingent upon the participants' abilities to successfully *enact* and *embody* their emerging recovery projects by navigating the institutional uncertainty and complexity that was often characteristic of shelter living. Realising recovery also entailed doing things *with and through* others in ways that were deeply meaningful, humanising and constitutive of a positive self-identity. In particular, brokering an optimal and effective mix of formal and semi-formal supports was challenging and had a direct bearing on participants' holistic well-being and recovery. Furthermore, effective symptom management did not necessarily resolve the participants' existential and interpersonal concerns.

This second over-arching theme encompasses the participants' lived experience of *enacting and sustaining* recovery. The super-ordinate themes elaborated below reveal the participants' efforts to reclaim valued social roles and identities, and to provisionally enact new such roles and identities, as well as to (re)connect with patterns of meaning (such as cultural and family values, and spirituality) that offered purpose and coherence in life. The IPA resulted in four super-ordinate themes: *positive* *coping and self-management*; *nurturing a strong and positive sense of self; dilemmas of meaning;* and *feeling 'wanted, accepted and needed'*.

2.1. *'It's a daily process'*: Positive Coping and Self-Management

Table 13*:* Overview of the Subthemes for the Super-ordinate Theme, 'It's a Daily Process': Positive Coping and Self-management

a. Strategies of, and barriers to, effective coping with SMI
b. Mental illness as borne out of the volatile living environment
c. The intrinsic value of '*doing things'* and the perils of boredom
d. Formal support services as key enablers of positive coping and self-management

Strategies of, and Barriers to, Effective Coping with SMI

Mastering effective coping strategies amidst the limitations and physical and mental strains imposed by homelessness, poverty and other adversity emerged as a major theme in virtually all narratives (See Table 13). The IPA distinguishes between *positive coping*, which was associated with the effective and recovery-oriented management of SMI, and *negative coping*, which several participants described as counter-therapeutic and even self-destructive.

Overall, the participants discussed resorting to both informal (e.g. through personal self-management strategies) and formal coping strategies (e.g. psychotherapy and psychiatric medication). Among the effective and *positive* coping strategies discussed were cognitive strategies such as identifying and *'battling'* negative thought patterns; keeping oneself occupied; relaxation and reflection; distancing from one's problems; having a sense of humour, and others.

Some participants, however, recounted using *negative* coping strategies that had exacerbated their mental illness and prevented them from achieving insight and engaging with support services. Substance use, self-isolation and denial were mentioned by most participants as common negative coping responses that aimed to help them *'block out'* unwanted thoughts and feelings. Those negative coping strategies were experienced by Craig, Matthew, Neil, Simon and others as *'an escape'* and a '*relief*' from the unsatisfactory present, and as a '*deflection*' from the '*real issues*'.

Similarly, Scott discussed having used drugs to deflect his attention away from his underlying mental illness:

> *'I needed to...to stuff these feelings of depression and anxiety. And not having medication, I went out and used drugs […] I didn't have to think about depression, anxiety, homelessness-I didn't have to think about that cause I was so occupied with all the negative behaviours that I was into […] It was a coping mechanism […] It took me out of myself.'.*

This testimony reveals the profound impact that substance use had had on Scott's mental illness and his sense of self. Scott described how his (perceived) lack of alternatives for coping (*'not having medication'*), coupled with the overbearing effects of depression and anxiety, had steered him into addiction. Scott's account betrays his uneasy relationship with his mental illness, which is denoted by the verb *'to stuff'*, which signifies his distancing from the symptoms. He also shared he had often managed his symptoms through denial. The cycle of avoidance and substance use had distanced Scott from his own self (*'It took me out of myself.'*), which had amounted to a state of self-fragmentation and an inauthentic existence.

For Scott, therefore, recovery started with confronting and constructively managing his painful feelings and *‘negative thinking’* as a daily *‘battle’*. This battle was characterised by intensified self-reflection, self-evaluation and purposeful action:

> *‘It's a daily, it's a daily process.’*

The accounts of two participants, Matthew and Ashton, vividly demonstrate the experience of *not* coping with mental illness, which exacerbated their psychological and existential suffering. For Ashton, past traumatic experiences had had a profound impact on his present-day capacity to cope with his mental illness:

> ‘*Feelings coming up, do you know what I mean? Some feelings that come up-just...they are hard to deal with.* […] *I isolate. I block them out. I just stay in constantly.’*

The unpredictable nature and intensity of his painful ‘*feelings*’ seemed to undermine Ashton’s sense of control. As a result, Ashton shared, he tended to cope by self-isolation and avoidance.

Matthew’s testimony is another stark demonstration of the incapacitating effects of complex life adversity on one’s ability to make sense of, and cope with, mental illness in the context of homelessness:

> *‘Now, there is a bomb that actors call a clusterbomb. Now, I feel clusterbombed. It's a whole bunch of bombs going on but it's also this thing, it's called bombarded. I feel bombarded with so many different issues that the only way out of it, because of my incapacity to deal with the mental issues, is, is to erm...avoid it and to erm (...) ignore it, and not deal with it.’*

The multiplicity of Matthew's current hardship (demarcated by his current homelessness, physical and mental health problems, and loneliness) was experienced as *'a whole bunch of bombs'*-as a brutal, destructive force that paralysed him. As a result, he felt overwhelmed and ill-equipped to meet the physical, emotional and psychological demands of engaging in recovery and navigating transitional housing. Like Ashton, Matthew coped by self-isolation and avoidance:

> *'I'm very good at erm...distancing myself from that feeling because I don't allow many people close to erm...my being.'*

All in all, the participants emphasised the importance of replacing 'negative', learned coping behaviours with 'positive', effective and recovery-oriented coping strategies. The analysis also revealed a diversity of participants' espoused coping responses-ranging from actively *'focusing on'* one's mental health to consciously distancing oneself from one's mental health problems as a means of self-preservation.

Mental Illness as Borne out of the Volatile Living Environment

Several participants (e.g. Claire; Mary; Craig; Kelly; Susan) discussed the volatility of their temporary accommodation as a significant barrier to coping with mental illness. Mary, for instance, shared that the transitory nature of the shelter engendered a sense of insecurity and lack of control, which exacerbated her mental health difficulties:

> *'[…] It's quite a volatile place-it's no (?) safe! […] Your mood, everything is always up and down-especially in these places. You don't know who you're gonna bump into, you don't know...'.*

Henry and Mary (both living in temporary accommodation in Glasgow) shared that while they recognised that aspects of their current living circumstances impaired their well-being, they had no other options: *'The options were either going there or the streets...There was no in-between.'* (Mary). This realisation often created a sense of entrapment and vulnerability.

Similar testimonies were offered by Susan, Kelly and Craig, who recounted traumatising experiences in homeless shelters. Craig, in particular, detailed how the social environment of the first shelter he had resided in had severely exacerbated his depression and triggered his anxiety:

> *'I just started sinking right downhill because I did not like that place at all. […] It was just...It just created a phobia…[…] Even in there-hearing noises, hearing people speaking outside your window and stuff-my heart would be racing. Every little aspect of being in that place would just kick me off. And then, I would get panic attacks when I had to leave the place and I had to go outside...'*

Paradoxically, the homeless shelter-a facility designed, by definition, to offer respite and temporary protection from danger-was experienced by Craig as an illness-inducing and traumatising space. For this participant, entering 'the system' had forced him into a downward spiral of SMI and gradually diminishing control and autonomy, which he viscerally described as *'sinking right downhill'.*

Susan recounted a similar experience as a first-time shelter client in the U.S. She felt that the rigid rules and regulations of traditional shelters had impaired her mental well-being:

> *'We need to have these homeless people out and gone by 6 am.' And that is really tough.* […] *That whole schedule was very stressful to me. And again, I didn't know it-it just...was 'Oh God! I can't do this anymore!'.* […] *that really wreaked havoc on my anxiety.'*

For the three NYC participants that were street homeless and attended the drop-in centre at the time of the study (Oliver, Susan and Edward), the day centre environment was often unpredictable and volatile, which tended to negatively impact their mental well-being. For instance, Edward described occasionally having emotional crises as a result of the chaotic environment at the day centre. Such situations had made him resort to an emergency temporary retreat service, rest beds, where he had been provided with a private sleeping space, as well as one-to-one psychological support. Edward described those emotionally taxing periods using metaphors relating to the somatisation of psychological distress:

> *'I'm just...hanging in there until I get my place. And it would be more easy for me. I would not have so much headaches...My mind won't be like it `want to explode... […] I felt my body like...wanted to get out...because of all the nonsense.'*

The metaphoric verbs *'hanging'* and *'explode'* convey this participant's embodied lack of control over the environment.

Furthermore, Oliver's mobile phone diary entries vividly captured the volatility of shelter living and street homelessness. Oliver was an African-American safe haven client in his 50s, who had spent four years being homeless. On one of the diary logging days, he messaged:

> *'It's a good day because I have something to do and it makes me feel good. God bless.'*

On the very next day, however, he recorded:

> '*I am having a very bad day. Trying to get myself together.'*

Both Oliver and Edward managed the chronic stress of shelter living through stoic endurance:

'I'm trying to stay steady.' (Edward);

'*I had to overcome it by just...'Just hold on. Hold on. Things will get better.'* (Oliver)

Those accounts acutely demonstrate that, in many cases, the participants' mental ill-health could be interpreted as the embodiment of the counter-therapeutic arrangements of shelter living. The analysis revealed the interaction between the adverse physical (headaches, fatigue, backpain) and psycho-emotional (stress, anxiety, depressed mood, anger) aspects of shelter living, which amounted to the participants' experiences of mental illness and, at times, emotional crises.

The Intrinsic Value of 'Doing Things' and the Perils of Boredom

'*Doing things'* and keeping oneself occupied were, for many participants, essential to their efforts to create structure and order out of the chaos and precariousness in the shelter. For instance, goal-setting and small daily accomplishments appeared fundamental to Claire's coping and recovery. Claire's everyday life narrative demonstrates that her involvement in social and other leisure activities was a *choice* that manifested her commitment to recovery:

> *'I can go lie in my bed all day long, right, and...think: '[…] What's the point ?! What's the point?! It's the same stuff every day.' And then I really feel I'm down that wee hole, down that black hole […] I don't like sitting about...Like the other day when it was raining, I was in here all day/I've been here all weekend because of the rain and it was...boring and it's when you're bored, you start feeling dead...((sighs)) horrible.'.*

This excerpt also situates *boredom*, sameness and the lack of opportunities for social activities as antithetic to optimal coping and recovery. For this participant, boredom was synonymous with depression. For Claire, chronic inactivity induced feelings of hopelessness and helplessness, which she expressed using the idiom of the *‘black hole’*, which she used several times to refer to her depression. Claire then went on to discuss the intrinsic value of *‘being out and about’* for maintaining positive well-being. When feeling depressed or bored, she shared she would take up arts and crafts or communal gardening activities:

> *‘I like doing stuff takes your mind away from it. If you focus on something, it takes your depression mode away. […] It feels good because you've done/you've achieved something, you've done something so it's good […] it was a...therapy […] If you keep yourself active and keep yourself motivated-that's the word that they use-erm...you don't think about your depression.’*

The repetitive descriptor *‘good’* conveys the embodied sense of well-being that those therapeutic activities brought about.

Figure 9. A photograph taken by Claire showing the gardening activities that she enjoyed

Figure 9 depicts Claire's favourite pastime-gardening. For Claire, being occupied provided her with focus, structure and motivation, which, she believed, buffered against *'thinking about'* depression.

Boredom emerged from the analysis as a major inhibitor of at least seven participants' efforts to cope with their mental health difficulties. Most of those participants were from the Scottish sub-sample. The diary entries and interview accounts of Neil, Craig and Henry, for instance, were pervaded by the often-debilitating effects of what they described as *'boredom'*. Neil, for instance, experienced boredom as an overwhelming sense of entrapment:

> *'It's not like being in prison because you can go out. But it's similar to being in an open prison.* […] *The four walls-that's what leads me into trouble.'*

For Neil, boredom was an immensely depriving experience, which he compared to an open prison. This extreme metaphor reflects the profound restrictions on Neil's opportunities to engage in occupational, recreational and other forms of social interactions, which were imposed by homelessness, social isolation and financial difficulties. It was those opportunity limitations (rather than concrete illness symptoms) that Neil highlighted as most psychologically and emotionally debilitating. Unsurprisingly, Neil's mobile phone diary images mostly depicted his room in his temporary accommodation:

> *'-I: You took this photo in response to the question about what best captures your life.*
>
> *-P: Because that was what my life was that day-I spend the whole day doing nothing, looking out of the window.'*

Living was experienced by Neil as repetitive and restrictive, whereby he was a passive bystander to the life 'outside' his room. When asked via the mobile phone diary what was something that made his situation worse, he replied succinctly: '*Depression, boredom, alcohol*.' Neil experienced this 'unholy trinity' as interlinked and mutually curbing hinderers of coping and recovery.

Unsurprisingly, Neil shared he very much enjoyed opportunities to take part in social and leisure activities such as outdoor trips organised by the shelter staff (See Figure 10). The image Neil took of his outdoor trip in the countryside symbolises the therapeutic and social importance of movement and activity.

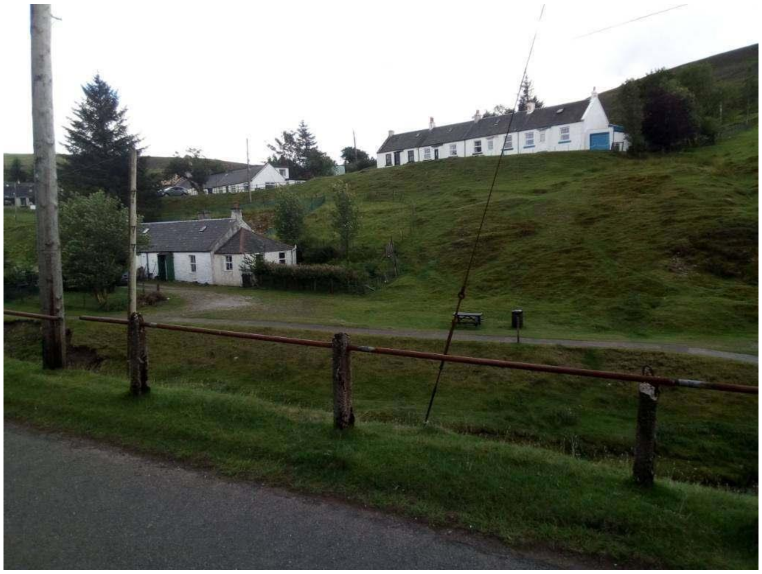


Figure 10. A photograph by Neil of an outdoor trip in the countryside

Boredom and its impact on mental well-being and recovery were a prominent theme in Craig's present-day narrative, as well. For Craig, chronic boredom was not only depression-inducing but also existentially threatening. His account of his day-to-day life reveals a state of passivity and hopelessness. For him, it seemed that homelessness was a dead-ended journey. In that journey, time was experienced as painful; not as a resource to be used for self-betterment but as something to be stifled. Time was experienced as entrapping:

> *'Boredom. Just trying to kill the day and night away. It's basically all you do every day, all day-just...kill time. Every morning that I wake up, I can't wait until the next time I to go to sleep again...just...try to get away with the days […] I'd rather be doing more aye...It's just...obviously the predicament that I am in...I'm kinda caught in that trap.'.*

Craig's mobile phone diary entries were also dominated by references to boredom, drinking and isolation (See Figure 11). Figure 11 depicts a photograph Craig took of empty bottles of alcohol stored in his kitchen cupboard. Those empty bottles appear to signify the painful absences, disappointments and unfulfilled needs and wants that pervaded Craig's existence.

Craig also shared that he preoccupied himself with excessive drinking and with solitary recreational activities such as engaging in online communities as means of an imaginary escape from the confines of homelessness, unemployment and social isolation.

Figure 11. An image generated by Craig, with the caption 'have nothing to do and nowhere to go'

In another photograph, Craig depicted the view from the shelter (Figure 12). The numerous images Craig generated of him looking out from his room at the shelter seemed to symbolise his sense of forced passivity and exclusion from society. As a homeless man, Craig felt forced-by the system and by his circumstances-to be a passive bystander in life rather than an active agent.

Figure 12. An image by Craig depicting the view from his room at the shelter

Lastly, the adverse effects of boredom and isolation on one’s mental well-being were acutely demonstrated in another Scottish participant’s account- Henry’s. Henry was generally hesitant and somewhat reluctant to disclose his feelings and emotions during the single interview he chose to participate in. And yet, his seemingly brief and ‘thin’ account offered a profound insight into the interlacing of homelessness, isolation and mental illness. When asked whether he had ever experienced problems with his mental or emotional well-being, Henry replied somewhat indirectly:

> *‘It's...the boredom and filling your day, do you know I mean...There are no a lot of places to go from here, do you know what I mean, that doesn't cost money and you don't have a lot of money so...[…] when you start to stay in, and there are only four walls...You can't sit and watch television all day...You've got to go out and about and...it's down to funding, do you*

> *know what I mean...so...and...it doesn't last long, do you know what I mean, £40. […] It has affected my mental health, yeah. […] You've got to get out, even if you just go for a walk, do you know what I mean? You go nuts...just...being in here watching telly all day.'*

It appeared that the sense of entrapment was so emotionally overwhelming that Henry was struggling to fully comprehend its impact. This was signalled by his multiple uses of *'Do you know what I mean?'*, along with his frequent pausing. The use of the impersonal 'you' (e.g. '*You can't sit and watch television all day…'*) seems to reflect his desire to not only receive the interviewer's understanding and empathy but also to connect with the audience's sense of shared humanity. Henry's anguish at the constraining effects of his complex predicament culminated in an affective rhetorical statement:

> *'Where can you go?! You've just got to endure it, do you know what I mean, (researcher's name)?* […] *It's...it's...it's hard to explain...it's just...you've just got to endure it... ((starts stuttering slightly)) You can't just... (?) (stutters) a sleeping bag or whatever...!* […]'.

Henry concluded with a statement that reaffirmed partaking in social and leisure activities as a core human need that he felt deprived of:

> *'We are social creatures so we have to...socialise.'*

This statement served to not only humanise Henry's struggles but also emphasise social interactions as integral to his mental and emotional well-being. Henry felt powerless and forced to passively wait for a better outcome:

> *'It's just...I'm here and...what else have you got do...? ((voices becomes weaker)) There's nothing else you can do apart from just wait and bite*

> *your time, and hopefully something comes along, do you know what I mean?'*

The repeated *'bite your time'* indicates this participant's perception of time in the shelter as prolonging his emotional suffering and purposelessness.

Altogether, boredom and isolation were, for several participants, sources of psycho-emotional and existential suffering. In several cases, boredom seemed to pervade the experience of shelter living, which profoundly hindered those participants' abilities to engage in recovery-promoting activities.

Formal Support Services as Key Enablers of Positive Coping and Self-Management

Last but not least, formal and semi-formal support services represented other key enablers of positive coping and self-management for virtually all participants. Overall, the participants discussed the importance of several types of support services-including psychiatric medication, SU treatment, psychotherapy, case worker support, Alcoholics Anonymous/Narcotics Anonymous (AA/NA), and other forms of peer support. Each type of support seemed to serve a distinct function in the participants' coping and recovery efforts.

To begin with, psychiatric medication was discussed by several participants as a lifeline and a critical intervention that enabled them to engage in focused, rational reflection and decision-making (e.g. '*Medication makes that possible because it slows down the negative thought process'* (Scott). While those participants generally viewed psychiatric medication as instrumental for initiating positive coping and recovery, they were considerably more ambivalent about the role of *long-term medications*. Three participants, specifically, Claire, Conor and Scott, reflected on the impact that medication-taking had had on their sense of self. All of them shared that they struggled with the idea of being permanently dependent on the medication. For Claire, for instance, getting off psychiatric medication was important for restoring her sense of autonomy, normality and productivity:

> *'I don't wanna be taking tablets for the rest of my life. […] At the present moment, I try to come off my tablets. I don't want to be on tablets for the rest of my life. […] I'm not a tablety person so...[…]'.*

The colloquialism, *'a tablety person'*, appears to reveal her disidentification with the stigmatising label of the needy and vulnerable long-term medication user. Indeed, this participant shared how she believed her taking medication for her depression and anxiety had made others perceive her as *'vulnerable'* and therefore as an unreliable parent. This seemed to threaten her valued identity as a capable parent. For Claire, gradually coming off medication was a recovery-relevant goal that she associated with gaining social recognition and respect.

The participants also highlighted the irreplaceable role that the empathetic and enriching interactions with a therapist or a support worker played in the recovery process. Scott, for instance, stressed the importance of therapy for optimally managing his *'negative thinking'* above and beyond the effects of medication:

> *'Therapy is the difference. Therapy is a very big part of wellness.[…] Unless they know what's going on inside of a person, they can't help; they don't know how to tackle a situation. Medication helps me (...) act on proper thinking. But therapy (...) erm...reinforces (...) proper think/a healthy thinking […] That's what it is to have another human being turn around and say: 'But look what happened. Would you rather be this or would you rather be that? Would you rather be in the streets or would you rather have a roof over your head? […]'.*

Scott's account exemplifies the importance of disclosure, introspection and positive reconstruction of past experiences, all of which were facilitated by counselling. Scott prioritised the rational and thoughtful examination of his own past decisions, current commitments and future priorities, which was effectively enabled within the therapeutic dyad.

The importance of counselling was also supported by Conor's, Neil's and Oliver's accounts. Those participants emphasised the significance of having a non-judgemental and encouraging human being to listen to them, validate their experiences and offer constructive advice.

Conversely, several participants expressed their disappointment and frustrations at the inadequate, inappropriate and/or insensitive counselling services they had received. Those participants shared they often struggled to receive sufficient counselling time from specialist services. To demonstrate, Kelly believed counsellors should take a more active interest in their clients' prior life experiences in order to provide more tailored and effective support:

> *'I want the counsellors to be more specific and start helping. […] They don't ask that-they don't ask about the childhood, 'What happened to you in your childhood?' 'No:::! You gotta ask that! That was what you went to school for!'*

Furthermore, Claire felt that counsellors' insensitive probing into a client's childhood and other intimate life experiences could do more harm than good:

> *'-I: Did that* [counselling] *help you? -P: No, because it opened a can of worms from way back in the day. […] It wasn't helping me. It was making matters worse. It was just opening a can of worms that I wanted to forget about so...'*

Claire and Craig both expressed their concerns at the inadequate availability of mental health and well-being resources in the community. Claire shared her regret at the closure of community centres in Glasgow, where people could '*go and have support and sit with people'*. She also believed there should be more mental health counsellors and that mental health problems should be focused on as much as substance use problems. Craig, on the other hand, believed counselling should be more widely available and more professionally conducted:

> '[…] *basically, doctors don't have the time for the patient. If they hear something, they are too quick and basically they through an examination can remedy your problem and give you pills for it. They never give you pills to cure. It's always to mask your pain. So I don't see anybody getting cured in society, maybe the odd one. The biggest majority is punting out drugs for the world health, and that's it.'*

This quote seems to reflect Craig's dissatisfaction with the treatment of what may be complex human problems with quick fixes such as medication. It also conveys what he believes is a disregard from health professionals towards clients' unique struggles.

Furthermore, virtually all participants stressed the critical importance of help-seeking, while also highlighting that deciding to seek help and trust a care provider could be a difficult process. When asked about what advice he would give to another person facing the same issues as him, Ashton replied:

> *'Take all the help you can get. Accept the help that has been offered to you. […] It took me years to accept the help because of trust issues […]'*.

Conor, similarly, highlighted the importance of taking initiative in accessing support: *'But help doesn't come to you. You need to go out there and look for it.'*. Lastly, Benjamin and Oliver discussed the importance of not being ashamed to ask for help and that of being patient when asking for and receiving help.

Virtually all participant accounts contained references to recovery-promoting attributes of case workers, social workers, counsellors, and other support staff. Matthew, for instance, felt that being heard, seen and validated was integral to him beginning to make sense of his complex predicament and easing his anguish and despair. He expressed, however, his frustrations at his current case workers' failure to offer understanding and empathy. As a result, he felt he was often misunderstood and sometimes even demeaned and neglected:

> *'-I know what you're talking about.' -'No, no. You don't know what I'm talking about.' […] allow me to express to you what mental stage of mine I'm in. […] The approach...that I deem erm...the most erm...helpful erm...in...most productive (...) is to give mental support to try to (...) give some type of (...) like [stutters] 'I know what you're talking about.' And I know what you're feeling is real. And I'm in touch with what you're talking about. And since we have that in common, let's see how we can change it. […] And then, you know, you're putting yourself like 'I'm not better than you and I'm not worse than you.' Like 'I'm right here with you.'*

Matthew's emotive account reveals the importance of feeling 'visible', equal and recognised as a human being with complex emotional and practical concerns. It also underscores the role of client-practitioner partnerships (*'let's see how <u>we</u> can change it').*

Matthew seemed to particularly enjoy participating in the research interviews as this offered him a safe space to vent his feelings and emotions. As he shared:

> '[…] *there's a lot to be said with somebody who listens….*'.

When asked when the last time he had felt listened to was, Matthew replied:

> *‘A long time. A long time. A long, long time. No one has let me talk without interjecting or...erm...interrupting my chain and train of thought. […] My case managers-forget it. They're constantly erm...trying to 'Just hold on a minute.'-like that-'Hold on, hold on a second.' Like that. And then you lose your train of thought. […]’.*

Matthew then emphasised the importance of ‘*understanding, compassion and empathy’,* which he felt had been lacking in his interactions with the support staff at the safe haven. He also expressed his dissatisfaction with what appeared to be a mismatch between the case worker’s and his own priorities:

> *‘[…] like you're really not concerned with anything I'm saying. You just wanna get this, you know, 'OK. You want your medication for sleep. Let me get you that. That's the most important thing.' 'No, that's not the most important thing. [raises his voice] No, that's not the most important thing! The most important thing is can you listen to what I'm going through?! […] Can you help me with this, you're my case manager?!’.*

Matthew seemed to emphasise the importance of the case worker’s understanding of the complexities of his holistic experience (*‘…what I’m going through’*). He contrasted the genuine caring stance with some case workers’ provision of quick and temporary fixes (e.g. sleeping pills). His case workers’ seeming lack of empathy and genuine engagement with his lived experience perpetuated his feelings of invisibility and inferiority. Several other participants also stressed the importance of case workers’ and counsellors’ receptivity, flexibility and genuineness.

Notably, several participants did appreciate the emotional and psychological support they had received from their case workers. Edward, in particular, shared how his case worker's helpful and approachable demeanour had impacted positively on his mental well-being:

> '[…] *I could just talk to her about anything. She will just break me out-I even forget that I was depressed.'.*

Several of the participants recognised, however, that an effective caring relationship was also enabled by the client's willingness to trust, '*open up'* and disclose their experiences to the case worker or counsellor. Some participants also commented that establishing trust with the care providers was difficult due to the high staff turnover:

> '*Who are you? I don't know who you are and you want me to sit and explain myself to you?' No, sorry. I'll just go up to my room and feel sorry for myself.'* (Claire)

Peer support was only discussed by a minority of participants and primarily in the context of their attendance of AA/NA meetings. Peer support had an especially significant role in Scott's recovery. In his peers' testimonies, Scott had found hope that recovery was possible. It had also helped him normalise his experiences:

> *'It* [listening to peers at support meetings] *reinforces the belief that it works if you give it a chance, if you do it the way they suggest...you do it...you know, a better life is possible.'*

Finally, a number of participants discussed the importance of aftercare following their transition to permanent accommodation. For Ashton, for example, ongoing support was essential for mastering self-management skills and becoming more independent. For Conor, efficient aftercare was synonymous with '*empowerment'*, which he described as having continuous support with independent living.

Collectively, virtually all participants recognised the importance of a diverse mix of formal and semi-formal supports for enabling better coping, well-being and recovery. The extent to which the participants received such comprehensive and tailored support varied, however. While some participants seemed to benefit tremendously from appropriate and sensitive service provision, others struggled to broker such optimal support, which often made them feel unheard and invisible, and perpetuated their distress.

2.2. Nurturing a Strong and Positive Sense of Self

Table 14*: Overview of the Subthemes for the Super-ordinate Theme, Nurturing a Strong and Positive Sense of Self*

a.	Rediscovering one's *'strong'* self;
b.	Impaired sense of self-worth;
c.	Sources of positive self-identity

Rediscovering One's 'Strong' Self

The IPA revealed the importance of re-discovering and re-affirming a positive sense of self for recovery (See Table 14). This was strongly conveyed in several participants' pronounced self-efficacy beliefs. For instance, when asked what they needed to promote their recovery, several participants emphasised their own abilities and strength of character:

> '*I need myself to be well* […] *You can manage it by doing it on your own.*' (Liam);

> '[…] *I want to fight it myself* […] *I'm a fighter. I will get there.'* (Claire);
>
> '*Think it's just your willpower, cause nobody else will do it for you*. […] *I don't need protection. I'm alright myself.'* (Mary).

The categorical statement, '*I need myself to be well*.' (Liam), was not interpreted as this participant's denial of the importance of professional and social support. Indeed, this participant also stressed the role of responsive professional support and that of genuine friendships. Rather, this statement appears to denote the significance of reclaiming one's authentic self-a self that was aligned with one's beliefs, values and aspirations.

Overall, the narratives contained detailed reflective accounts of the participants' past, including strong self-evaluations, which resulted in either self-blame, self-reassurance, or both. The past seemed to carry a dual meaning in relation to the participants' self-identities. In some instances, the past was perceived as threatening to one's coherent sense of self (e.g. Edward; Simon; Matthew), which led those participants to *'distance'* themselves form the feelings engendered by the in-depth reflections on the past, '*block*' them out, or '*push everything to the side'*. For other participants, their past was a testament to their resilience, perseverance and inner strength, and was therefore a positive source of self-identity.

Kelly is an African-American woman, who had been a client at her temporary accommodation facility for more than six months. Kelly had grown up in the 'Project' amidst widespread substance use, deprivation and violence in the community. As a result of family difficulties and separation, she had had 'no childhood' and 'no time for myself', and had lost her home. She had had multiple homeless episodes as a mother, which had included traumatic experiences in shelters. She had also spent time in inpatient care. On the streets, she had survived by being vigilant and 'staying away from' people.

At present, she lived in unsatisfactory and demeaning living conditions. She prayed every day and relied on the support from her partner. Kelly struggled to receive adequate psychotherapeutic support. She also experienced food insecurity and poverty.

Figure 13. Case summary: Kelly (35-40 years of age; safe haven client in NYC)

Kelly was a safe haven client in NYC in her late 30s (See Figure 13). Participants such as Kelly stressed the importance of re-discovering their *'strong' self* as their 'constant' self:

> *'I've always been strong so I gotta repeat it. […] For what I went through, when I was a child, I'm strong. So if I did that and went through what happened to me then, I could finish this.'*

The language of continuity that Kelly used ('*always*'; '*finish*') appears to signify Kelly's efforts to preserve and re-kindle a continuous sense of self despite the deleterious psychological and emotional impact of the chronic disadvantage she had endured.

Furthermore, at least three participants highlighted their abilities to '*adapt*', which helped them self-preserve during times of adversity (*'I'm a chameleon. I will just adapt easily.'* (Neil). Edward, for instance, compared his adaptability to a fictional movie character: *'I adapt. It's like the movie...Heartbreak Ridge with Clint Eastwood. He's a troop sergeant.'* His comparison to a heroic character who had undergone tremendous suffering and challenges could be interpreted as a manifestation of this participant's efforts to positively reinterpret his past and present predicament as worthwhile and temporary.

In several participants accounts, their coherent sense of self was the victim of the long-term substance use. Drugs were frequently described as '*a crutch'*, as *'false strength'*, and as something that was *'always there'* to replace, at least temporarily, those participants' deprived social and emotional needs. For Benjamin, drugs had been his main source of strength for many years:

> *'I felt power. I felt like I could have gotten into the ring and beat Mike Tyson. That's what it gave me […] And it's false. It gives you false strength*. […] *When it wears off...you gotta go get the next one. And the next one, and the next one...You know...and then....it's gonna stop you from growing.'.*

To Benjamin, recovery meant repairing his ruptured sense of self, which had been weakened by the mind- and identity-altering influence of long-term drug use. For participants such as Benjamin, enacting recovery was contingent upon rediscovering their resilient and authentic selves.

Impaired Sense of Self-Worth

Participants such as Matthew, Craig and Ashton experienced considerable difficulties regaining their self-esteem and self-efficacy, which they considered a significant barrier to recovery. While discussing the impact of chronic housing instability, the loss of employment and relationship breakdown, Craig shared:

> *'I don't have any self-esteem anymore. […] I am physically and mentally shattered […] Trying to pick yourself up again and starting to feel good about yourself again was just a no-no because...it's just been a long time, a very long time...[…] I just feel so depressed and it takes me right down a slope.'.*

This quote illustrates the relationship between cumulative adversity, self-esteem and hopelessness in Craig's biography. Craig highlighted the importance of having a positive sense of self as integral to enacting and sustaining his recovery. However, achieving a positive sense of self was impeded by his homelessness, financial struggles, mental illness and overpowering feeling of a wasted life.

Matthew and Ashton also discussed having impaired self-esteem as a result of adverse life events, including homelessness, victimisation, substance abuse and toxic relationships. Matthew, for instance, felt that his chronic lack of self-esteem had contributed to his existential fear and loneliness:

> '[…] *a lot of it has to do with self-esteem* […] *I'm almost to the point that I'm petrified. I don't know if you understand that word but erm...it's like a bone that turns to rock. I'm scared. I'm not confident and I'm/because I've been betrayed many a time in my life.'.*

Similarly, Ashton referred to his traumatic childhood experiences as the cause of his chronic sense of low self-worth. As a result, he shared he had become *'scared*' and had attempted to ‘*compensate*’ this by engaging in negative behaviours such as drug use. That was accompanied by a persistent sense of failure (‘*I was never good enough.*’). This feeling had been exacerbated by the derogatory public attitudes towards him while he was street homeless:

> *‘I thought of myself as a low-life, do you know what I mean? As if I wasn’t worth anything. As if I would be better off not being here…A lot of suicidal thoughts came into it…’.*

Altogether, those participants highlighted the cumulative effects of a range of adverse life experiences on their self-identities.

Sources of Positive Self-Identity

The IPA discerned several sources of positive self-identity that the participants drew upon. Resuming meaningful occupation was an important enabler of a positive sense of self for several participants. For Neil and Craig, occupational engagement not only helped ameliorate mental illness symptoms but also represented a route back to ‘normality’. Neil, who was in the process of developing his work-related skills and job-searching, was eager to return to employment. To him, employment offered a sense of control and meaningful direction.

Similarly, Craig shared that resuming employment would help him regain his independence, productivity and sense of accomplishment and self-worth. For him, resuming his occupation would stimulate his ‘*excitement*’ and *‘up-and-go’*, all of which were antipodes to his depression and lack of self-esteem or, as he described it, to feeling *‘right down in the gutter’*. However, Craig’s work-related ambitions were constrained by his financial circumstances, lack of own housing and mental and physical health problems.

Finally, three participants (George, Joshua and Edward) discussed how their family and cultural values and morals were a valuable source of positive self-identity. Joshua, for instance, commented on how, by leading a life that had been dominated by substance use, he had disrespected the cultural values and norms that his family had taught him:

> '*I was raised with moral: church, school and work. But I kept getting irresponsible and neglectful.'*

Joshua was an African-American safe haven client in NYC in his late 50s. He had spent more than 30 years being homeless, in addition to several years in institutional care. Recovery, for Joshua, entailed reconnecting with those cultural and family values:

> '[…] *all of us were brought up...to morality. So I'm turning back around to that.'*

It seems that Joshua perceived his substance use as a moral deviation and a fault of character, which had impaired his authentic, 'moral' sense of self ('*Drugs took a lot out of me, you know* […]'). For this participant, recovery meant giving up the '*crutch*' that substance use offered and *'doing the right thing'* by adhering to his treatment and by 'remembering' who he really was.

In addition, George and Edward, both Hispanic men in their late 50s living in NYC, briefly underscored their cultural identity as being integral to their positive sense of self. George, for example, emphasised his Mexican heritage as a source of cultural pride and a guidance for a dignified life ('*You start with your roots-where you're coming from, how you were raised, what you believe in* […]'). He, however, was separated from his family due to his homelessness, financial difficulties and physical health problems, which did not allow him to reunite with them.

All in all, identity dynamics emerged as an important factor in participants' efforts to enact recovery. Amidst the socially and economically disempowering and existentially threatening conditions of homeless living, the re-affirmation of the 'strong' self as one's constant self was challenging. In those efforts, identifying and connecting with sources of positive self-identity were crucial. The participants' life stories also revealed the continuities and discontinuities in participants' self-identities, which was also important for their recovery.

2.3. Dilemmas of Meaning

Table 15*:* Overview of the Subthemes for the Super-ordinate Theme, Dilemmas of Meaning

a.	*'Trials and tribulations'*
b.	Loss of meaning and hopelessness
c.	Faith in God and spirituality
d.	Routes to wisdom and personal growth

This super-ordinate theme encapsulates the fragility of hope and meaning in life that many participants had experienced (See Table 15). They commonly discussed how the multiple problems they had faced had presented them with existential dilemmas-for instance-concerning whether their struggles and efforts to attain a better life had been worth it.

'Trials and Tribulations'

In their efforts to impose meaning and coherence to their precarious and sometimes chaotic present-day lives, two participants (Scott and Oliver) described their hardship as their *'trials and tribulations'.* Trials and tribulations are a central Biblical theme referring to the experience of profound uncertainty, suffering and sacrifice that the believer must endure in order to prove their faith and grow closer to the image of God. This Biblical metaphor is therefore associated with stoicism, patience, foresight, faith, purpose and the receipt of an eventual reward. Both Scott and Oliver shared that achieving recovery, positive well-being and rehousing required daily labour, which involved withstanding the stresses and strains of homelessness.

Scott's and Oliver's construction of their predicament as '*trials and tribulations'* could be interpreted in several ways. On a spiritual level, it seemed that faith helped them transform the meaning of homelessness as the precursor to a better life-a life in recovery and permanent housing. On a psychological level, this framing of their current and past adverse experiences could serve to help them rationalise their predicament and even justify their suffering. On an existential level, those participants appeared to 'mould' their suffering into a familiar (in this case, Biblical/mythical) plot that seemed to help them navigate the uncertainty that characterised their present circumstances. Those participants' narratives could, at least in part, be interpreted as the active 'emplotment' of their biographies as '*suffering towards'* a higher, more satisfactory state of being (McGraw, 1995, p. 43, citing Frankl, 1969).

It was unclear whether those participants felt they were being punished or were to blame for their life adversity. Overall, the participants' perceptions of the main causes of their adverse life experiences were ambiguous. While some participants did blame themselves *('I made my own mistakes.'* (Simon); '*We, including myself, we dug our own hole…*' (George), others emphasised the role of factors beyond their control-including their upbringing, the social environment, the unavailability of housing, the economy and others:

> *'I've done mostly everything I could...to come to this place and time but...It happens to the best of us…'* (Edward*);*

> *'I did blame myself for a while. I just knew I (should?) look at it as 'It's life. It's just something that happens*.' (Claire);
>
> '*Well, recession happened, so that's out of your control…*' (Susan)

The participants' perceptions of choice, self-blame and the inevitability of life struggles appeared to shape the extent to which they viewed the current adversity as meaningful and surmountable. Those beliefs seemed to infuse their recovery efforts with a greater sense of purpose, tenacity and direction.

Loss of Meaning and Hopelessness

In contrast to Scott and Oliver, the narratives of participants such as Matthew, Craig and Henry revealed a state of '*existential vacuum'* (Frankl, 1969). Existential vacuum describes those participants' daily battles with meaninglessness and the sense of the unavoidability of suffering. Craig, for example, shared:

> *'On a day-to-day basis, I don't know...I still go through it every day, even sitting at nighttime, I always have this thought that I don't wanna be here....in life itself. [...] Every morning that I wake up, I can't wait until the next time I to go to sleep again...just...try to get away with the days. […] I would say that: constantly feeling depressed, constantly feeling down, constantly not wanting to be here...even getting my own place, climbing the ladder again-it doesn't take away that. I don't wanna be here. It's constantly there. It's been there for too long.'.*

Craig attributed his sense of meaninglessness to the chronicity and severity of his adverse life experiences, which was conveyed by the repetitive, *'constantly'*, and the adverbial phrase, *'too long'*. This participant believed that regaining stable housing and returning to employment would not completely dissipate those existential concerns.

Yet, Craig seemed to preserve an inkling of hope for his recovery. He believed his current situation could be metaphorically described as a *'juncture'*, which conveyed both his uncertainty and existential disorientation *and* his fragile belief that a good outcome was possible:

> *'So I am kinda...50/50* […] *I am kinda stuck right here in this kinda...'don't know what's gonna happen'.*

For Craig, his current circumstances appeared to be experienced as a *'boundary situation'* (McGraw, 1995). McGraw (1995) defines boundary situations as conditions that are often emotionally and existentially challenging and difficult to comprehend or rationalise, but that are '[…] *potential turning points in one's life and are mandatory for the development of authenticity.*' (p. 57).

Similar dilemmas of meaning are demonstrated in Oliver's reflections on the fragility and contingency of hope that characterised the experience of street homelessness and other forms of human suffering. Oliver described the plight of a fellow drop-in centre client:

> *'She is sitting there every day like that. […] She sits there like that, like she is just waiting for shut her eyes and that's it.* [discusses her personal circumstances] *She is grieving. […] She just wants to give up. […] I told her, you know: 'It's not over. You're here for a purpose […] That can happen to anybody just like that and I can be in her shoes […]'.*

Oliver emphasised that despondency and hopelessness were an inherent human vulnerability ('*That can happen to anybody just like that* […]'). He also shared that he had indeed had similar experiences of hopelessness but that he had managed to '*come out on top'* by not giving up and reminding himself of his purpose in life. This account by Oliver demonstrates his acute awareness of the existential threats of homelessness as a boundary situation.

Another participant’s account, Matthew’s, poignantly revealed the loss of meaning and purpose in life as a result of cumulative life adversity (See Figure 14):

> *‘My life has been a <struggle>. It has been <so disappointing.>* […] *I can't wait for my life to be over. I really can't. I just can't wait! This is so painful...! This is so lonely! This is so...just terrible...!’.*

Matthew had been a safe haven client for about one year. Matthew had not experienced homelessness until he has 40. The main reasons for him losing his home for the first time were separation, unemployment and financial difficulties. At the time of the study, Matthew was experiencing his longest period of homelessness-seven years. In his early life, Matthew had experienced bereavement and a dysfunctional family environment, in which he had ‘never felt loved, cared for or wanted’ and had never felt 'part of anything'. As a result, he had become a 'needy person'. After becoming homeless, Matthew suffered a range of adverse experience such as victimisation, food insecurity, squatting, and others. He had also drunk excessively, developed depression and had multiple ‘breaking points’. He had eventually been approached by the homeless outreach team and asked to become a client at the safe haven.

At present, Matthew kept no contact with his family or significant others. He had several friends and acquaintances but still felt lonely, isolated and ‘depressed’.

Figure 14. Case summary: Matthew (55-60 years of age; safe haven client in NYC)

Matthew felt indescribable anguish, hopelessness and disappointment in others and in life itself, which was overwhelming and paralysing. Matthew did not feel part of the rest of society; he felt marginalised and discarded. Those feelings were exacerbated by his current lack of dignifying housing conditions, as well as by the severe poverty and food insecurity that he faced on a daily basis.

Matthew's mobile phone diary entries indicate that his profound sense of hopelessness was not a momentary heightened emotional reaction but rather a chronic and enduring state that permeated his entire being. The entries were pervaded by his sense of desperation and his feelings of not being wanted by society. In an audio entry, for example, he shared:

> *'Feeling kinda like…trash. Feeling kinda like…discarded. Feeling like even the garbage man doesn't want to pick me up. […] I don't know-I just…I feel depressed. […] I've nothing. It's like a daily struggle. It's like, I wake up and people are like: 'God bless! I'm alive today.' Well, sometimes I don't wanna be alive. […] Everyone wants to use you cause you're homeless. And they figure they can get something from you. And take advantage of you.'*

Matthew's hopelessness had emerged from a series of adverse biographical events, from the constraints of homelessness and financial insecurity, and from his experience of being treated as insignificant by both society and the system. His feelings of invisibility and insignificance were perpetuated by his unsatisfactory relationships with the support staff at the safe haven:

> *'Honestly, I'm tired of the struggle of trying to reach out and ask for help. I'm tired of trying to explain that […] I'm tired of this journey. I'm tired of...I've lost everything.'*

‘*I’m tired’* possibly signifies his state of both physical exhaustion and his existential pain.

Most of Matthew’s diary-generated images reflect his internal state of feeling unwanted and trapped (See Figure 15). For instance, he took a photograph of a drain basin:

Figure 15. A photograph of a drain basin obtained by Matthew

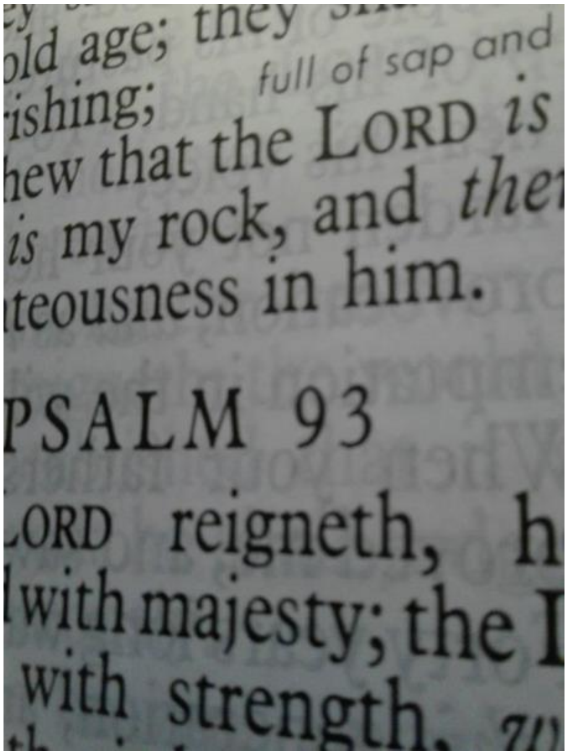
This photograph captures Matthew’s unspeakable anguish and emotional pain. Matthew’s account revealed his painful sense of separateness from others. The poignant metaphors, '*trash*’, ‘*discarded*’ and ‘*melt away’*, indicate his experiential state of emptiness, ‘*non-being’*, disintegration and vanquishing from full existence (McGraw, 1995).

Those data acutely show how the loss of meaning and hope inhibited several participants’ recovery. Those participants’ entrenched sense of meaninglessness was rooted in series of adverse institutional and interpersonal life experiences. Collectively, the data convey those participants’ experiences of ‘*non-identification, non-participation and non-presence’* (Scott, 2018, p. 3), which dominated their present-day lives. In those participants’ biographical contexts, *‘nothingness’* did not merely represent inertness, absences and unfulfilled wishes and wants, but symbolised their deepening social exclusion and disidentification with the possibility for recovery.

Faith in God and Spirituality

The faith in God and spirituality were a major source of meaning in life for several participants, most of whom were African-American and Hispanic participants in the NYC sub-sample. Seven participants shared that they held religious or other spiritual beliefs, which, they shared, had fuelled their inner strength, courage and perseverance. Benjamin, for instance, took a photograph of his Bible and later discussed the image at the elicitation interview (See Figure 16):

> ‘*I took a picture of this: it says, 'The Lord is my rock.' You know...It makes it a good day because I always tell everybody, you know. I say: 'Good Morning!' Sometimes they'll say: 'What's good about it?' -'Well God woke you up this morning.' You know...This is when I'm feeling alright-when I'm reading my Bible.’*.



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PSALM 93

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Figure 16. A photo of the Bible obtained by Benjamin

Benjamin also emphasised the importance of practising humility and gratitude every day:

> ‘*Sometimes, people don't appreciate the things that they have, you know...until...they don't have no gratitude. You gotta have gratitude. You have to practice humility-being grateful and thankful.’.*

Furthermore, Matthew recounted an intense and illuminative spiritual experience that had offered him a sense of intimacy and belonging:

> ‘*It gave me...a strong sense of faith. Not hope. Faith. […] It just gave me something I didn't have before. It gave me faith and hope that no matter no happens, when the end comes for me, I'm in God's family […] it spiritually inspired me...in a way that nothing else in this world has done.’*

This metaphysical connection with God seemed to be Matthew's only antidote to the precariousness, fragility and loneliness that consumed his life. Matthew clarified that he had 'faith' but had lost 'hope'. Faith, it seems, refers to this participant's emotional attachment to a metaphysical entity ('*God's family'*), while hope(-lessness)- to his separateness and emotional detachment from the objective world-a world rife with deprivation, humiliation and physical and emotional pain.

For a few participants, therefore, spirituality represented a valuable recovery resource as it seemed to facilitate their perseverance, positive meaning-making and sense of belonging. Spirituality seemed to also enable them to transcend the fear, losses and disappointments in life, and enhance their awareness of the possibility for a better life.

Routes to Wisdom and Personal Growth

Several participants also shared that cultivating their wisdom and personal growth was important for sustaining recovery. Claire shared that her personal mantras were sources of wisdom that helped her overcome the obstacles in her life, including the sense of meaninglessness:

> *'Life's like a bed of roses-it keeps growing so...That's what helps me every day-that wee saying. […] Life grows.'*

This mantra conveyed the belief that no suffering was inevitable and imbued Claire's life with the excitement from the anticipation of a positive outcome. It also appeared to fortify her resilience and perseverance in the face of adversity and uncertainty.

Spending peaceful time on her own also helped Claire gain a sense of comfort and inner peace. She took a photograph of a place that she frequently visited to reflect on her life *('I feel comfortable going there and sitting there.*'; See Figure 17).

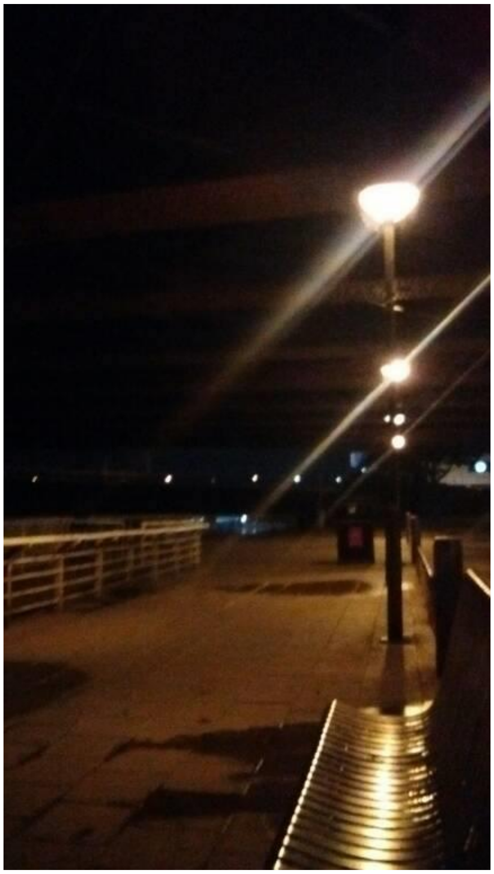

Figure 17. A photograph of a place Claire liked to visit to reflect on her life

A further route to meaning in life and personal growth was some participants' pursuit of voluntary and other occupational activities. For some, engaging in voluntary, including altruistic, and professional occupations seemed to foster their sense of purpose and meaning in life and thus facilitate their recovery. For Benjamin, for instance, becoming a mentor to people struggling with substance use issues seemed to bestow his past suffering and '*mistakes*' with even more meaning:

> *'Because I know there is somebody out there that is making the same mistakes that I did, you know, some little kid (...) making the mistake I did. […] There's somebody out there, you know, who is struggling with the truth within himself, you know...[…]'*

Furthermore, Benjamin explained that pursuing his education and a potential mentoring role would give him a sense of accomplishment and meaningful direction and an opportunity to nurture a positive sense of self.

Altogether, the participants commonly faced dilemmas of meaning, the resolution of which facilitated their recovery. For many of them, the orientation towards spirituality, personal growth and wisdom was an antidote to the existential threats posed by chronic life adversity.

2.4. Feeling '*wanted, accepted and needed'*

Table 16*: Overview of the Subthemes for the Super-ordinate Theme, Feeling 'Wanted, Accepted and Needed'*

a.	Family experiences, vulnerability and deprived socio-emotional needs;
b.	The value of social and emotional connectedness

The final super-ordinate theme, '*feeling wanted, accepted and needed'*, underscores the all-pervasive influence that interpersonal connections had on whether and how the participants' enacted and sustained their recovery (See Table 16).

Family Experiences, Vulnerability and Deprived Socio-emotional Needs

Most participants' life story narratives featured accounts of dysfunctional and/or unstable familial relationships, particularly in early life and before the onset of homelessness. Importantly, those participants tended to explicitly relate those adverse events to their *current* difficulties with envisioning and enacting recovery. Among the reported adverse family-related experiences were care-leaving experiences, tragic losses of family members, family estrangement, substance use in the family and domestic violence. Those events were often discussed as having significantly affected the participants' mental well-being and/or substance use habits, their positive sense of self, social connectedness and the sense of purpose in life.

Biographical continuity patterns connecting significant relational life experiences with participants' current mental well-being and relationship with recovery could be discerned across multiple accounts. The IPA revealed that those early life experiences often served as *structuring organisers* (or *biographisers*; Mader, 1996) of subsequent choices, relationships, identities and emotions. Ashton, for instance, discussed growing up in a dysfunctional and violent family environment:

> *'I was brought up with violence.'.*

The sentence structure, *'I was brought up with…',* followed by the antipode of loving and harmonious family relationships- '*violence*', seems to signal not only this participant's experiences of victimisation but also his deprived needs for love and affection. Those adverse early life experiences seemed to have had long-lasting and life-defining consequences for this participant. His recollections of his first episode of homelessness at a fragile age revealed his vulnerability, loss of innocence and deprived socio-emotional needs:

> '[…] *I'd never been out in the...the big, bad world. So I was scared.'.*

The phrase, '*big, bad world'*, and the confessional, *'scared*', strongly convey Ashton's acute sense of '*unhomelik*e' being-in-the world (Svenaeus, 2000). Those *'unhomelike'* experiences and feelings had been exacerbated and entrenched by his subsequent experiences of violence as a young homeless person involved in the drug scene. Ashton demonstrated a painful awareness of the chronicity of his adversity, which he felt had profoundly impacted not only his emotional and mental well-being but his coherent sense of self:

> *'That leads me to today, that's...what made me turn out the way I did. […] A lot of violence in my life, from when I can remember really...*[…] *it made me scared, it made me a scared person. Do you know what I mean? Fear of violence. Fear of people judging me. Not being good enough. […] And always trying to compensate with things...'.*

Ashton's life story resonates with Mary's account of the instability in early life as a result of her being a care leaver, which had precipitated her homelessness. Mary described entering the shelter system and feeling vulnerable and frightened, and lacking adequate information and social support. Mary reflected on her unfulfilled need to belong, which she had attempted to gratify by trying to *'fit in'* and be *'part of something',* even if that meant joining *'the wrong crowd'*. Mary also vented her frustrations regarding the lack of adequate social and welfare support she had received during those critical life transitions.

Furthermore, in several participants' narratives, the tragic loss of the motherly figure (such as a mother or an elderly sister) had not only marked the onset of family breakdown, housing instability and homelessness, but had also induced an enduring sense of vulnerability and emotional pain. Scott, for instance, shared about his late mother:

> *'She was a very great enabler. […] She was always there to rescue me and erm... […] I was mama's little boy.'*

Scott's mother had been his main source of care and protection. He had felt vulnerable ('*mama's little boy'*) but safe *('She was always there to rescue me.'*). Scott's description of the motherly support (as an *'enabler'*) seems to indicate the fulfilment of fundamental human needs such as safety, warmth and emotional intimacy. Accordingly, the loss of his mother and the ensuing family breakdown seemed to have marked the loss of emotional intimacy and safety for this participant.

Simon also highlighted his adverse family experiences as having had a profound and enduring impact on not only his life path but also his current psychological and emotional well-being. In particular, Simon shared that his *'[l]ack of guidance, lack of love, lack of discipline'* had undermined his abilities to envision and pursue a better life. Simon underscored the importance of having one's emotional needs met (*'love'*, caring, affection), as well as being provided with knowledge, advice, structure and direction ('*guidance*' and '*discipline*'), in order for one to achieve a good life.

Finally, Matthew offered an emotionally intense account of his family dynamics and his unfulfilled social and emotional needs, which had had a profoundly deleterious influence. When asked about the causes of his depression, Matthew responded:

> '[…] *I have no one. There is nothing.* […] *So the thing is that I believe that a lot of it has to do with self-esteem and I think a lot of has to do with feeling wanted, needed and accepted. And if you don't have all three of these ingredients, you really erm...are losing out, you know.'*

Matthew's account evocatively reveals his sense of chronically unmet socio-emotional needs-the needs of being '*wanted, accepted and needed'*. 'Wanted' possibly refers to the affective need to feel cared for and loved. 'Needed' seems to denote the ability to fulfil valued social roles-of a father, of a husband, of a friend, of a son, as well as to be socially recognised as a result of those roles. ‘Accepted’ may refer to the feelings of affirmation and inclusion in a collective. It was deficiencies in those three dimensions of connectedness that Matthew emphasised as impeding his efforts to achieve better well-being and recovery.

Matthew also took several photographs of empty streets (See Figure 18). When asked about the significance of those images, he replied:

> *‘Isolation. Abandonment. Loneliness. […] [I]t's lack of any people at all. You're all by yourself-just me and the camera on the street. Not a car, not a person walking by-all by yourself. Isolation.’*

Figure 18. An image of empty streets generated by Matthew

The negative effects of social isolation on well-being and recovery were also evident in the narratives of Neil, Craig, Ashton, Henry, Mary and Conor.

The Value of Social and Emotional Connectedness

Most participants emphasised the importance of at least one form of social engagement and social support for enacting and sustaining their recovery journeys. Conor, for instance, particularly appreciated taking part in social leisure activities and having regular contact with his case worker as a source of continuous encouragement and social support:

> *'I feel that little bit of support behind me-that does help. […] When I am hearing that-the amount I've* [achieved] *in the four weeks-I am actually proud of myself for that.'*

Furthermore, several participants shared that maintaining regular contact with their siblings and extended family provided an indispensable source of moral and emotional support, which was critical at times of emotional difficulties. Benjamin (See Figure 19), for instance, highlighted the significance of the family for his well-being and recovery:

> '*What's important to me is…my family. […] You know, that's what helps me. […] It helps me get through the day, and I thank God […] I think family is really important to me cause family is unconditional love.'*

Benjamin is an African-American man, who had been a safe haven resident for three years. Benjamin had been without own, permanent place to stay for most of his life ever since his adolescence, when, due to family breakdown, he had found himself homeless for the first time. He had 'messed up' at school. He had grown up without a father and some of his family members had gone 'in and out of jail'. Benjamin also experienced bereavement and family separation, which had turned him to serious substance use and socially deviant activities. During his involvement in the drug scene, his substance use had gotten worse, which had led him to 'lose everything'. He had received substance use support (AA/NA) on multiple occasions throughout his life.

At present, Benjamin had stopped using drugs and was working on his recovery. He 'hustled' for money every day and made great efforts to reach his appointments. He felt safe at the safe haven and had re-established contact with his family, which had had a positive impact on his mental well-being. He was currently awaiting rehousing.

Figure 19. Case summary: Benjamin (55-60 years of age; safe haven client in NYC)

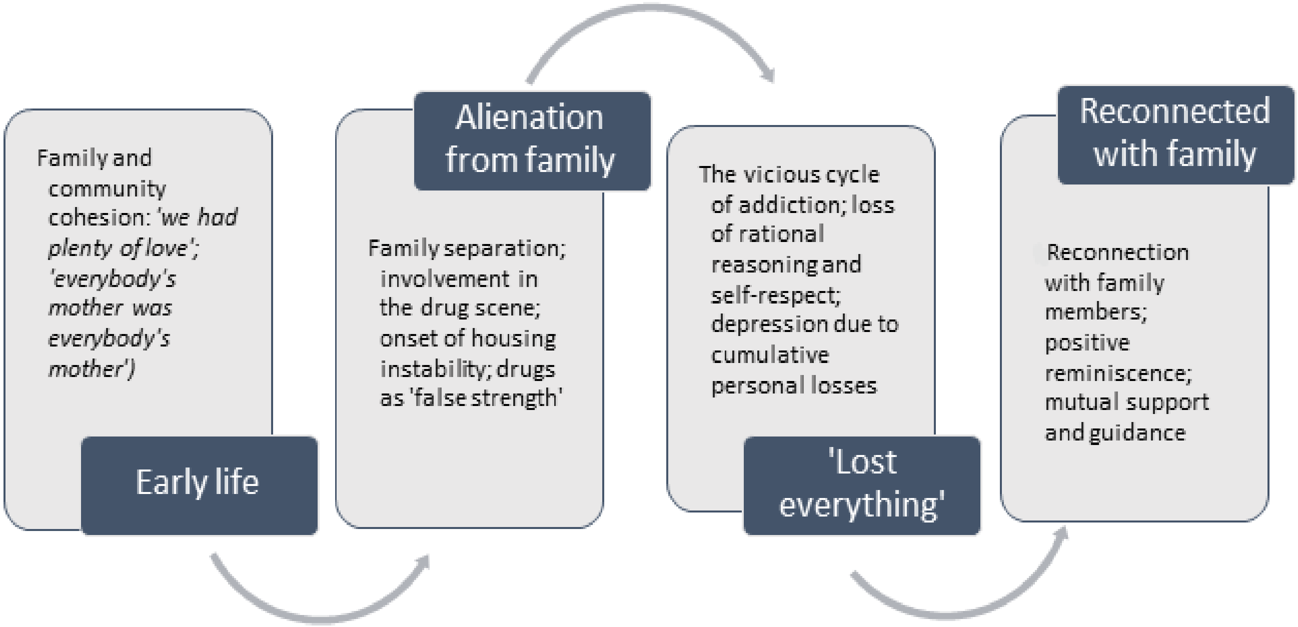

Figure 20. A visualisation of the dynamics of family connectedness in Benjamin's life story

Figure 20 exemplifies the biographical dynamics of Benjamin's social and emotional connectedness with his family, and its importance for his recovery. He discussed having reached a low point in his life when drugs and his addiction had displaced, at least temporarily, the emotional connection he had had with his family. Benjamin reported losing self-respect and alienating himself from his family due to shame and the overpowering influence of the drugs. His needs for intimacy and social support were substituted by the drugs:

> ‘[…] *I put that drug before* *<u>anything</u>. Before* *<u>anything</u> I put that drug. […] This came first. Everything else was secondary. 'This* [the drugs] is my woman. *She ain't gonna argue back at me. She won't be mad at me...'*

Benjamin’s subsequent resolution to break away from his self-defeating lifestyle and engage in abstinence was followed by his reconnection with family members. Benjamin also emphasised the emotional connectedness that the Narcotics Anonymous (NA) support groups had offered him:

> ‘*Even though I was an addict, people showed me love.’*

Benjamin also stressed the importance of maintaining positive daily interactions with friends and acquaintances in the city. This helped him feel supported and encouraged. Figure 21 is a photograph Benjamin took showing the area where he would meet his friends and engage in casual conversations. It seemed that the ordinariness and consistency of those interactions supported Benjamin in his recovery by offering structure and a sense of belonging.

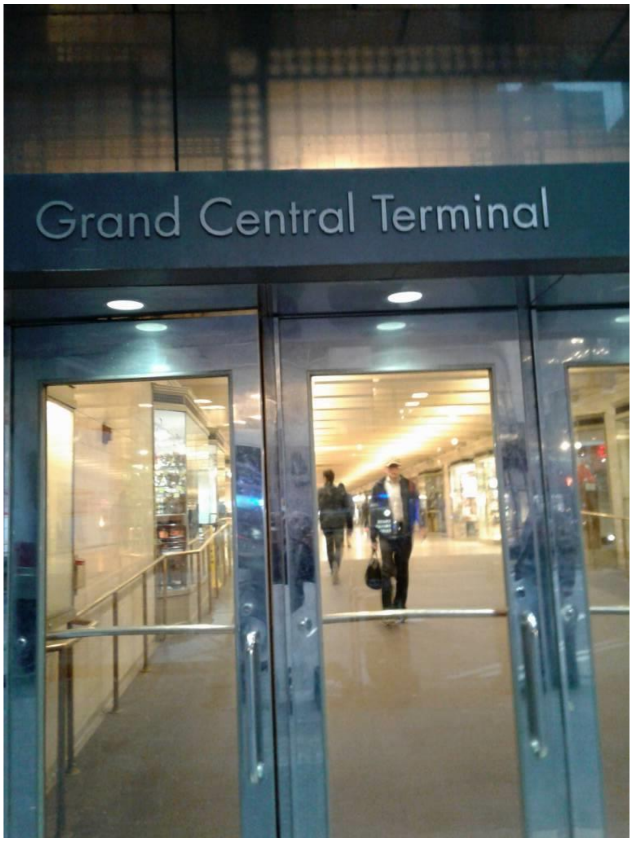

Figure 21. A photograph by Benjamin of a part of the city where he would often meet his friends

In addition, Oliver shared that he often contacted his family and close friends for support at times of personal crises as a source of advice, reassurance and encouragement:

> *'Because, you know, before I called them, I was feeling some type of way. But after talking to them, and they give me a few brownie points, I feel a lot better. […] I give them some kind of feedback on how I feel about it. And they just let me know, you know, to have something to think about, you know, before I jump outta window.'.*

For at least four participants, however, social connectedness and intimate relationships, in particular, seemed to carry a more ambiguous significance. Kelly, for instance, who shared she had experienced negative encounters and relationships, including within her own family, emphasised the importance of '*not trusting'* in people and avoiding interpersonal confrontations and toxic relationships. Similarly, George, who had discussed the negative influence his peer circle had had on his addiction and his life, shared that he wanted to be '*left alone'* and that he stayed away from new acquaintances and relationships.

To summarise, feeling '*wanted, accepted and needed*' refers to the participants' expressed human need for emotional and social connectedness. They discussed multiple routes to being '*wanted, accepted and needed*'-including reconnecting with family members and significant others, performing valued occupations and other social roles, reconnecting with cultural and spiritual values and patterns of meaning, and others. Beyond *social connectedness*, which can be defined as the availability of valued social relationships and attachments, participants seemed to place emphasis on *emotional connectedness*, which meant *'an enduring and ubiquitous experience of the self in relation with the world'* (Townsend & McWhirter, 2005, p. 193, citing Lee & Robbins, 2000, p. 484).

Summary of Super-Ordinate Themes (2.1)- (2.4): Enacting and Sustaining Mental Health Recovery

The participants' accounts of their day-to-day negotiations of the '*trials and tribulations'* of shelter living were imbued with intense reflections on their life adversity and its impact on their sense of self, on their (inherent) human vulnerability, as well as on the precarious path to re-establishing meaningful roles and identities. Their painful awareness of the far-reaching effects of chronic life adversity seemed to be both emotionally harmful *and* cathartic. The current analysis illuminates the numerous contingencies associated with several fundamental recovery-promoting processes: (a) mastering positive coping strategies and unlearning ‘*self-defeating’* coping responses; (b) ‘salvaging’ a strong and positive self-identity; (c) negotiating feasible and meaningful involvement in the lives of others; and (d) rekindling and preserving hope amidst the volatile, precarious and uncertain ‘atmospheres’ of temporary housing.

Cross-Country Comparison of the IPA Findings

While the cross-country comparison between the data from the American and the Scottish participants was not a primary goal of the current study, the analysis of any divergences between the findings obtained in those two settings offers potentially useful insights into the contextual variation of the recovery process. Overall, all super-ordinate themes were strongly supported by the participants’ narratives across sites in both countries. The consistency of themes across such markedly different geo-spatial settings corroborates the findings about their centrality in the recovery process. At the same time, however, several country-specific nuances and variations in some of the main themes are worth discussing.

To begin with, while participants in both countries emphasised the role that the ***unstable and/or dysfunctional family environment*** had had on their life paths, sense of self and opportunities for recovery, they seemed to differ in their discussions of the wider structural contexts and causes of such family dynamics. With the exception of Mary, who believed there had been inadequate support for care leavers like herself, the majority of Scottish participants discussed their family hardship in a rather individualistic manner. For instance, those participants pointed out the roles of substance use in the family, domestic violence, family separation and care-leaving experience as adverse factors that had impacted on them. In contrast, the discourses surrounding family dynamics offered by the U.S. participants had stronger links to a range of socio-structural factors that they believed had contributed to their family breakdown. Specifically, several U.S. participants talked about adverse socio-economic and socio-cultural conditions such as the failing economy, community violence, including gun and gang violence, the phenomenon of fatherless families, the widespread use of drugs and other societal factors that they believed had eroded the stability of the family unit in their communities.

Benjamin, an African-American man, for instance, discussed how the 'government' and its policies had led to the erosion of young people's (particularly men's) self-esteem and '*made them' 'run astray'*. This, in turn, Benjamin believed, had undermined familial and community cohesion. Indeed, his biographical narrative contained an account of his father leaving the family, which had had a profound impact on Benjamin's life.

Benjamin also discussed race relations and the many '*stumbling blocks'* that African-Americans had to overcome in order to achieve the *'American dream'*:

> *'He* [the African-American person] *doesn't achieve the goal that everybody else does. It's more difficult. Whatever we do, we gotta work extra hard than everybody else ((bangs on table)) […] All this stumbling, stumbling, stumbling, stumbling, you know. Sometimes, you know, things happen, though, that's out of anybody's control…'*

He then discussed how prison, crime, poverty, and other adverse factors had led to alienation in his family, which, in turn, had increased his vulnerability to PSU, homelessness and mental illness. Notably, race relations were only explicitly discussed in Benjamin's account.

Two other American participants' accounts, Oliver's and Kelly's, contained references to the endemic drug use in their poverty-stricken communities (e.g. the Project). Both participants discussed having been exposed to death and violence from a young age and having had to '*grow up quickly*' (Kelly) to take on family responsibilities. For Kelly, an African-American woman in her late 30s, growing up in an extremely hostile community environment had led to her not having '*time for herself*' and to family conflict and alienation.

The themes of ***abject poverty*** and ***financial struggles*** were more prominent among the American than the Scottish participants. Specifically, the American participants offered more detailed accounts of the pressures-practical and psychological-of relying on food stamps and/or having to engage in small daily jobs in the community to earn extra cash ('hustling'). This could be traced down to the more generous welfare regime in Scotland, as well as the more pronounced ethnicity-related health and social disparities in the U.S. (Shinn, 2007; Fitzpatrick & Christian, 2006).

A further cross-country divergence relates to the participants' espoused ***culturally-specific conception of 'the good life'***. Several of the U.S. participants discussed their desires and perceived failures in life with reference to ***the 'American dream'***. For instance, George reflected that although he had been 'successful' in providing for himself by engaging in socially devious activities and avoiding legal punishment, he perceived himself as having 'failed' to reach the 'American dream', which he exemplified as being in legal employment and paying taxes for a year. The cultural trope of the American dream was associated with the notion of good citizenship and productivity. Importantly, it was this ideal of productivity and citizenship that incentivised George to overcome his current homelessness and retain his future permanent housing.

In addition, several other U.S. participants emphasised the importance of '*making it'*, of achieving a socially recognised status of success and accomplishment. This seemed to provide those participants with impetus for action, as well as with self-belief and self-reliance. In contrast, the Scottish participants' conceptions of the 'good life' seemed to revolve around achieving occupational success, reconnecting with family members and learning the life skills to become independent.

Furthermore, ethnic differences were also observed in the sample with regards to the resources (internal and external) the participants highlighted as instrumental for ***achieving meaning and purpose in life***. While the African-American and the Hispanic (all in the U.S.) participants tended to emphasise the importance of ***religiosity and faith*** and ***cultural values and morals*** for achieving recovery, the majority of the Scottish sample were more likely to discuss ***reconnecting with and providing for their families***, and ***engaging in volunteer work*** as sources of meaning and purpose in life.

A number of themes related to the participants' community and social contexts were more pronounced in the Scottish sample. For instance, the experiences of ***activity poverty and boredom*** were much more prevalent and intense among the Scottish participants. Several socio-structural factors could possibly account for this observed difference, apart from the lack of financial resources. Those include ***the paucity of community resources***, which was highlighted by a couple of Scottish participants, and the ***single-room structure*** of the Scottish shelters, which seemed to predispose those participants to loneliness and isolation.

In contrast, several of the U.S. participants occupied dorm-style accommodation, which, despite impeding those participants' privacy, autonomy and well-being, did seem to provide (oftentimes unwittingly) more opportunities for ***social interactions***. In addition, several of the U.S. participants explained they had to go out and 'hustle' on a daily basis by completing small jobs in their community in order to provide for themselves. While those participants did struggle severely financially, those jobs allowed for more social interactions.

Altogether, although the themes about the core enablers and hinderers of recovery were shared by the majority of participants across the two countries, several apparent contrasts between the two countries were found in the emphases on particular economic and interpersonal (family- and community-based) structures and circumstances that seemed implicated in recovery.

Participants’ Reflections on the Study

During the later phases of the study, each participant was asked about their experience with, and perceptions of, the interview encounter and their study participation overall. Their feedback demonstrates the potentially cathartic and empowering impact of study participation. Conor, for instance, appreciated the opportunity to discuss his personal experiences in a therapeutic-like, supportive environment:

> *‘I actually think that pure weight has been lifted off me. Sometimes I feel that I had just left it build all up and when I do talk about it, sometimes I do feel I'm glad that I had that wee chat sorta thing.’.*

This participant also described the interviews as ‘helpful’ and ‘comfortable’.

Another participant, Kelly, shared she was surprised by how much she had allowed herself to talk in the course of the interviews. Furthermore, Matthew shared that he had established ‘trust’ with the Researcher, which made for a pleasant, helpful and even cathartic interview encounter:

> *‘I want everyone to know that erm...it has been such a wonderful experience talking to you. Like you've happened to erm...gained my trust […] It has been a pleasure. […] I think you've been very helpful in erm...not only what you're trying to investigate and research but, you know, you have actually erm...opened my mind erm...and more than likely have improved my life. […] I really think if I had money, I'd pay you for this.’*

Matthew also appreciated the self-knowledge that he had gained by participating in the study. He also shared his positive experience with the mobile phone diary, particular the voice-recording option:

> '[…] *it gave me a way to vent my erm...disappointment, frustrations and most incredibly, my fear.'*

Lastly, Benjamin discussed how participation in the mobile phone diary phase had been a deeply introspective experience for him. In particular, it had helped him develop self-awareness about his accomplishments and awareness of his sources of gratitude:

> '[…] *that helped me bring my awareness up somewhat. It really did, you know. It made me pay attention more to what I was doing and where I was at* […].'

All nine participants that engaged with the mobile phone diary reported positive experiences with this data collection tool. Those participants described the mobile phone diary as 'fun', 'interesting', 'helpful', 'alright', 'modern', 'up-to-date', enjoyable, 'cool', 'great', and even 'exciting' and 'enriching'.

Summary of the Findings from the IPA Phase

The IPA generated rich and nuanced insights into the participants' lived experience of mental well-being and recovery in the context of homelessness. The findings combine biographical depth (i.e. embeddedness in the participants' life stories) with ethnographic understanding (insofar as the mobile phone diary offered a unique perspective into nine participants' daily lives and routine activities). Ultimately, the analysis discerned the complexities of the participants' relationship with recovery, as well as the processual nature and the enablers and hinderers of envisioning and enacting recovery.

The majority of participants described their lives ‘before’ as a chronic state of ‘unhomelikeness’, which had been associated with short-termism, existential disorientation, lack of progress and inertia, and ‘self-defeating’ behaviours such as substance use, social isolation and engaging with the ‘wrong crowd’. According to most participants, the experience of chronic homelessness represented a multi-pronged assault on their capacities to engage in recovery. In many cases, the legacies of adverse, including traumatic, life events and living conditions had had an enduringly deleterious impact on their sense of security and constancy, sense of self, meaningful coherence in life and social and emotional connectedness with others. For virtually all participants, the admission into their current temporary accommodation represented a critical turning point in that it connected them with valuable recovery-promoting resources such as professional support, including case management, and safe housing. Simultaneously, however, the volatile and hostile social environment of the shelter, the susceptibility to boredom, the lack of adequate and responsive professional support and financial constraints often posed significant barriers to recovery.

The analysis indicates that having security, safety and a sense of constancy in life was a precondition for engaging in sustained rational, contemplative and imaginative practices that helped some participants meaningfully re-construct and accept their past, enhance their mindfulness of the present and clarify their values, priorities and aspirations for the future. Those activities involved not only reacting to the contingencies of homelessness, SMI and/or PSU but also towards cultivating self-transcendence, personal growth and recovery. Achieving insight, which manifested itself in self-knowledge, self-acceptance and the clarification of personal priorities, was also perceived as vital for initiating recovery. Insight was commonly experienced as a *‘wake-up call’* and as ‘*finding*’ oneself, which were cathartic and potentially transformative processes.

A related yet distinct cluster of processes seemed to aid participants in *enacting* and *sustaining* their emerging recovery projects. To the participants, enacting and sustaining recovery were contingent upon: (a) the provision of formal support for coping with the symptoms of mental illness; (b) engaging in occupational activities and valued social relationships in order to restore one's positive sense of self; (c) restoring meaning and purpose in life; and (d) feeling '*wanted, accepted and needed'*.

Chapter Seven

Findings from the Critical Realist Analysis

Logic of the Chapter

This chapter presents the findings from the second analytic phase-the critical realist analysis. This mode of analysis aimed to generate explanatory understanding of the socio-structural conditions and contexts that were implicated in participants' personal recovery, and of how participants navigated and negotiated those conditions and contexts to enable better well-being and recovery. Archer's morphogenetic model and theorising about personal reflexivity were used as a theoretical framework to help discern (or *retroduce*) the interplay between social structures, social relations and individual agency and its effects on recovery outcomes. An additional theoretical resource was Emirbayer and Mische's (1998) conceptualisation of human agency as a temporally embedded phenomenon composed of three orientations-*iteration, practical evaluation* and *projectivity.* As a result, a multi-level (or 'laminated') explanation of personal recovery in the context of chronic homelessness was generated.

Applying the Morphogenetic Model to Explain Personal Recovery in the Context of Chronic Homelessness

The preceding chapter presented the findings from the IPA pertaining to how the participants conceptualised and made sense of recovery (RQ1), and what their perceived facilitators and hinderers of recovery were (RQ2). This inductive, phenomenological layer of analysis was concerned with the participants' lived experience and sense-making. While informative about participants' lived realities, the findings from the inductive IPA phase alone are insufficient for *explaining* how social structures interacted with participants' personal agency to affect recovery. As explained in '*Chapter Four*', constructing a causal explanation of social phenomena requires going 'beyond' the level of the observed and self-reported (the level of 'the empirical') by mobilising theoretical perspectives that can help identify (or *retroduce*) the abstract, 'invisible' causal entities (i.e. social structures and human agency) at the levels of the 'actual' and the 'real' that ultimately generated the outcomes of interest (Bhaskar, 1989; Danermark et al., 2005; Fleetwood, 2014). Such explanatory theorising is concerned with temporal patterns and sequences (Pentland, 1999; Wynn & Williams, 2012).

The critical realist, abductive-retroductive analysis (Danermark et al., 2005) aimed to address the following research questions:

- What socio-structural conditions and contexts are implicated in participants' personal recovery, and how? (RQ3); and
- How do participants navigate and negotiate those socio-structural conditions and contexts to enable better well-being and recovery? (RQ4).

To satisfactorily answer those questions, an explanation of personal recovery in the context of chronic homelessness was generated that integrates structural, relational and agential influences. Guided by the morphogenetic model, the next few sections will account for the following components of the critical realist explanation of personal recovery (Archer, 1995; 2003; See Figure 22):

T1: *Structural and cultural conditioning*: This section articulates the structural and cultural conditioning contexts that enabled or constrained participants' individual agency in relation to recovery. Two such types of influences are discussed: conditioning that apparently provided participants with *directional guidance*, and conditioning that apparently affected participants' *degrees of interpretative freedom* (See '*The Morphogenetic Model*' in '*Chapter Four*'; Archer, 1995).

T2-T3: *Socio-cultural interaction*: This section accounts for the activation of participants' personal agency in response to the structural/cultural enablements and constraints and influenced by the social relations within which participants were embedded. Specific consideration is given to whether and how participants *discerned*, *deliberated upon* and *dedicated* themselves to their recovery projects (Archer, 2003; 2007). As a result of this structure-agency interplay, participants' recovery capacities are either enhanced or impeded (at T4; See Figure 22). As can be seen in Figure 22, the present study elaborates on the classic morphogenetic model by delineating social relations at T2-T3 as an entity distinct from the conditioning context (See '*Critique and Limitations of Critical Realism*' in '*Chapter Four'*). This means that, according to this elaborated model, social relations exert a more immediate and contemporaneous effect on the internal conversation than conditioning structures/cultures, and thus mediate the effects of those structures/cultures.

The analysis of the T1-stage primarily addresses RQ3: '*What socio-structural conditions and contexts are implicated in participants' personal recovery, and how?'.* The analysis of the T2-T3-stage primarily addresses RQ4: '*How do participants navigate and negotiate those socio-structural conditions and contexts to enable better well-being and recovery?'*.

To maximise the explanatory utility of the analysis and consistent with the theoretical pluralism associated with critical realism (Fleetwood, 2014), additional theoretical concepts were employed pragmatically as an ancillary theoretical resource. Those include capabilities, affect, stigma, Emirbayer and Mische's (1998) agency modes, and several others. This allowed for the identification (or retroduction) of a wider set of plausible causal entities and mechanisms (Danermark et al., 2005; Edwards et al., 2014).

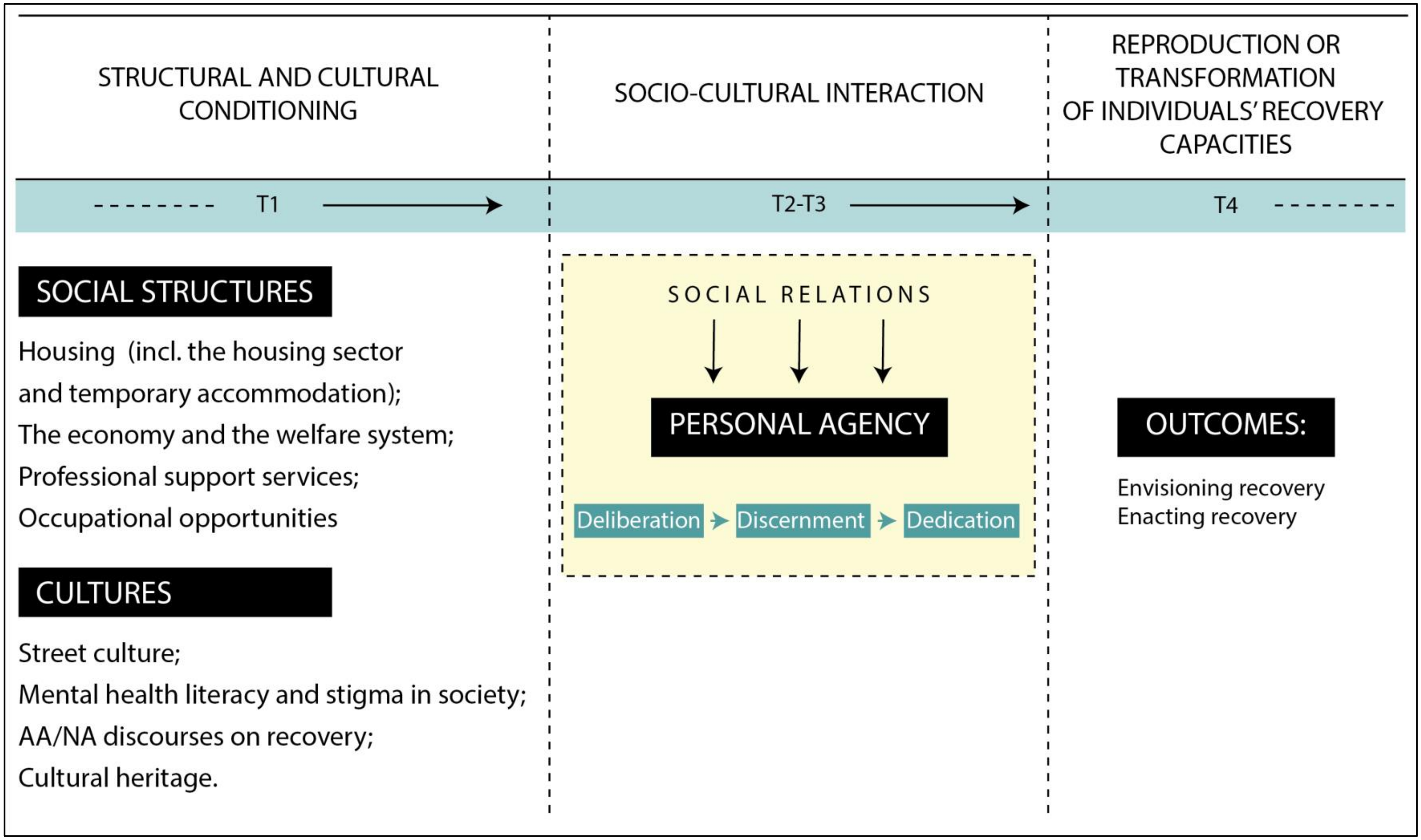

Figure 22. The morphogenetic model as applied to the participants' capacities for recovery (Adapted from Archer, 1995)

(Note. T1-T4 denote the temporal separatedness of the various influences upon recovery-a key premise of the model)

What Socio-Structural Conditions and Contexts are Implicated in Participants' Personal Recovery, and How? (RQ3)

Structural and Cultural Conditioning (T1)

The abductive-retroductive analysis identified a range of structural and cultural entities that apparently exerted a conditioning influence upon the participants' recovery capacities. Those entities seemed to exert their effects primarily by restricting the means available for participants to envision and enact their recovery projects (*directional guidance*), as well as by modulating the scope of personal projects that the participants perceived as feasible and/or desirable (*degrees of interpretative freedom*; Archer, 1995). Two types of conditioning are considered: *structural conditioning* (i.e. material constraints and enablements) and *cultural conditioning* (ideational constraints and enablements; See Figure 22). The life story interview approach allowed for those shaping influences to be traced at various points in the participants' lives.

Structural Conditioning

The structural conditioning entities identified in the abductive-retroductive analysis are listed in Figure 22 and include: ***(1) housing (incl. housing instability, the housing sector and temporary accommodation); (2) the economy; (3) the welfare system; (4) professional support services; and (5) occupational opportunities.*** The shaping effects of those social structures on participants' recovery are detailed below. Participants' verbatim quotes are used to contextualise and concretise the entities and mechanisms under discussion.

Housing-its availability, stability, quality and fairness-seemed to have exerted a long-term (incremental) conditioning influence upon the material and psychosocial resources that the participants had had at their disposal to support their positive well-being and recovery. Indeed, the participants' time spent homeless in lifetime ranged from 2-30 years, with approximately half of them having had their first episode of homelessness before the age of 20 (See Table 1 in '*Chapter Five*'). This indicates a common pattern of chronic housing instability and suggests the enduring and often adverse effects of the structural conditioning of housing policies and provision.

Collectively, the participants' life story narratives seem to indicate the interruption of flows of social, material, psychological, identity and cultural forms of capital as a result of housing instability and homelessness (Scambler, 2001). The interactions between those capital restrictions seemed to have impeded participants' capacities to recover in diverse ways. For instance, Neil's, Claire's and Craig's long-term lack of own stable housing and stays in the shelter system had precluded them from effectively managing their mental health problems (psychological capital) and maintaining family ties (social capital), which, in turn, had impinged upon their positive sense of self (identity capital). The simultaneous impingement upon those various forms of capital had hindered those participants' capacities for recovery (such as insight, positive coping, a positive identity and feeling '*wanted, accepted and needed*').

For all those participants, the chronic lack of adequate housing had also impeded opportunities to exert control over their social and physical environment. Those capability deprivations had been exacerbated by structural and organisational deficiencies in the housing sector, which could be traced in the narratives of both the American and the Scottish participants. Those included the shortage of appropriate permanent housing options, which, for many participants, had meant extended periods of time of occupying the transitional and precarious space of the homeless shelter. This, in many cases, had been accompanied by frustrations at the inefficiency of the housing services, as well as anguish and desperation. Moreover, the rigid and dehumanising rules and regulations within the housing sector, as well as the (perceived) lack of transparency in the rehousing policies, had often impeded participants' access to the resources necessary to sustain valued personal and social identities, meaningful coherence in life and social and emotional connectedness. Examples of such disabling and disempowering procedures and policies were the inadequate availability of appropriate housing options and the cumbersome and uncertain housing application process.

Ultimately, those deleterious socio-structural conditions had manifested themselves via ideational constraints on those participants' capabilities to '*think, imagine, perceive'* (Nicholls, 2010, p. 33) an alternative life-a life in stable housing and in recovery. In other words, chronic housing instability hindered participants' capacities for contemplating, envisioning and planning recovery:

> '[…] *it's still an ongoing cycle'* (Mary);
>
> '*There's no way out of this for me.*' (Matthew).

The participants' *current temporary accommodation* (e.g. the safe haven) was an ambivalent conditioning context in that it was associated with both limitations and potentialities in relation to participants' recovery. In many cases, the temporary accommodation offered the physical preconditions for developing the sense of safety, security and constancy, which, in turn, offered the psychological preconditions for the participants to authentically reflect on their lives and on their '*constellation of concerns'* (Archer, 2000). Furthermore, the current temporary accommodation had provided participants with a routine and structure, which positively shaped several participants' efforts to cope with their SMI. In addition, and crucially, temporary accommodation had connected participants with valued professional support services, as well as with recreational and other social opportunities (such as communal gardening, community football, outdoor trips, arts and crafts and others). As such, in many cases, temporary housing had offered resources that expanded participants' capabilities for reason and reflection, control over the environment and leisure and affiliation (Nicholls, 2010). All of those enablements appeared to facilitate their recovery.

In other cases, however, aspects of the temporary housing were shown to exert a negative conditioning influence on recovery. To demonstrate, it exposed a number of participants to an unpredictable, precarious and, at times, threatening and violent environment, which impeded those participants' sense of 'homelikeness', meaningful coherence and positive mental well-being. The shelter could also reinforce the recovery-impeding effects of institutional uncertainty and complexity (e.g. *'I am kinda stuck right here in this kinda...'don't know what's gonna happen.'* (Craig).

The welfare sector and *the economy* were two other interacting macro-structural contexts that had impinged upon several participants' capacities for recovery. Several participants (both in Scotland and the U.S.) shared that they had permanent or other physical disabilities, which prevented them from engaging in paid employment and thus made them vitally dependent on welfare support. Several participants, particularly the American participants, shared that they found the welfare system to be inadequate, unfair and demeaning. The meagre financial support (e.g. food stamps) available to those participants who were unemployed and/or disabled hindered not only those participants' physical survival but also their dignity and hope. For Matthew, for example, his severe poverty impeded not only his control over his daily life but more profoundly his ability to establish a sense of meaningful direction:

> '*I have no income. I'm living on $17 every two weeks. $17 every two weeks. It's impossible. It's totally impossible. I'm in trouble* […] *It's pathetic and it's sad. It's frustrating. It's [stutters] almost...it's depressing* […]' (Matthew)

He also believed the employment prospects for people like himself were extremely limited and often ill-suited for individuals with pre-existing conditions and those living in extreme deprivation, which was unjust, perpetuated their disadvantage and was indicative of an ideology of paternalism and responsibilisation:

> ‘*There's no way out of this for most of us homeless people, you know*. […] *They're denying us the opportunity to succeed and to be self-sufficient in our lives*. […] *Because there are fewer jobs available*. […] *And then you have society saying: ‘’Ah...'F' them! 'F' them! They're lazy. They don't wanna do anything*.’’. […] *So you're stuck. It sucks! Sometimes, I just wanna like give up*.’

In some instances, the welfare provision seemed to exert a more subtle conditioning influence. To demonstrate, while Benjamin did not explicitly single out poverty or the inadequate welfare provision as a significant factor in his recovery, and even showed gratitude for the amount he received *(‘I only get $45 a month from the State. So that’s a blessing.’*), the inadequate welfare provision seemed to nonetheless inhibit Benjamin’s recovery. Benjamin’s mobile phone diary entries revealed that the insufficient State support he had been receiving had forced him to go out and ‘*hustle’* daily for cash in the city. This placed considerable demands on Benjamin’s time and physical stamina, which often made it difficult for him to attend all of his appointments and fully engage in his recovery:

> *‘I’m just going out ((sound of his cane hitting the pavement))…making the way to have (?) money. I mean, that helps…a lot. You know, without money, you can’t do a lot of things […] I don't have a whole lot of money and all that stuff.’* (Benjamin)

Macro-economic processes, particularly the Great Recession (2007-2009), and the concomitant unemployment and financial instability, also appeared to exert an enduring conditioning effect on recovery. A handful of participants vividly described the pervasive influence losing their job as a result of the recession had had on both their mental well-being and housing stability. Those participants also discussed how their internalised negative sense of self had impeded their confidence in pursuing employment and socially distanced them from others-ultimately hindering their recovery. Susan, for instance, discussed how her self-concept had been shaped by those events:

> '*Self-doubt starts creeping up.* […] *I'm still kinda living that right at this minute. I don't have any self-esteem anymore.*' (Susan).

Unemployment had constrained Susan's capacities to exercise her individual agency by restricting the resources (such as financial independence and social status) necessary for, among other things, the maintenance of a positive self-identity. On an experiential level, those adverse macro-economic events had manifested themselves in Susan's self-blame, sense of vulnerability and precarity, diminishing self-efficacy and emerging depressive symptoms.

Similarly, Craig discussed losing his business to the recession, which had been followed by his increased self-doubt and poor mental health:

> *'It (my business) was great up until the point when the recession hit. Basically, affected the general public and affected me quite a lot cause a lot of […] I started losing customers and I had started to worry (...) […] that kinda hit me...'* (Craig)

The recession, therefore, seemed to have limited Craig's access to valuable resources such as money, reputation, social contacts, social recognition and other forms of material, social and identity capital. Interestingly, Craig later contradicted himself and made the rather ambiguous statement:

> '[…] *it* [the recession] *never affected myself but looking at it from that point of view....I started feeling down about myself* […]' (Craig)

Despite those seemingly inconsistent statements by this participant, his life story narrative in its entirety seemed to indicate the pervasively negative conditioning effects of the recession and unemployment on his mental well-being and access to recovery-promoting assets, tangible and intangible.

In addition, as vividly demonstrated in the IPA findings*, professional support services* were another major conditioning influences on participants' recovery. The resources, including medication and psychoeducation, offered by the support services at the shelter and beyond seemed to expand participants' range of recovery capabilities-such as the capabilities for reasoning, introspection, decision-making, which, in turn, aided their symptom management and recovery (Nussbaum, 2011). Among the key contextual preconditions for those enabling effects of professional support were the degree of trust in the provider, the accessibility of the provider, the good coordination between different types of support (e.g. substance use and mental health support), as well as the provider's honesty, credibility, genuineness and constructive feedback. The potentially iatrogenic effects of professional support-such as inappropriate counselling and the side effects of SU and mental health treatment-were also evident in several participants' accounts.

Lastly*, occupational opportunities* refer to participants' opportunities to engage in recreational and social activities, and to the potentially therapeutic and empowering effects of employment. As a conditioning influence, occupation could be conceptualised as an affordance of the organisational (e.g. shelter) environment and of the wider socio-political (e.g. city council or state) environment. An affordance describes an environmental attribute that offers valued activities and functions to the individual (Fayard & Weeks, 2014). The participants' narratives indicated that they placed great emphasis on performing social, leisure and professional daily activities as a source of mental health, social and existential support (See 'IPA Findings'). Various socio-material attributes of those affordances seemed to have a significant conditioning influence on participants' recovery. Those include gardening facilities, social meeting spaces, exploratory and relaxing organised activities (e.g. day trips, design activities, community football), volunteering opportunities, and others. Those various occupations conditioned participants' capacities to engage in recovery by affording resources for respite and relaxation, SMI and SU management, reflection, focus, aesthetic pleasure, social interactions, physical activity, skill- and self-esteem building, and others.

Cultural Conditioning

The abductive-retroductive analysis traced cultural conditioning effects to the (1) ***mental health literacy and stigma in society***; (2) ***street culture***; (3) ***AA/NA discourses on recovery***; and (4) ***cultural heritage*** (See Figure 22). Those cultural entities seemed to have exerted their effects via ideational constraints and enablements such as rules, traditions, schemas and discourses.

*The lack of mental health literacy in society***,** including the *stigmatisation* of mental health difficulties by family members and others, especially in the 70s and 80s, had shaped several participants' knowledge of, and relationship with, their mental illness and their opportunities for recovery. Those participants recounted how family stigma (for example, blaming and distancing) and the lack of awareness in society about mental illness had, in part, led to their mental health struggles being misattributed to learning difficulties, personality deviations and substance use. This cultural context had constrained those participants' opportunities for both insight into their illness and the prompt seeking of professional help. As a result, some participants shared they had had to resort to alternative and often maladaptive coping strategies such as substance use and self-isolation. In other words, therefore, stigma and the lack of mental health literacy had affected those participants' capacities for recovery by both influencing their interpretation of their mental health struggles *and* by restricting the resources (e.g. professional support) available for initiating treatment.

Although mental health stigma was explicitly mentioned by only one participant, its enduring conditioning effects on recovery were retroduced from several participants' accounts. As highlighted in the super-ordinate theme, '*Achieving Insight'* (See '*Chapter Six'*), several participants shared they had experienced negative family and societal attitudes towards their emerging mental illness symptoms in childhood and early adolescence. In some cases, their illness symptoms had been dismissed as illegitimate:

> '[…] *when I was younger, I couldn't talk to anybody about that. It was just like: 'Pull yourself together! Get on with it!'*' (Neil)

It, therefore, appears that those closest to Neil commonly failed to acknowledge his struggles as a distinct and serious mental health problem. This process of *normalisation* of mental illness could have been one conditioning mechanism implicated in some participants' late help-seeking, negative self-concept and social alienation.

Pathologisation may have been another mechanism via which stigma had conditioned participants' recovery. In this case, mental illness is attributed to personality deviations, faults or immorality (Scambler, 2009; Young, 1990). Pathologisation was retroduced from several participants' accounts:

> *'They think you are weak […] I just feel like nobody takes you really seriously because they think you're a wee bit...ten pence short of the pound really…'* (Mary);
>
> *'When I was a teenager, people didn't look up to me and said: 'He's got depression.' They'd look at me and say: 'He is a bad lad and is out of order. Send him to prison.' That's what it was like.'* (Neil);
>
> *'People have always thought I've been nuts all my life* […]' (Simon);
>
> '*They just blamed it all on drugs* […] (Scott).

Those *misattributions* and *misinformation about mental illness* had possibly contributed to those participants' stereotyping, distancing from family and mainstream society, lack of disclosure (e.g. *'You'd sort of hide it, pretend that everything was fine.'* (Neil), lack of insight and self-acceptance, and self-blame (See the *'Strategies of and Barriers to Effective Coping with SMI'* section in '*Chapter Six*').

The participants seemed to agree that, nowadays, mental health literacy in society had significantly improved, which provided enabling conditioning effects on their disclosure, help-seeking, coping and self-concept:

> *'It's gonna make them feel a lot more comfortable. I do, anyway. I feel a lot better about it. Now you are getting the proper help, someone that understands what you are going through.'* (Neil)

Street culture was identified as another pervasive conditioning context that had likely affected participants' subjective perceptions of the possibilities for an alternative, better life, as well as the socio-material resources they could utilise to attain recovery. Street culture is a contested term (Ilan, 2015). In the current analysis, street culture broadly refers to a web of prolonged exposures and modes of interaction-specifically- (a) participants' prolonged (voluntary or involuntary) time spent on the streets; (b) involvement in the street economy-including illicit and socially deviant activities; and (c) exposure to the multiple threats of street life such as violence, incarceration, addiction and stigmatisation (Lankenau et al., 2005; Fitzpatrick et al., 2013). Street culture seems to be a rather ambivalent conditioning context in that it appeared to have availed participants both certain opportunities and freedoms *and* certain limitations in relation to their well-being and autonomy.

Rather than a defiant opposition to mainstream culture (Ilan, 2015), participation in street culture seemed to have mainly served as an attempt to meet basic psychosocial needs such as the need to survive, belong, be accepted and cared for (See '*Feeling 'wanted, accepted and needed'* in '*Chapter Six'*). Indeed, several participants discussed street life having afforded them opportunities to '*fit in*' (Mary), feel empowered (Benjamin) and be respected (George).

To fully account for street culture as a conditioning context, consideration should be given to the wider socio-economic and socio-cultural context which had shaped those alternative cultures. Participants' entrance into street culture had been conditioned at an earlier time (pre-T1) by a range of structural and relational factors and other life events *beyond homelessness* such as 'the wrong mob', unemployment, area deprivation, criminal history and barriers to entering education (Craig); foster care and care leaver experience and substance use and violence in the family (Mary); gang violence and family neglect (Conor); lack of parental guidance (Ashton); family separation and the drugs epidemic (Ashton and Simon), and others.

Once confronted with the threats and challenges of street life, those participants had engaged in social relationships afforded by street culture and had exercised their personal agency to convert the available street capital into street competencies necessary for self-preservation, and, in the cases of Scott and George, for example, into dividends in terms of power, social influence and financial gain.

While participation in street culture had generated certain enablements (e.g. financial independence, autonomy, expanded social circle), in the long-term, it had also amounted to significant constraints. Specifically, for several participants, the long-term participation in street culture seemed to have constrained their capacity to imagine alternative life projects other than street life. In other words, participation in street culture had limited several participants' *interpretative freedom* (Archer, 2007), which, even after giving up street culture, had constrained their agency to envision and pursue personal recovery.

From George's, Simon's and Benjamin's narratives, for instance, it could be retroduced how street culture had shaped those participants' life preferences and perceived scope for action in various ways. Scott, for instance, criticised himself and his peers for having been driven by short-term gratification, which, Scott believed, had been self-defeating and exacerbated their social exclusion, housing instability and, for some, their addiction. The culture of street life, it seems, had shaped his beliefs and values, together with the '*projects to be conceived, entertained and sustained'* (Archer, 2007, p. 200). Scott contrasted his past lifestyle with his current efforts to pursue recovery-relevant goals. He discussed his increased reflexive competencies ('*I have some small goals that I wanna achieve* […]') as a result of the enablements of his safe temporary housing and accessible professional support.

Another participant, Simon, demonstrated a painful awareness of the deleterious impact of street culture on *'moving forward'* in life. His narrative of his participation in street culture reveals a culture of inertia, false hopes and goals, and a lack of purpose and direction ('*on a mission to get nowhere'*). He also emphasised that such a life had considerably impaired his life chance and opportunities. It had also entrenched his 'otherness' and exclusion from mainstream society. From his account, it could be retroduced that street life, together with the unstable family environment and the associated lack of role models ('*no guidance'*), had constrained Simon's scope for action towards upward social mobility, personal growth and self-realisation *('There was no moving forward*…').

The *AA/NA discourses on recovery* also seemed to have exerted incremental conditioning effects on the participants' capacities for recovery (See Figure 22). AA/NA discourses on recovery and abstinence seemed to have had both positive and negative conditioning effects on how the participants who had had contact with those support groups contemplated and envisioned recovery. To begin with, Benjamin, Oliver and George discussed how their participation in AA/NA support meetings had increased their awareness of the potentially negative effects of '*people, places and things'*. Those participants seemed to have applied this critical awareness of the environmental influences upon substance use recovery to their current efforts to cope with, and recover from, their mental illness. In addition, for those participants, AA/NA seemed to have helped de-stigmatise and normalise their substance use problems:

> '*Even though I was an addict, people showed me love.'* (Benjamin);

> '[…] *it's not just me, it's a lot of us out there-there's a lot of recovering people out there* […] *and seeing people that recover and seeing people in recovery, and knowing that it's possible for me, too.'* (Scott).

The socially inclusive and empathetic AA/NA atmospheres seemed to have helped those two participants foster self-acceptance and envision their own recovery.

Furthermore, some participants found the *'one day at a time'* AA/NA maxim particularly helpful in navigating the challenging conditions of shelter living, thereby helping them cope with their mental illness symptoms on a daily basis.

Notably, however, two of the participants that reported that AA/NA meetings had had a major influence on their recovery (Neil and Scott) seemed to conceptualise their mental health recovery as complete illness disappearance, which triggered anxiety. Scott, for instance, shared:

> '*Well, mental disability (...) You can recover from an illness such as the cold, the flu...you know, you can't recover from a disease. […] mental illness, you know, it's/at some time an illness or a disease can be arrested but there is no known cure, you know. See, that's, that's...I'm caught in the simple phrases that I've learned in Narcotics Anonymous. Okay...And when I put down a drink or a drug for a period of time, recovery is then possible (...) Ever heard ...You can recover from cancer, you know, but that's, that's an illness.'.*

It was unclear as to whether the NA discourse on addiction as a disease might have conditioned Scott's interpretation of his mental illness and his personal construction of mental health recovery as symptom disappearance. It remains possible that the recovery discourse of 12-Step programmes that emphasised 'surrender', 'powerlessness' and trusting a force greater than oneself might have narrowed Scott's perceived scope for action towards achieving mental health recovery.

Finally, for several participants, especially the African-American and the Hispanic participants in the U.S., their *cultural heritage* seemed to also have conditioned their capacities for recovery. As highlighted in the '*Sources of Positive Self-identity'* sub-section in '*Chapter Six*', several participants emphasised the significance of cultural and family values, morals and traditions for guiding their efforts to re-build their lives. What the abductive-retroductive analysis added was illuminate the possible mechanisms via which those participants' own cultures could have enhanced their capacity for recovery.

To demonstrate, from Joshua's and Benjamin's life story narratives, it could be retroduced that the values and traditions of the African-American community related to caring, interdependence and morality (e.g. '*Everybody's mother was everybody's mother.'* (Benjamin) provided enabling ideational conditioning of Benjamin's and Joshua's recovery-oriented life projects. Indeed, both those participants stated their commitment to living '*with morality*', helping others and re-connecting with their families. Religiosity and spirituality could also be interpreted as parts of those participants' cultural repertoire that they could draw upon to inform their moral responsibility and self-directedness.

Summary of the Effects of Structural and Cultural Conditioning on Recovery

The abductive-retroductive analysis discerned a plethora of social structures and cultures that were implicated in participants' capacities to recover. Those include chronic housing instability, the housing and welfare sectors, street culture, temporary accommodation, professional support, and several others. Those entities exerted conditioning effects on participants' recovery-relevant agency and recovery outcomes. Altogether, those structures exerted two types of effects-(a) expanding or constraining participants' access to recovery-promoting resources such as professional help, safe housing and occupational opportunities; and (b) expanding or constraining participants' degrees of freedom to conceive recovery-oriented life projects.

Those structural/cultural influences shape *but do not determine* individuals' recovery-relevant agency or outcomes (Archer, 2007). Instead, they offer resources, rules and reasons for individuals to act in a certain way and not in another. A related but independent causal entity, participants' *individual agency* is another causal mechanism that accounts for the observed recovery-relevant outcomes. Using their independent agential powers, the participants could, at least partially, critically interrogate, strategically circumvent and creatively reinterpret those circumstances, resources, rules and reasons. Alternatively, in some cases of extreme socio-economic deprivation, institutional uncertainty and poor social relationships, those agential capacities could be severely impaired-leading to powerlessness, passivity and distress. The next section details this second and crucial stage (T2-T3) of the morphogenetic model.

How do Participants Navigate and Negotiate those Socio-Structural Conditions and Contexts to Enable Better Well-being and Recovery? (RQ4)

Socio-Cultural Interaction (T2-T3)

As shown in the morphogenetic model (See Figure 22), the influence of structural and cultural entities at T1 conditions individuals' personal agency at T2-T3. At T2, those entities exercise their conditioning effects by constraining or expanding individuals' scope for action in relation to individuals' life concerns and commitments. At T3, individuals exercise their personal agency *in response to those enablements and constraints* and deliberate upon, circumvent, mobilise and/or *elaborate* those conditions in pursuit their personal projects and commitments (Archer, 2003).

The abductive-retroductive analysis discerned two broad types of agentic responses displayed by the participants: ***autonomous reflexivity*** and ***fractured reflexivity*** (Archer, 2012). Those two reflexivity modes were associated with distinct recovery-relevant outcomes. Participants' *enhanced autonomous reflexivity* could explain a range of recovery-enabling outcomes-for example, the increased insight and self-knowledge, effective coping and the sense of security and constancy. In contrast, participants' *induced fractured reflexivity* could explain the plethora of recovery-impeding outcomes-including the lack of (perceived) capacity to cope, self-defeating coping behaviours, the lack of constancy, hopelessness and others. To achieve a fine-grained analysis of the workings of participants' agency, the analysis will focus on their reflexivity as manifested in and through their *internal conversations* (See '*Chapter Four*').

Importantly, participants exercised their agential powers in the context of various social relations (See 'Figure 22'). Those relations could strengthen or weaken participants' discernment of, deliberation upon, and dedication to recovery-relevant goals.

The Effects of Social Relations

The context in which internal conversations take place shapes how personal agency is exercised. In a theoretical elaboration of the morphogenetic model, the causal effects of ***social relations*** on how individuals deliberate upon, discern and dedicate to their recovery-oriented projects will be examined (See Figure 22). The analysis identified several kinds of social relations which seemed to exert an effect on participants' internal conversations: (1) *interactions with service providers*; (2) *past and present relationships with the family and with significant others*; and (3) *daily interactions with fellow shelter residents and other acquaintances*.

As highlighted in the '*Formal Support Services as Key Enablers of Positive Coping and Self-Management'* in '*Chapter Six*', most participants emphasised the importance of professional support for symptom management and recovery. The abductive-retroductive analysis builds on those IPA findings by illuminating *how* client-practitioner interactions influenced participants' reflexive deliberations about recovery and therefore moderated the adverse conditioning effects of housing and other structural factors.

One possible relational causal mechanism appeared to be the *emotional elaboration* of participants' internal conversations (Archer, 2000). The emotional elaboration of the internal conversation involves overriding one's initial emotional response to one's objective circumstances, and transforming it in accordance with one's more authentic, higher-order concerns and commitments. In the context of the present study, the participants emphasised the affective component of their interactions with service-providers as having a significant impact on their capacities to manage their symptoms and to engage in recovery.

For Edward, for instance, having a humanising, empathetic and reciprocal relationship with his case worker had often served as an enabler of a coherent internal conversation. Edward's daily interactions with his case worker had helped him '*stay steady'*, prevent *'his mind'* from '*exploding*' and even *'forget'* that he was depressed.

Participants' accounts of their interactions with trusted professionals, such as psychiatric nurses, case managers and counsellors/psychiatrists reveal evidence of *emotional elaboration* and even *transformation* of participants' concerns and commitments in relation to recovery. Scott's account of the value of the therapeutic support he had received for overcoming his hopelessness and a sense of an irrevocably wasted life demonstrates the recovery-enabling effects of client-practitioner relationships upon this client's internal conversation:

> *'And then there is always other things, there's always other negative thought that I'm gonna have...like 'My life is finished. My life is through. What do I have left of my life?'* […] *That's what it is to have another human being turn around and say: 'But look what happened. Would you rather be this or would you rather be that?'*

This quote shows the role of the therapist in aiding Scott's reflexive deliberation on the possibility of recovery, as well as his dedication to pursuing recovery-oriented goals.

Similarly, Oliver expressed an appreciation of the '*feedback*' provided by his case workers and significant others, especially when Oliver had faced considerable emotional turmoil and psychological distress:

> *'But after talking to them, and they give me a few brownie points, I feel a lot better*. […] *And they just let me know, you know, to have something to think about, you know, before I jump outta window. So after that, after I get the feedback, I think about it for a while and then I let them know: 'Do*

> *you know what-you're right. It does make sense to do it this way than to do it that way.'*

Those excerpts exemplify how those participants' interactions with professionals, as well as with significant others, appeared to facilitate the articulation, monitoring and transmuting of participants' emotions and reflexive deliberations, and therefore promote their capacities for recovery (Archer, 2000). A client-practitioner atmosphere of safety, encouragement, understanding and non-judgemental communication appeared to have fostered their reflexive deliberations about and commitment to recovery.

Particularly conducive to such reflexive deliberations and even reflexive transformations appeared to be not only providers' instrumental help but also their gestures, expressed emotions, silences, subtle acts of caring and other everyday '*small things*', which, however, appeared to have immense effects on clients' identities and recovery (Topor et al., 2018):

> '[…] *not everything is just about keeping schedule. Not everything is so black-and-white. Some things [are] […] out of your control and...at that point, the only thing anyone could erm...provide or understand is that you just might need an ear. Because sometimes that is just...enough.'* (Susan)

Relatedly, other participants emphasised the importance of working '*together*' with providers to identify shared understanding about clients' concerns, values and goals. Emotional intimacy, shared understanding of the problem space *and* collaborative action, therefore, all appeared to be important mediational preconditions for participants to exercise their autonomous reflexivity in the context of the caring relationship.

Participants’ *relationships with family and significant others* also shaped their internal conversations as they deliberated and enacted their recovery. From the participants’ life story narratives, it was retroduced how their *actual* and *imagined* conversations with, and their emotional relations with, family members and significant others played a significant role in their deliberations about a life in recovery (Holmes, 2010).

Virtually all participants shared having experienced unstable, violent or dysfunctional family environment. The psychological trauma and emotional pain caused by dysfunctional family environments seemed to have hindered some participants’ agentic capacities to cope with mental illness, as well as their reflective and projective capacities for envisioning a better life. Participants’ emotional relations with their families tended to operate as schemas that shaped participants’ internal conversations as they deliberated and attempted to enact their recovery. To demonstrate, several participants discussed the enduring influence of their adverse familial experiences upon their self-concept and emotional and existential well-being:

> ‘*I was never good enough.*’ (Ashton);
>
> *‘Never felt part of anything. And it's a very terrible feeling*. […] *It goes to the core of your soul.*’ (Matthew);
>
> ‘[…] *it's all building down on me-from childhood to now*.’ (Kelly).

Conversely, supportive present relationships with family and significant others seemed to enhance participants’ reflexive deliberations about the possibility of recovery, as well as participants’ access to recovery-promoting resources such as socio-emotional support.

Finally, the *daily interactions with fellow shelter residents and other acquaintances* also seemed to have a shaping influence on participants’ internal conversations. The participants often conveyed their experiences of recovery (or non-recovery) as changes, and sometimes fluctuations, of a range of feeling states (or affects), for example sorrow, anguish, desperation, motivation, hope and gratitude. Those feeling states oftentimes emerged from participants' daily encounters with fellow shelter residents. In many instances, it seemed, participants' recovery-relevant agency was shaped by their emotional relatedness to others within their everyday encounters (Burkitt, 2016). For instance, Oliver, an NYC-based drop-in centre client, shared how several shelter residents, including himself, would purchase goods and lay them out on a table in the communal space for all clients to come together and enjoy. Those collective acts of empathy and altruism seemed to co-create hope, joy, friendships and a sense of togetherness. Those *relational goods* appeared to foster reflexive deliberations about hope, perseverance and collective acts of resilience as integral to recovery:

> '[…] *I can't help nobody that doesn't want to help themselves. But I can just give them some good things and try to make them smile or try to make them feel a little better than what they're feeling*. […] *even if somebody is down, we try to lift them up, you know, by talking to them, make them laugh, say something funny. In this room, we try to keep the atmosphere OK. We don't want it to be really a sad, sad atmosphere. We try to bring it up. ''Listen, you still got love in this room no matter what happened. You still got love in here.* […]*''* […] *It works. It helps a lot. It really helps a lot so*...' (Oliver)

Relatedly, Susan's, another NYC-based drop-in centre resident, account also possibly reveals *hope* and an *enhanced projective agency* as relational goods emerging from close friendships with other shelter residents. When asked what her one close friendship brought her, she explained:

> '*A conversation was not ever about your so-called daily life in the shelter.* […] *We already can see it. We know it. We deal with it every day. We talk about everything else because that is what your life should be-it's not just what's*

> *going on with your life, but it should be about what you still value and look forward to and...you know, what keeps you erm...your goals and your motivations*...'

From Susan's statements, it could be inferred that one of the functions or consequences of this friendship was what Bennett Helm (2010) terms '*plural goal-directedness'* and '*plural agency*'. Those relational phenomena appear to emerge from having identified shared goals worth pursuing (in this case, exiting homelessness, staying hopeful and/or pursuing recovery); from exercising one's emotional capacities by influencing, and being influenced by, others in the pursuit of those shared objectives; as well as from engaging in plural action (e.g. '*We deal with it every day*' (Susan); Helm, 2010). According to Helm (2010), such emergent, plural agency is also demarcated by each individual's self-identification with a collective, which, in Susan's account, is conveyed by the repetitive '*We*'. As a result, as a manifestation of *projective agency*, Susan appeared to display an enhanced ability to transcend or distance herself, in part at least, from the confines of the objective present circumstances (Emirbayer & Mische, 1998; See '*Conceptual Framework of the Current Study*' in '*Chapter Four*').

Last but not least, Claire, a Glasgow-based women's shelter resident, discussed the significance of her helping out other people without a home and of their daily conversations. When asked about why she felt the need to help others in a similar predicament, she replied: '*Cause I know how hard it is*.'. She then described her daily conversations with a street homeless young woman that she would help make sense of, and navigate, homelessness and mental illness:

> […] *You just need to look at the system-we're all homeless-I'm homeless, you're homeless. Your homeless is different than my homeless. We're all different people. You're a drug user; he's got alcohol use and I've got a mental health problem.* […] *'Is that your own fault for taking drugs?' Is her fault that she's homeless? She does need help and I got to help her yesterday and I felt good. I*

> *felt amazing!'* […] *You feel like there is nobody out there wanting to help you, there's nobody listening to you-even though you know deep down in your heart there are thousands of people that listen* […]'

Claire's conversations with the young woman seemed to be an external extension of Claire's own internal conversation regarding the systemic injustices, the possibility for recovery and the moral agency of offering help, asking for help and even possibly challenging those very injustices. This interpersonal relationship seemed to be based on both personal (both struggled with mental health difficulties and housing instability) and value-based (insofar as they were both negatively affected by '*the system*') concerns. Importantly, those external conversations appeared to 'scaffold' the formation of Claire's recovery-oriented, autonomous reflexivity through her own internal conversation (e.g. '[…] *me personally anyway, I can't get back to that hole. I've climbed out of it three times and I'm hoping I'm staying on that level* […]).

The next two sections detail the participants' agential responses to the structural/cultural conditioning, within the context of interpersonal relations. It is demonstrated how participants' enhanced or hindered autonomous agency could be linked to the recovery-relevant outcomes and processes discerned in the IPA phase (T4-stage in Figure 22). Archer's concept of the internal conversation and the 3 D's of reflexivity (discernment, deliberation and dedication), in addition to Emirbayer and Mische's (1998) agentic orientation modes, were deployed to flesh out the agential dynamics in this component of the morphogenetic model (See '*Conceptual Framework'* in '*Chapter Four*'). Accounting for participants' reflexivity at this stage helps explain why and how some participants envisioned and enacted change (including recovery-oriented change), while others tended to struggle to conceive and enact alternative courses of action.

Autonomous Reflexivity

Enhanced *autonomous reflexivity* was identified in those participants that demonstrated the adoption of a strategic stance towards the constraints and enablements engendered by their circumstances, as well as the promotion of a future orientation, which was conducive to the productive contemplation and enactment of recovery. In this process, two types of changes in the temporal orientation of the participants' agency were observed (Emirbayer & Mische, 1998). The first one was the activation of participants' *practical-evaluative agency*, which enabled them to strategically reinterpret and navigate the structural and institutional uncertainty and complexity of shelter living by, for example, focusing on the 'here and now' contingencies and priorities, taking things 'one day at a time', not thinking about the past 'too much', invoking effective mental health coping strategies on a daily basis, and others. The second one-*projective agency*-was characterised by enhanced reflective and imaginative capacities to contemplate and envision alternative course of action and outcomes, including recovery. Collectively, participants' enhanced practical-evaluative and projective capacities enabled them to partially mitigate the structural constraints of their circumstances and to mobilise the available structural enablements in support of their recovery. This allowed them to envision recovery as a valued and viable way of living (*discernment*); evaluate the potential benefits and limitations associated with a life in recovery, as well as plan concrete actions to attaining it (*deliberation*); and commit to pursuing recovery as an '*ultimate concern'* (*dedication*; Archer, 2007; See Figure 22).

A dominant autonomous reflexivity mode could be identified in several participants such as Claire, Conor, Ashton, George, Edward, Benjamin and Scott. They seemed to respond to the structural constraints and uncertainty of their circumstances by mobilising their capacity to '[…] *make practical and normative judgments among alternative possible trajectories of action, in response to the emerging demands, dilemmas, and ambiguities of presently evolving situations.'* (Emirbayer & Mische, 1998, p. 994). In the participants' accounts, this practical-evaluative agency was manifested by positive 'self-talk', re-examination and reinstatement of their priorities and commitments, and the mobilisation of their internal resources such as inner strength and perseverance. An enhanced practical-evaluative reflexivity aided those participants in contextualising their current lack of housing as a *'here-and-now situation'*, as opposed to as a chronic and inevitable state of existence. In several accounts, *'adapting to*' the demands of homelessness and *'being strong'* in the face of predicament were manifestations of the participants' heightened *'maneuverability, inventiveness, and reflective choice'* (Emirbayer & Mische, 1998, p. 964):

> '*You have to have a strong mind, I would say. Because if you have a weak mind, you are gonna explode*.' (Edward)

Edward's '*strong mind'* could be interpreted as an emergent property (at T4) of his enhanced autonomous reflexivity, which had been conditioned, *but not determined by*, the enablements offered by the safe temporary housing (at T1), and which was exercised within the supportive relationships with his service-providers (at T2-T3; See Figure 22).

It was the enhanced practical-evaluative agency that enabled Ashton to circumvent the constraining conditioning of structural uncertainty and complexity and engage in productive recovery-oriented reflexive deliberations:

> *'If I concentrate day-to-day, then...I'm in control of what happens that day.'* (Ashton)

Those participants also exercised *projective agency*-manifested by their enhanced abilities to envision their recovery as an authentic, self-directed life project, as well as to plan and enact concrete recovery-oriented actions. Claire, for instance, discussed her focused practice of setting daily goals for herself in the strategic pursuit of recovery and rehousing:

> *'This year, I want to fight it [the mental illness] myself […] cause this is me looking at that big picture […] that's my motto. My motto is my goal. It's just…trying to get there.'* (Claire)

Altogether, the autonomous reflexivity that some participants displayed was associated with increased self-knowledge and self-awareness, which were mobilised in their strategic design and pursuit of recovery-relevant goals (at T4 in Figure 22). Those reflexive *achievements* seemed to allow those participants to partially mitigate the constraining conditioning effects of the structural context (e.g. homelessness) by creative *'circumvention and subversion'* (Archer, 2003, p. 139), which was ultimately driven by the participants' emerging recovery projects and commitments. Autonomous reflexivity accounted for the range of recovery outcomes and processes reported in the IPA phase-such as envisioning and 'owning' recovery, achieving insight, positive coping; having meaning in life; nurturing a positive sense of self and others (at T4; See Figure 22).

Fractured Reflexivity

Fractured reflexivity manifested itself in some participants' impeded (fragmented, diminished or unproductive) internal conversations (Archer, 2012). Fractured reflexivity did not allow them to recognise recovery as a realistic life project (lack of discernment), to plan and prioritise feasible recovery-relevant goals that were likely to bring desired outcomes (lack of deliberation), or to believe recovery was possible and to commit to pursuing recovery as an ultimate concern (lack of dedication; Archer, 2007). Importantly, fractured reflexives were the outcomes of the adverse conditioning effects of chronic housing instability, poor economic prospects and welfare support, and inadequate professional support and occupational opportunities at T1 (See Figure 22). Fractured reflexives were further perpetuated by the mediating effects of dysfunctional, insufficient or affectively poor social relationships at T2-T3.

A few participants-particularly Matthew, Craig and Henry-demonstrated this dominant agential mode. It was commonly experienced by them as increased mental distress, a sense of forced passivity, a '*paralysis of action'* (Caetano, 2019, p. 147), and existential disorientation (at T4). As a result, they tended to struggle to identify with, and articulate, recovery as a feasible personal project (See *'Participants' conceptualisations of mental health recovery'* in *'Chapter Six'*). They also tended to question their own agential capacities to transform their predicament:

'There's no way out of this for me.' (Matthew)*;*

'There's nothing else you can do apart from just wait and bite your time […]' (Henry)

Two agential orientations seemed constitutive of those participants' fractured reflexivity (Emirbayer & Mische, 1998). *Suppressed projective agency* was displayed in response to the multiplicity and severity of structural constraints, which led to one's (perceived) incapacity to cope with mental illness and to imagine alternative courses of action, including one's recovery. *Activated iterative agency*, on the other hand, entailed resorting to negative, escapist coping strategies in attempts to cope with the structural uncertainty and complexity, emotional trauma, or mental illness, which, in turn, could result in *impeded practical-evaluative agency.*

Those participants' inhibited projective agency was demonstrated in their self-reported emotional distress, disorientation *('I really haven't got a clue.'* (Craig), hopelessness and a sense of abandonment ('*I don't hold up any hope for my recovery.'* (Matthew); '*I feel that it is a bit too late for me in life to actually make a new life.*' (Craig). Indeed, the inexpressibility and ineffability of the painful feelings and emotions experienced by some participants could be reconceptualised as manifestations of fractured reflexivity. Those participants' internal conversations did not seem to generate viable recovery-oriented courses of action. The emotional distress that resulted from their inability to engage in coherent and action-oriented reflexive deliberations seemed to preclude recovery.

Housing (including homelessness and the housing sector) was identified as a significant conditioning influence on recovery (See Figure 22). Structural (institutional) uncertainty and complexity refer to the (perceived) unnavigability of institutional systems due, for example, to the overwhelming demands of service use, to the volatile nature of institutional arrangements (e.g. curfews, church beds, regulated time in the dormitory, lack of control over the physical and social surroundings), and to the (perceived) lack of transparency of institutional practices (e.g. rehousing procedures and policies). The participants' narratives demonstrate that this institutional uncertainty and complexity can engender mental health symptomatology (e.g. Susan; Craig), exacerbate and perpetuate pre-existing mental health difficulties (e.g. Matthew; Claire; Henry; Edward), and altogether diminish participants' autonomous reflexive capacities.

In response to the overwhelming demands and contingencies of the present, Matthew tended to revert back to his habitual responses to manage the overbearing stress and mental illness symptoms-avoidance and self-medication with alcohol *('[…] the only way out of it is to erm...avoid it and to erm (...) ignore it, and not deal with it.'*). In other words, for participants such as Matthew, those structural constraints had activated iterational agency, which, however, reproduced unhelpful habitual behaviours (such as escapist drinking).

Participants' experiences of '*waiting*' acutely exemplify the divergent effects of autonomous reflexivity and of fractured reflexivity on their recovery. *Waiting* was a circumstance that the participants involuntarily faced as shelter residents. Waiting could be interpreted as the result of the conditioning effects of an inefficient housing sector, which imposed long times to rehousing. Participants who exercised their autonomous agential powers managed to, at least to a certain extent, circumvent those structural constraints by transforming *waiting* into a meaningful experience. For participants such as Claire, Conor and Oliver, waiting was a strategic, agential response to the institutional constraints of homelessness. It was a testament to their perseverance and goal-directedness. It was experienced as synonymous with patience and rationality:

> '[…] *months and months go by...you feel like...you know, you know what you want, you want it when you want it* […] *It took me a while, it took me some time to have patience like that. Because you know, just like some of the people do, walk outta door and don't even care, you know, and then...*' (Oliver)

For those participants who tended to exhibit fractured reflexivity, however, waiting was experienced as existentially threatening and disorientating:

> *'It's just been a waiting game, do you know what I mean? […] Yeah, you've got to be [patient] yeah. Cause Rome wasn't built in a day... […] It's not easy. […] ((voices becomes weaker)) There's nothing else you can do apart from just wait and bite your time, and hopefully something comes along, do you know what I mean?'* (Henry).

For those participants, *waiting* was a disorientating and emotionally and psychologically debilitating experience, which further undermined their abilities to recover.

Altogether, fractured reflexivity in response to both chronic and situational socio-structural adversity seemed to account for several participants' reported disidentification with recovery, hopelessness, low sense of self-worth, feeling emotionally disconnected from others, among other experiential outcomes antithetic to recovery.

Conclusion

This chapter presented the findings from the critical realist analysis, which sought to identify what socio-structural conditions and contexts were implicated in participants' recovery, and how (RQ3); and how participants navigated and negotiated those conditions and contexts to enable better well-being and recovery (RQ4). The morphogenetic model was utilised to generate a layered explanation of the participants' recovery capacities. This explanatory model was selected because it helped account for the structural, relational and agential influences upon recovery as analytically distinct entities, which, albeit interrelated, had distinct causal properties. The model demonstrates how a range of structural and cultural contexts at T1 conditioned participants' recovery-relevant agency at T2-T3 (See Figure 22). Those structural/cultural entities had exerted enabling/constraining material and ideational effects on participants' abilities to discern, deliberate upon, and dedicate themselves to their authentically defined recovery projects. The participants exercised their personal agency not as a lone, merely cognitive act but as a relational process, which, albeit largely autonomous, was shaped by participants' emotional relations with others.

Two main types of agential responses were retroduced from the data. In the case of *enhanced autonomous reflexivity*, participants tended to constructively reinterpret the past as a source of meaning, flexibly adjust to the contingencies of the present, and orientate themselves towards their desired future. Common structural and relational antecedents of such an agential response included safe housing, adequate professional support, the availability of meaningful occupations and the availability of positive affect in their daily interactions. Common experiential outcomes of enhanced autonomous reflexivity were increased insight, sense of ‘homelikeness’, self-efficacy, positive coping, and others. In the case of *induced fractured reflexivity*, however, participants could not identify viable routes to realising their life projects and their internal conversations tended to be unproductive. Common antecedents of fractured reflexivity were the disjointed and inadequate professional support, dehumanising staff attitudes, precarious housing conditions, the lack of positive social interactions, and others. Common outcomes of fractured reflexivity were increased distress, hopelessness and the disidentification with recovery.

Chapter Eight

Discussion

Logic of the Chapter

The chapter begins by synthesising and interpreting the main findings from the two 'Findings' chapters ('*Chapter Six*' and '*Chapter Seven*') in relation to the four research questions and the insights and gaps illuminated in the critical literature review ('*Chapter Three*'). Collectively, the two sets of findings reveal the multi-layered, idiosyncratic and dynamic nature of recovery in the context of homelessness. The idiographic IPA phase helped discern the nuances, ambivalences and psycho-emotional complexity of how the participants made sense of, envisioned and enacted their recovery. In contrast, the critical realist analysis revealed the plausible underlying configuration of socio-structural, relational and agential factors that enabled or constrained recovery. The findings also further the understanding of how chronic homelessness, temporary accommodation and professional support services could diminish or enhance clients' imaginative and transformative agential capacities that give rise to recovery. The present findings are situated within the broader literatures on recovery, homelessness and inequalities. The study limitations are also discussed, which allows for the critical assessment of the trustworthiness and credibility of the findings. The chapter concludes by proposing recommendations for theory development, directions for future empirical research, as well as recommendations for social work and mental health practice and policy. Specific consideration is given to designing and implementing recovery-oriented and person-centred care for individuals who are homeless and have complex needs.

Restatement of the Context, Aims and Original Contribution of the Current Study

The persistently high rates and the ever-increasing complexity of need in individuals who are homeless demand a more in-depth and contextually-informed understanding of their subjective experiences of health, illness, housing instability and service provision. Individuals who have been chronically homeless and have a history of SMI have been a particularly marginalised client group in both Scotland and the U.S. (Aldridge et al., 2018; Watson et al., 2016; Homeless Link, 2014; Fitzpatrick et al., 2013). Their holistic care needs have often remained unmet and misunderstood, which has been exacerbated by the lack of adequate housing and mental health provisions in both jurisdictions (Crosby et al., 2018; Hamilton et al., 2012; Kerman et al., 2019). As a result, the realisation of the recovery ideal in this sub-population has been undermined by overlapping institutional, socio-economic and ideological challenges (Padgett, Tiderington, Tran Smith, Derejko, & Henwood, 2016; Henwood et al., 2012; Karadzhov et al., 2020; Gillis et al., 2010). Furthermore, relatively little is known about *how* individuals with SMI transitioning from chronic homelessness make sense of, envision and navigate their personal recovery amidst the disempowering conditions of housing instability, socio-economic deprivation, discrimination and other socio-structural arrangements (Henwood et al., 2013; Iaquinta, 2016).

Furthermore, the bulk of the personal recovery literature has tended to neglect the experiences of those who face severe and multiple disadvantage (Harper & Speed, 2012; Morrow & Weisser, 2012). As a result, how individuals occupying such precarious social locations negotiate and realise recovery has remained underresearched and undertheorised (Stuart et al., 2017; Watson, 2012a). The failure to situate individuals' struggles to achieve and sustain hope, empowerment, self-determination and connectedness, among other cornerstones of recovery, within the web of oppressive forces that systematically diminish opportunities for autonomy and well-being risks perpetuating the harmful ideologies of self-responsibility and the medicalisation of social disadvantage and exclusion (Onken et al., 2007; Stuart et al., 2017; Morrow & Weisser, 2012; Rose, 2014; McWade, 2016).

This transatlantic qualitative study aimed to address this gap in the empirical research on the experiences of personal recovery in individuals who are chronically homeless, as well as the gap in the theorisation of recovery in the context of socio-structural disadvantage. Specifically, this study endeavoured to understand how individuals with a history of SMI and chronic homelessness make sense of, and conceptualise, their personal recovery (RQ1); what helps and what hinders their personal recovery (RQ2); what socio-structural and contextual influences are implicated in the recovery process, and how (RQ3); and how those individuals navigate and negotiate those external influences to enable better mental well-being and recovery (RQ4).

The philosophical and methodological orientation of this study reflects its commitment to privileging participants' own voices while also generating a sociologically-informed explanation of *how* recovery happens (or does not happen) within their unique biographical and institutional contexts. In an innovative multi-site qualitative research design, this study combined the theoretical and analytic capabilities of critical realism with those of personal narratives and visual elicitation (Bhaskar, 1989; Archer, 1995; Danermark et al., 2005; Padgett et al., 2013; See '*Chapter Four*' and '*Chapter Five*'). The data collection settings of choice, New York City (U.S.) and Glasgow (Scotland), not only diversified the current sample but also offered the unique opportunity to explore how 18 temporary accommodation clients navigated and negotiated their recovery amidst distinct socio-political, socio-cultural and organisational settings. The analysis captured a complex web of contextual influences upon recovery-from the role of the low-threshold temporary accommodation safe haven facilities in NYC through to the lack of occupational opportunities in Glasgow, Scotland.

The present investigation makes a significant contribution to the scarce body of empirical work exploring the mental health recovery experiences in individuals who were currently homeless (as opposed to, for example, recently rehoused or formerly homeless; Padgett et al., 2016; Kirkpatrick & Byrne, 2009; Karadzhov et al., 2020). By revealing how the 'in situ' experience of homelessness frustrated or impeded participants' efforts to engage in recovery, the present study addresses the need to more fully account for *'the diversity of recovery experiences'* (Duff, 2016, p. 59; Davidson et al., 2010; Rose, 2014). Those commonly neglected dimensions or stages of recovery that were explored in the present study include the earliest stages of recovery, as well as the lived experience of those who might not consider themselves to be '*in recovery*' (Davidson et al., 2010; Rose, 2014; Fish & Freshwater, 2014; Stuart et al., 2017).

By foregrounding the voices of lived experience of marginality and inequalities, the present study helps expose some of the systemic impediments to those individuals' authentic, meaningful and self-directed lives (Watson & Cuervo, 2017; Morrow & Weisser, 2012; Karban, 2017). It also positions those individuals as possessors of unique and valid knowledge of the inherent human struggle to regain control and dignity from the pits of deprivation and exclusion. Thus, this study advances the conceptualisation of the recovery journey as a struggle for social justice (Morrow & Weisser, 2012; Harper & Speed, 2012; Costa et al., 2012). This emancipatory commitment counterposes the professionalised, medicalised and co-opted discourses on recovery as an individual problem equated with treatment compliance, symptomatic remission and restored pre-illness productivity (Harper & Speed, 2012, Rose, 2014; Vandekinderen et al., 2014; Deegan, 1988; Pilgrim & McCranie, 2013; Voronka et al., 2014). Despite its methodological limitations (See '*Limitations of the Study*' in this chapter), the present investigation generated rich and multifaceted data that adequately address the research questions-therefore making significant contributions to advancing theory and research and informing practice in the areas of homelessness assistance and recovery-oriented care.

The discussion of the present findings is organised in two main sections: (a) the complex *experience* of recovery amidst homelessness; and (b) the complex *causality* of recovery amidst homelessness. The first main section discusses the findings that correspond to RQ1 and RQ2 relating to the lived experience of recovery. The second main section discusses the interplay between socio-structural and relational entities and human agency and its effect on participants' recovery, which corresponds to RQ3 and RQ4.

'*It's a few different things that make it whole*': The Complex Experience of Recovery amidst Homelessness

The seven super-ordinate themes (See Table 9 in '*Chapter Six*') derived from the IPA of the life story interviews, mobile phone diary entries and elicitation interviews unravelled the multifaceted nature and biographical embeddedness of personal recovery in a multiply marginalised and underresearched group-adults with a history of chronic homelessness.

Envisioning and Initiating Recovery

'Owning' one's recovery, having a sense of constancy and 'homelikeness' and achieving insight were found to be the crucial preconditions for envisioning and initiating recovery. The super-ordinate theme, '*participants' conceptualisations of mental health recovery*', revealed a diversity of ways of reflective engagement with the recovery idea-from the tentative and somewhat implicit recognition of the importance of recovery (e.g. *'It's not just one aspect. It's a few aspects. It's a few different things that make it whole*.' (Scott); '*That helps*.' (Neil), through to expressed fear ('*…recovery is fearful to* *me*.' (George) and the explicit disidentification with the possibility of recovery ('*I don't hold (up) any hope for my recovery*.' (Matthew). Those findings underscore the inherent complexities and ambiguities associated with making sense of, and envisioning, one's recovery but also the likely impact of chronic disadvantage on individuals' capacities to imagine an alternative life. A negative, contradictory or implicit relationship with recovery could be a conscious or unconscious act of resistance against the unjust, unnavigable and undignifying socio-structural conditions that are often imposed upon individuals who are transitioning out of chronic homelessness (Kerman et al., 2019; Padgett et al., 2016; Watson, 2012a).

The present findings of the *apophatic* (implicit, negatory; Slee, 2001) dimension of personal recovery appear to concur with Fullagar and O'Brien's (2014) findings of the importance of their participants' *'tacit knowledge about recovery*' (p. 116) as they embarked on a journey of *'realising and recognising capacities and self-knowledge'* (p. 116). Indeed, several of the present participants seemed to possess an embodied and holistic understanding of recovery (e.g. '*a sense of well-being'* (Ashton); *'a sense of completion'* (Ashton); *'self-comfort'* (Scott). Similar to Fullagar and O'Brien's (2014) participants, some of the current participants seemed to struggle with the normalised discourse of recovery such as the idea of recovery as symptom elimination, return to normality and invulnerability (e.g. '*I know I'll always have it forever*. […] *I'm stuck with it*.' (Neil); *'I'm not a tablety person.'* (Claire). This authentic, albeit implicit and often-contradictory, understanding of recovery could be interpreted as an alternative form of *recovery knowledge*-as complex experiential forms of knowledge that sit outside of what can be easily measured, codified, formalised and institutionalised (Fullagar & O'Brien, 2014; Topor et al., 2011).

The present study's findings also seem to cohere with Borg and Davidson's (2008) and Gwinner et al.'s (2013) findings of some participants' ambiguous, embodied, indirect and negatory relationships with recovery, which are not adequately captured by well-established definitions of recovery within service provision. Borg and Davidson

(2008, p. 134), for instance, found that '[r]*ather than being the planful, rational, and stepwise process suggested by treatment plans, initiating recovery appears to be experienced as a somewhat desperate effort to break out of a cycle of recurrent problems associated with mental illness* […]'. Relatedly, Gwinner and colleagues (2013) found that their participants frequently 'adjusted' the meanings attributed to recovery and wellness in response to the shifting practical demands of daily living. As such, for some participants, recovery was a fleeting, often-unstable and changing 'occurrence'. Similarly, in many instances, the current participants' responses to the idea of recovery were heavily grounded in their efforts to interrupt the cycle of '*chaos*' and suffering by '*just hanging in there'* (Edward), '*taking it one step at a time'* (Susan; Scott) and escaping the grip of meaninglessness and hopelessness. Those findings underscore the idiosyncratic and processual nature of recovery and demonstrate that approaches to client empowerment should be attentive to clients' unique preferences, interests and outlooks (Roe & Davidson, 2005; Slade et al., 2008; Leonhardt et al., 2017).

Further empirical research should aim to unravel the underlying reasons for clients' perceived unreadiness and/or unwillingness to engage with the recovery notion. In particular, future research should examine the potential discord between institutionalised definitions and models of recovery and clients' own understanding of recovery. It could be that the participants in the present study were apprehensive regarding the perceived expectation that they needed to be held personally responsible for their recovery. As O'Keeffe and colleagues (2018) caution, this expectation is likely to be unrealistic for clients '[…] *whose sense of self is engulfed by symptomology*.' (p. 644). Alternatively, it may be that the ideas about the restoration of pre-illness functioning, sense of self and social recognition that are sometimes implied by the terms '*recovered*' or '*in recovery*' are not applicable to individuals that have endured severe and chronic disadvantage (Sørly et al., 2018). As cautioned by Padgett, Tiderington, Tran Smith, Derejko and Henwood (2016, p. 61), '[…] *the emphasis in some recovery programs on returning to before-illness (pre-morbid) functioning presumes* *there is a prior life desirable enough to restore.'*. For participants such as Ashton, the sense of security, stability and authentic self-direction associated with recovery was something they had self-admittedly never acquired as a result of chronic life adversity. As argued by O'Keeffe and colleagues (2018, p. 644), '[t]*he recovery model may ignore context and strain to account for the social determinants of health and the relationship between social inequity and recovery*.'.

This critique of recovery can also be extended to the mental health service provision to multiply marginalised individuals, whereby clients' suffering resulting from social, economic or political disenfranchisement often tends to be medicalised by reducing it to a psycho-emotional or a mental health problem (Harper & Speed, 2012). In the present study, a number of participants hinted at the tendency of service providers (such as case managers, counsellors and psychiatrists) to neglect the complexity of their concerns and over-emphasise clients' adherence to medication and the treatment plan (e.g. *'OK. You want your medication for sleep. Let me get you that. That's the most important thing.' 'No, that's not the most important thing* […]' (Matthew). The possible impact of reductionist, medicalised professional notions of recovery on clients' capacities to engage in, and envision, recovery warrants further empirical investigation.

The super-ordinate theme, '*the need for safety, security and constancy'*, captures the desired transition from the '*unhomelike*' life '*before*' to the structure and constancy proffered by the safe temporary housing and ultimately, by permanent housing. Stable housing and the adequate and accessible professional support associated with it represented a potentially transformative set of resources for participants to conceive, plan and pursue their recovery. Svenaeus's (2000) concept of '*unhomelike being-in-the-world*' was used in the present IPA as an experiential category encompassing the enduring psycho-affective, existential and embodied consequences of chronic housing instability and other forms of social marginalisation. The concept of '*homelikeness*' is helpful in understanding losing one's home as not only the loss of physical shelter and privacy but also as an existentially threatening event (Padgett, 2007; Öhlén et al., 2014). Those findings help further the understanding of the role of temporary and transitional accommodation in the recovery journeys of clients with SMI (Meanwell, 2012; Mayock et al., 2015; Paul et al., 2018; Chamberlain & Johnson, 2013; Burns, 2016; Fotheringham et al., 2014).

The present findings concur with the findings from several narrative reviews on the vital importance of access to affordable and safe housing as one of the prerequisites for recovery (Drake & Whitley, 2014; Onken et al., 2007; Tew et al., 2012). Furthermore, the theme of the importance of safety, security and constancy calls for an expansion of the CHIME (connectedness, hope and optimism, identity, meaning in life and empowerment) framework of personal recovery (Leamy et al., 2011), which has insufficiently accounted for the effects of ongoing difficulties such as financial hardship, unmet basic needs and the inequitable distribution of power and resources (Stuart et al., 2017; Onken et al., 2007; Tew et al., 2012; Brijnath, 2015). For the present participants, the effects of chronic housing instability and co-occurring disadvantage, particularly the sense of 'unhomelike' being-in-the-world, seemed to pervade all other components of recovery such as social connectedness and identity. The present study, therefore, enriched the evidence base for the CHIME framework by highlighting the embeddedness of its components in individuals' socio-economic contexts.

'*Insight*' emerged from the IPA as another multi-dimensional facilitator of envisioning and initiating recovery. Several participants emphasised the importance of gaining skills (e.g. self-reflective skills, cognitive-behavioural skills) and knowledge (e.g. knowledge about mental illness and addiction). Insight was often experienced as a renewed sense of possibility, an increased sense of self-efficacy and a rediscovery of one's 'true' self and 'true' purpose in life. Insight was most commonly facilitated by the constructive re-evaluation of one's past, often guided by a counsellor or another professional, which generated new perspectives about oneself and one's place in the world, as well as internal shifts in beliefs (e.g. *'I realised I did not want the negative life.'* (Scott). Although *insight* is absent as an explicit theme in CHIME, it resonates with elements from the identity, meaning in life and empowerment CHIME categories (Leamy et al., 2011). The present study, therefore, calls for a greater emphasis in future models of recovery on the shifts in self-knowledge and self-awareness that represent *insight* and on how those can be catalysed by the provision of basic needs and therapeutic support.

The super-ordinate theme of *insight* strongly emphasises the transformational nature of the recovery process in the context of major life transitions. Those findings add valuable insights to understanding the earliest stages of recovery-those that have been characterised as '*pre-recovery*' and '*contemplation*' (Leamy et al., 2011; Davidson et al., 2010). The findings of the present study indicate that those early recovery stages may involve both gradual processes and epiphanous transformational events of expanding awareness and self-knowledge. In either case, as Lysaker, Yanos and Roe (2009, p. 116) posit, '[t]*o be meaningful in the larger frame, insight needs to be an element of a larger personal understanding of one's life […]'.*

The current study found that together with the capability for safety, security and the sense of constancy, the capability for insight was among the critical preconditions for the development of other recovery-relevant capabilities such as positive sense of self, emotional and social connectedness, and others. In that sense, the capability for insight could be conceived of as a *fertile capability* (Wolff & De-Shalit, 2013; Nussbaum, 2011). A fertile capability refers to a capability whose realisation is likely to foster the attainment of other capabilities (Wolff & De-Shalit, 2013).

Enacting and Sustaining Recovery

While safety and constancy and insight were identified as crucial for participants to envision and initiate recovery, a range of other processes seemed to enable participants to enact and sustain their emerging recovery projects. Those processes ensured that participants' enhanced self-knowledge and ownership of recovery could translate into coherent self-identities, as well as into valued and meaningful practices, routines, accomplishments and connections. The IPA findings revealed that while self-reflection, insight and 'owning' recovery enabled participants to '*see themselves in the world*' (Potter, 2015, p. 88), achieving positive coping and self-management, nurturing a strong and positive identity, finding meaning and purpose in life and feeling '*wanted, accepted and needed*' allowed them to *enact* and *realise* themselves in the world.

On a conceptual level, the delineation of *envisioning recovery* and *enacting recovery* as two interrelated but analytically separable over-arching themes in the present study re-affirms recovery as a dynamic, processual and multidetermined phenomenon (Tew et al., 2012; Drake & Whitley, 2014). It also underscores that personal recovery is not simply achieved by the subjective altering of one's beliefs, motivation, habits and goals as purely cognitive events. Instead, as argued by William White (2007) in the context of addictions recovery, personal recovery requires *sustained effort* and *maintenance* as the individual navigates the relational and socio-structural dimensions of life such as health care, housing, the family, relationships and community living. As one American participant, George, shared regarding recovery as a long-term life project:

> *'…that's what recovery is about-what do you do with yourself after recovery... […] You can stop drinking, or you can stop getting high or both, you know...() […] But what happens when you stop? What are you gonna do with yourself?'*

As the present study demonstrates, this sustained effort was contingent upon participants' abilities to cope and self-manage, nurture coherent and positive identities, find meaning in life, and feel '*wanted, accepted and needed*', which, in turn, were shaped by the confluence of relational, institutional, biographical and other supra-individual factors. The following several sections discuss each of those super-ordinate themes.

Coping amidst an Assemblage of Disadvantage: 'Nothing to Do […] *and Nowhere to Go'*

Understanding the nature and process of coping is instrumental in devising appropriate interventions for optimising clients' symptom management, holistic well-being, engagement with services, and in the context of homelessness, housing readiness (Padgett et al., 2016; Potter et al., 2018; Washington & Moxley, 2008). The present study's findings regarding the diversity of coping responses and strategies (both positive and negative) the participants employed to manage mental illness make several important contributions to the literature on SMI. For one thing, those findings acutely demonstrate the severity and multiplicity of effects of chronic homelessness and temporary housing on mental well-being and therefore add to the scarce literature on the lived experience of transitioning out of homelessness in clients with complex needs (Donley & Wright, 2012; Lincoln et al., 2009; United States Interagency Council on Homelessness, 2018; Phipps et al., 2019; Karadzhov et al., 2020). Specifically, the chronic stress, uncertainty and sense of powerlessness engendered by shelter living profoundly undermined several participants' capacities to positively and effectively cope with their mental illness. Those findings provide evidentiary support for the concerns raised regarding the anti-therapeutic effects of shelter-type facilities, especially for clients with co-occurring conditions (Watts et al., 2018; Moffa et al., 2019; Coalition for the Homeless, 2018).

The findings about the pervasive deleterious impact of *boredom* on participants' symptom management and recovery shed valuable insights into chronic homelessness as a deeply affective, socially alienating and illness-perpetuating experience. Several participants' accounts of '*being bored'*, '*trying to kill the day and night away*' and '*biting your time*' were not interpreted by the Researcher as merely indicative of apathy, passivity and the lack of motivation. Rather, the boredom experienced by the participants seemed to represent a limbo-like, existentially threatening experience that had resulted from cumulative social exclusion. Those findings seem consistent with the small but growing body of work investigating the relationship between boredom, meaning in life and mental well-being (Fahlman et al., 2009; Marshall et al., 2017).

Relatedly, one of the most significant findings that emerged from the mobile phone diary data refers to the significance of the '*insignificant*'. Indeed, several participants' diary entries were imbued with what Susie Scott (2018, p. 3) calls '*negatively defined phenomena'* (See '*The Intrinsic Value of 'Doing Things' and the Perils of Boredom'* in *'Chapter Six')*. The lack of activity, empty streets, empty bottles and fruitless efforts to obtain small but significant goals such as getting a haircut can be interpreted as *'symbolic social objects'* (Scott, 2018, p. 3) that were co-created by the interaction between participants' concerns and commitments (e.g. to self-care, to socialise, to recover) and the lack of practical opportunities for realising them. Scott (2018, p. 3) argues that '[…] *nothing is always productive of something* […]'. In the present study, '*nothing*'-ness (for example, imposed passivity, paralysis of action, silences, uncertainty, avoidance) appeared to engender immense psychological distress, hopelessness and disidentification with the possibility for recovery. Future sociological enquiries are warranted examining the theoretical significance of '*nothing*' for understanding marginalisation and social exclusion (Scott, 2018).

The current findings also support the conceptualisation of boredom in the context of homelessness as a manifestation of occupational alienation and social injustice (Marshall et al., 2019)**.** Boredom has only recently been recognised as a profoundly influential determinant of homeless persons' health and well-being (Marshall et al., 2019). The findings from the current study support the findings from Marshall et al.'s (2019) review that found that emotional distress and the sense of imprisonment were common consequences of boredom in people who were homeless, and that certain transitions between housing circumstances may exacerbate boredom.

The present findings, therefore, should inform future empirical work, as well as concrete housing assistance interventions focusing on mitigating the negative effects of social isolation and expanding the access to occupational activities. The value of occupation to the individual has been recognised in terms of both the final outcome it brings (e.g. positive social interactions; financial independence) and the *process* of pursuing meaningful and satisfying activities (Roy et al., 2017). Across the current participants, occupational engagement had a multitude of functions. For some, it acted as a buffer against depression and anxiety; for others, it was perceived as the route to 'normality', productivity and a sense of self-worth. Some participants also discussed the value of doing things and being active as being instrumental in sustaining their coping with SMI symptoms, their focus and self-management. Those findings of the multiple functions of occupations for the participants' recovery concur with Doroud and colleagues' (2015) scoping review regarding the interrelations between occupation and recovery for people with mental illness. Specifically, the authors concluded that occupational engagement promoted '*the inseparable interplay of doing, being, becoming and belonging'* (p. 388).

The present findings also underscore the importance of eliciting individuals' views of how and why occupation impacts mental well-being in the context of the everyday social ecologies of shelter living (Iveson & Cornish, 2016). Understanding the mechanisms via which occupational engagement nurtures individuals' self-efficacy and sense of agency is likely to inform strengths-based approaches for supporting clients with complex needs regain autonomy and recovery (Iveson & Cornish, 2016).

Role of Professional Support Services in Recovery

As argued in '*Chapter Three*', there has been a need to better understand how professionals can best support the recovery in clients who are homeless and have complex needs in a way that promotes clients' autonomy and self-determination (Gillis et al., 2010; Le Boutillier et al., 2011; Le Boutillier et al., 2015). The present study addresses this need by identifying what practitioner skills, practices and attitudes the participants perceived as integral to their recovery.

The majority of participants recognised professional support services as key enablers of illness management and recovery. Similar to other studies with mental health service users, the participants emphasised both useful practical (e.g. medications, skills learning, therapy, instrumental assistance) *and* relational and emotional aspects (e.g. being 'there with' the client; being treated like a family member; flexibility) of the service provision (Topor & Denhov, 2015; Lietz et al., 2014). Among the enablers of recovery identified were the reliability, accessibility, empathy and appropriateness of the support services (including their case managers, housing workers, medical doctors, psychiatrists and counsellors). Listening with a non-judgemental stance was singled out as one of the most important attributes of case workers ('[…] *there's a lot to be said with somebody who listens….*' (Matthew). Those findings are consistent with the literature on recovery-oriented practice advocating the importance of relationality in day-to-day practice (Williams & Tufford, 2012; Lietz et al., 2014; Ådnøy Eriksen et al., 2014; Zerger et al., 2014).

Several participants also appreciated having opportunities to explore their past in a guided, supportive environment, as a means of working through trauma, re-establishing a positive self-identity and regaining a greater sense of autonomy and control. In addition, disclosure, mutual respect and common priorities were also highlighted as vital for enabling an effective client-practitioner relationship. Those findings concur with Roberts and Boardman's conclusion (2014, p. 37):

> '*Practitioners cannot 'recover' people. Services can in many ways provide the preconditions of recovery through opportunities and supports but not recovery itself, as it needs to be discovered by the person themselves.*'

In contrast, participants also experienced difficulties and frustrations with brokering optimal support from their various services providers. Among the most significant hinderers of recovery were not feeling listened to, validated and acknowledged, the rigid rules and regulations in some of the services, the insensitive or inappropriate therapeutic support, and the negative effects of substance use treatment on mental well-being. Those findings lend evidentiary support to other studies highlighting the difficulties homeless clients tend to face when navigating multiple and often-fragmented support services (Wusinich et al., 2019; Meanwell, 2012; Kerman et al., 2019). What the present findings add to existent literature is the evidence on the detrimental effect of ineffective service provision on some clients' mental well-being and recovery capacities-particularly the sense of hopelessness (Scott; Craig), frustrations and the sense of injustice (Kelly) and retraumatisation (Ashton).

In light of the evidence about the potentially *recovery-impeding* role of professional support services, including for those with lived experience of homelessness (Voronka et al., 2014; Slade et al., 2014; Ljungberg et al., 2016), the present findings warrant practice-focused research exploring approaches to improving the disconnect between clients' needs and experiences and system responses. Much of the prior research on the experiences with formal services in clients with a history of SMI and homelessness has only offered superficial accounts of whether or not clients relied on professionals for their instrumental and socio-emotional needs (e.g. Paul et al., 2018). Further research is needed, including research eliciting service-provider perspectives, into how providers' professional training, recovery orientation and relationships with clients '*erect*' or '*demolish*' barriers to recovery in clients with complex needs (Ljungberg et al., 2016, p. 276; Zerger et al., 2014).

Salvaging a 'Strong' Self and the Striving for Meaning

The present findings largely cohere with, and expand, the body of literature on the dynamic and multi-layered identity processes involved in personal recovery (Bonney & Stickley et al., 2008; Jacob et al., 2017; Wisdom et al., 2008; Kaite et al., 2015; Leamy et al., 2011; Shea, 2010). The present findings of participants' long-term struggles to nurture a positive self-identity by reconciling with, and positively integrating, traumatic life experiences, mental illness, the deleterious effects of unemployment and relationship difficulties, and/or the pervasive influence of substance use, resonate with other studies regarding the multidimensionality of influences upon identity in recovery (Kaite et al., 2015; Smith et al., 2015). Furthermore, the multiple sources of positive self-identity that the participants drew upon (such as occupations, reconnecting with others, cultural morals, constructively reinterpreting the past) provide an insight into the multiple pathways to recovery that practitioners should support (Buck et al., 2013). Those findings also challenge oversimplistic notions of the reconstruction of positive identity in recovery as a return back to 'normal' or to one's pre-illness self (Shea, 2010). For many participants, achieving a coherent sense of self represented a personal transformation that could lead to a life that was unfamiliar, ambiguous and, for some, even frightening ('…*recovery is fearful to me. Because it's the other side of life that I never experienced*.' (George).

Notably, unlike some prior work examining the intersectionality of influences upon identity in persons who were homeless, the present study yielded little evidence regarding the presence and role of interpersonal stigma on the basis of housing status, substance use, age, ethnicity, ability or gender (Gonyea & Melekis, 2017; Zufferey, 2016; Skosireva et al., 2014; Weisz & Quinn, 2018). Instead, participants tended to emphasise the shaping influences of substance use, mental illness, economic instability, family circumstances (including parenting) and the service provision upon their identities. It could be that they tended to prioritise the domains of their lives that they felt they had more immediate and personal control over such as abstinence, treatment adherence, job-seeking and re-establishing valued family relationships. Alternatively, the questioning strategy in this study may not have been optimal for eliciting the often-subtle influences of complex stigma upon identity and well-being. Future intersectionality-informed work should more comprehensively examine the confluence of various sources of structural and relational stigmas upon the identity work in persons with complex needs (Gonyea & Melekis, 2017; Kidd et al., 2014). It is also important to explore how the salience of individuals' multiple social identities changes as they transition from homelessness to permanent housing and community living (Smith et al., 2015; Desjarlais-deKlerk, 2018).

The striving for meaning in life was also found to be integral for enacting and sustaining recovery (See '*Dilemmas of Meaning*' in '*Chapter Six*'). For several participants, achieving the illuminative sense of insight and self-directedness, as well as mastering positive coping behaviours, did not fully resolve their *dilemmas of meaning*. In the precarious conditions of homelessness and shelter living, the boundary between hopefulness and the sense of existential vacuum and suffering was thin and fragile. Many participants preserved their sense of meaning and purpose in life by engaging in spirituality and self-transcendence, in altruistic occupations and in a constructive re-evaluation of the past. To the participants, preserving meaning in life and nurturing a positive sense of self were paramount to sustaining their recovery journeys through the ebbs and flows, or '*trials and tribulations'*, (Benjamin; Oliver; Scott) of homelessness and co-occurring disadvantage.

Overall, to the participants, temporary housing following a period of long-term homelessness was a liminal, ambiguous and potentially transformative space, which was associated with both opportunities and resources for recovery *and* with a multitude of threats to one's socio-emotional and existential well-being. Temporary accommodation was experienced as an island of hope and a lifeline; as an *'open prison'*; and as a test for one's perseverance and inner strength. Virtually all participants experienced temporary housing as a *boundary situation* (McGraw, 1995).

In this liminal space**,** the participants confronted existential uncertainty, fear and disorientation, but also identified and realised opportunities for self-knowledge and personal growth in support of their emerging recovery-relevant goals.

Those findings appear consistent with the mental health literature regarding the lack of attunement with oneself and with others as one of the core experiential categories characterising a life with SMI (Roe et al., 2006). The present study extends those findings to co-occurring chronic homelessness and SMI by demonstrating that forging meaning from existential and psycho-emotional suffering seems to be a crucial component of personal recovery.

Reconceptualising 'Hope' amidst Chronic Disadvantage

Hope was a prominent theme in the present findings mainly by virtue of its absence. Loss of the desire to live and hopelessness were found to be significant barriers to several participants' positive meaning-making, which, in turn, had an adverse effect on their recovery (See '*Loss of Meaning and Hopelessness*' in '*Chapter Six*'). The participants' narratives and diary entries illuminated the gradual erosion of hope as a result of persistent financial struggles and food insecurity (Matthew); severely limited social activities due to financial struggles and homelessness (Henry); and barriers to employment-all rooted in financial difficulties (Craig). For Matthew, in addition, his hopelessness was exacerbated by what he perceived were exploitative social relations in society, the structural injustices towards the homeless, as well as the lack of empathy from support staff. Matthew's exclamation, *'They're denying us the opportunity to succeed in life!'*, reflects his painful awareness of his restricted capabilities for recovery and rehousing as a result of systemic barriers. Those findings seem to contrast with the bulk of studies on recovery that emphasise narratives of *hopefulness* (e.g. Kirst et al., 2014). They also underscore the importance of exploring the full spectrum of recovery experiences, including subjective experiences of the lack of hope for recovery as a result of chronic adversity and repeated fruitless efforts to attain recovery-promoting resources.

Participants' hopelessness did not seem to reflect deficiencies in their '*motivation to change'*, '*positive thinking*', '*valuing success'*, or '*having dreams and aspirations'*-as one would have inferred from the uncritical reading of the CHIME framework (Leamy et al., 2011, p. 448). Rather, their narratives revealed that hopelessness was induced by multiple concrete non-happenings, denials of opportunities, and disappointments occurring on a day-to-day basis.

The present findings of the socio-structural and biographical antecedents of hope and hopelessness challenge Leamy et al.'s (2011) framing of hope as a '*characteristic*[s] *of the individual'* (p. 450). Instead, hopelessness experienced by persons with multiple disadvantage should be more aptly conceptualised as a consequence of chronic socio-structural impediments to individuals' abilities to enact valued outcomes that are instrumental to individuals' self-preservation, dignity and a positive sense of self.

Furthermore, some participants' explicit emphasis on coping with their predicament '*one day at a time*' and not overthinking about their future seems to reveal a more complex relationship between hope and recovery than previously assumed (Tang, 2018; Fisher & Lees, 2016). Fisher and Lees (2016), for instance, argue that hopefulness that is narrowly defined as a future orientation is not a universal condition for, or precursor of, recovery. Instead, the authors discuss '[…] *the value of a relational orientation towards well-being in the present, rather than fixating on future goals*.' (p. 599). They continue by arguing that for individuals who face severe forms of structural disadvantage and uncertainty, '[t]*he problem with placing one's hope in a particular future-based outcome is that it is often highly precarious.*' (p. 607). Those insights appear to indicate that the future orientation may not be the most significant temporal orientation in the experience of hope and that an enhanced focus on the present may be more facilitative of coping with the contingencies of homelessness and co-occurring disadvantage.

Those insights from the mental health recovery literature on hope necessitate future empirical work on individuals' understanding and experience of hope, especially in those who endure chronic structural disadvantage such as homelessness (Gřundělová & Stanková, 2019). Hope has remained relatively underresearched in relation to homelessness and yet understanding the workings of hope in different client groups is essential for implementing effective person-centred care (Kirst et al., 2014; Gřundělová & Stanková, 2019; Tang, 2018). Further research is warranted into the multiplicity of meanings ascribed to hope by those with lived experience of homelessness and its implications for mental health recovery (Partis, 2003).

The Striving for Socio-Emotional Connectedness

The final super-ordinate theme, *feeling 'wanted, accepted and needed'*, re-affirms the importance of social relationships for recovery as evidenced by the bulk of the mental health literature (Leamy et al., 2011; Tew et al., 2012; Padgett et al., 2008; Onken et al., 2007). This theme overlaps with some of the insights from several of the other super-ordinate themes, particularly regarding the relational and humanising aspects of professional support and the identity-enhancing role of reconnecting with family members, but also reveals the biographical embeddedness and continuities of participants' deprived socio-emotional needs.

One of the most prominent findings from the IPA phase concerns the participants' life story accounts of the chronic human needs deprivations and the resulting enduring sense of vulnerability (E.g. '*I was a very needy person.'; 'the big bad world'; 'I was mommy's little boy'; 'My mother was a great enabler.'; 'I didn't have love, discipline and support.'*). The current study indicates that the relationship between vulnerability and recovery seems to be complex and crucial for understanding the experiences of mental health and illness in individuals with a history of trauma and other adverse relational life experiences. Sharing their physical, psycho-emotional and existential vulnerabilities in their narratives could be interpreted as their endeavours to regain and convey their sense of shared humanity. Illness and recovery narratives that emphasise the narrator's shared vulnerability may be a deeply humanising experience because, as Ponce and colleagues (2012, p. 350) suggest, '[r]*ecovery links people's struggles and victories in relation to their mental illnesses to the struggles and difficulties that one faces as a person-in-the-world, whether or not one has a mental illness*.'. In addition, those accounts of vulnerability may serve the more instrumental functions of helping participants open up to help, as well as decrease self-blame for their mental illness and other problematic life experiences.

The dominant idea of personal recovery as a self-directed process of regaining control, independence and autonomy in life seems at odds with the present participants' emphases on their (inherent) human vulnerabilities. As argued by Anderson (2014), however, vulnerability and autonomy are not necessarily antipodes. Acknowledging one's vulnerabilities should not be interpreted as a passive, defeatist act but rather as a symbolic, narrative re-instatement of the participants' shared humanity. Further phenomenologically-informed research should unpack the meaning and function of vulnerability in recovery and examine therapeutic avenues that are informed by such insights (Dahlberg et al., 2009; Evans et al., 2017).

Finally, the present findings seem to support the more nuanced understanding of the role of social capital in those with severe and multiple disadvantage by highlighting the recovery-impeding effects of *negative social capital* (Padgett et al., 2008). For some of the present participants, the negative influences of 'street life' and 'drug culture', together with the volatile and often insecure shelter environment, made the forming of social relationships difficult and/or unwanted. Indeed, several participants produced rather 'solitary' recovery narratives, in which they de-emphasised the importance of an expanded social network for recovery (E.g. *'I need myself to be well.'* (Liam); *'I want to be left alone.'* (George).

From the current findings, it could be inferred that participants' experiences of social capital were rather complex, unstable and at times, contradictory. Those findings can stimulate further research unpacking the nature of social capital for individuals with SMI occupying homeless shelters, as well as identifying effective strategies for helping shelter clients accrue recovery-promoting social capital. The potentially neutral or negative effects of social relationships on well-being and social integration outcomes in homeless populations have led Fitzpatrick and colleagues (2007, p. 750) to suggest that '[…] *social capital's much touted benefits for personal well-being may not apply to disadvantaged populations*.'. Understanding the dynamics and limits of social capital in shelter clients, including in those with histories of relational trauma and/or PSU, is important for improving the social connectedness and recovery outcomes in this population.

Researcher Reflections on the Analysis

As part of the IPA procedure, I continuously self-examined my taken-for-granted assumptions and beliefs and reflected on how they evolved during the study and how they might have influenced the interpretation of the data. In IPA, it is generally accepted that the interpretation of participants' data is the product of both participants' voices (subjectivity) and the researcher's own beliefs and meaning-making (reflexivity; Willig, 2017). The degree of overlap between subjectivity and reflexivity in the current analysis varies, however, as I utilised both an empathetic and a questioning hermeneutic stances as I interpreted the data (Smith et al., 2009). The former stance meant that I aimed to capture participants' own understanding of their experience as authentically as possible. The latter stance, in contrast, was more concerned with what remained *unsaid* by the participants and why. In this case, my interpretations may naturally not coincide with the participants' subjective perceptions (Willig, 2017). The combination of those interpretative layers provided nuance and depth in the analysis (Smith et al., 2009).

The data challenged my pre-conceptions about recovery in several important ways. I was particularly surprised at the emerging data demonstrating that, for many participants, mental health and SU recovery were intricately interwoven (dual recovery), that envisioning recovery was often as difficult and cumbersome as enacting recovery, as well as that articulating one's recovery vision was not easily achieved by all participants. With each subsequent interview, I became more and more attuned to the diverse ways the participants experienced, related to, and communicated recovery, including participants' indirect (apophatic) ways of relating to recovery. Notably, in two participants' cases (Joshua and Henry), their relationship with recovery could not be ascertained due to the brevity of the interview encounters (only one interview was conducted with each of those two participants).

As a more fundamental challenge to researching recovery, during the analysis, I came to realise that recovery is an expansive concept that emerges from both individuals' biographies and their day-to-day lives and social ecologies. This multidimensionality of recovery sometimes made it difficult to make judgements as to how relevant each data unit or subtheme was specifically to the recovery process as opposed to, for instance, well-being. While the IPA focused on identifying common constituents of the experience of recovery across participants, I remained conscious of preserving the narrativity (biographical depth) of each account. Case summaries were added to the analysis to help capture the narrative 'wholeness' of participants' accounts.

As highlighted in the methodology, during the IPA, I endeavoured to keep 'in check' my pre-existing theoretical knowledge so that it did not 'contaminate' the analysis or obscure some potentially significant aspect of the phenomena under study. However, it remains possible that my interpretation of the data was influenced by my affinity towards certain nursing theories, particularly theories of self-transcendence and theories of suffering. Also, the derivation of the two over-arching themes came after considerable 'back and forth' between the empirical material, the super-ordinate themes and the research questions. The discernment and naming of the two over-arching themes (i.e. contemplating and envisioning recovery and enacting and sustaining recovery) may have been inadvertently influenced by theories of human agency such as Norbert Wiley's (2009) theoretical discussion of the distinction between *defining*, *choosing* and *enacting* an action or a goal, with which I became familiar during the IPA phase.

Furthermore, my social positioning as a Caucasian European man from a privileged background and a cultural outsider to the U.S. might have obscured my abilities to discern some of the ethnic, racial, class, gender and other intersectional nuances and contexts relevant to participants' lived experience. It also likely limited my ability to effectively probe into the importance of race, ethnicity and class for recovery. For instance, I might have failed to detect and analyse certain cultural tropes in the participants' accounts, which, however, might have pronounced significance for their lives and their socio-historical conditions of living. Such tropes include '*I'm sick and tired of being sick and tired*', which could have referred to racial inequalities experienced by this participant, and '*dope-fiend'*, which is a derogatory term to describe a person who is extremely addicted to drugs and which could express a rhetoric about power, capitalism, alterity and pathologising addiction.

The Complex Causality of Recovery amidst Homelessness

The critical realist analysis went beyond participants' self-reported experiences in order to generate a layered, theoretically-informed explanation of the impact of socio-structural conditions and of participants' agency on those recovery processes, experiences and outcomes (Danermark et al., 2005; Archer, 1995; See '*Chapter Seven*'). This analysis was carried out using Archer's morphogenetic model due to its ability to provide a fine-grained, multi-stage account of the structure-agency interactions over time (Archer, 1995; See '*Conceptual Framework of the Current Study*' in '*Chapter Four*').

The application of this model helped generate a sophisticated, theory-driven explanation of how various social structures and cultures possibly interacted with participants' agential capacities to shape the observed recovery-relevant outcomes. By the explicit incorporation of social relations and their impact on participants' deliberation, discernment and dedication in relation to recovery, the present study augmented the explanatory utility of the morphogenetic model (See Figure 22 in '*Chapter Seven'*). To the author's knowledge, the current study was the only empirical investigation to date to utilise the morphogenetic model in the study of personal recovery. In the following sections, the insights from this analytic phase are interpreted and contextualised.

The Role of Social Structures in Recovery: A Multiplicity of Conditioning Effects

As explored in '*Chapter Seven*', several socio-structural factors and contexts were distinguished as possibly implicated in participants' recovery-including housing, the economy and the welfare system, professional support services, street culture, mental health literacy and stigma in society, and others. Collectively, those findings of the multiplicity of conditioning structures/cultures and their effects contribute to the theorising of the socio-structural and cultural embeddedness of personal recovery (Tew et al., 2012; Topor et al., 2011; Hopper, 2007; Onken et al., 2007). They also support the view that homelessness, particularly chronic homelessness, represents an assemblage of disadvantage that can impede individuals' agential capacities in numerous ways over the individuals' life course (Karadzhov et al., 2020; Padgett, Tiderington, Tran Smith, Derejko, & Henwood, 2016; Voronka et al., 2014).

Crucially, those conditioning effects did not constitute direct cause-and-effect mechanisms (Sayer, 1992). Informed by the critical realist notions of the *stratified reality*, *transfactuality* and *mediated knowledge*, those structures/cultures were conceptualised as having *conditioned* (i.e. non-deterministically) participants' abilities to envision and enact recovery (See '*Chapter Four*' and '*Data Analysis Strategy*' in '*Chapter Five*'; Bhaskar, 1989; Wynn & Williams, 2012; Martinez Dy et al., 2014). Beyond adding to the scarce evidence base of what socio-structural factors influence recovery (Tew et al., 2012; Onken et al., 2007), the present investigation makes a significant and distinct contribution to understanding *how* such factors possibly come to impact on recovery-relevant outcomes.

Two main types of conditioning effects in relation to recovery were discerned: (a) the restriction or expansion of the means available for participants to realise their recovery projects (*directional guidance*; Archer, 1995); and (b) influence upon the types of life projects participants perceived as feasible and/or desirable (i.e. affecting participants' *degrees of interpretative freedom*; Archer, 1995). This distinction is theoretically valuable because it helps understand how social structures/cultures shape recovery by modulating individuals' access to both tangible (e.g. material, economic) and intangible (e.g. knowledge, ideas, discourses, values, schemas) resources. As such, it helps produce a more nuanced understanding of the mental health implications of the depleted social, economic, cultural and identity capitals frequently observed in homeless populations (Shinn, 2007; Barker, 2013; Barman-Adhikari et al., 2016; Fitzpatrick et al., 2007; Farrugia, 2011).

The present findings call for the more advanced understanding of how various forms of capital interact with one another to promote or hinder personal recovery amidst multiple disadvantage (Abel & Frohlich, 2012). Recognising the diversity of forms and sources of recovery-promoting capital in multiply marginalised populations is especially important for mental health and social work policy and practice. Specifically, practitioners and policy-makers should remain aware that simply increasing individuals' access to economic or housing assistance or wider social networks will not necessarily address the full scope of determinants of those individuals' well-being and recovery (Fitzpatrick et al., 2007; Tew et al., 2012; Malmberg-Heimonen, 2010).

Two over-arching conceptual contributions of the present critical realist-informed conceptualisation of social structures and their effects on recovery-relevant personal agency can be distinguished. First, the incorporation of the various structural/cultural influences shaping recovery in the context of homelessness advances the understanding of *severe and multiple disadvantage* (SMD; Fisher, 2015; Fitzpatrick et al., 2013; Bramley & Fitzpatrick, 2018). As Greg Fisher (2015, p. 8) notes, reconstructing the '*problem space*' demarcated by the co-occurrence of homelessness, mental health difficulties, substance use problems, chronic poverty and others is likely to offer useful guidance for meeting the complex and interconnected needs of individuals that have endured SMD. The examination of the synergistic effects of the conditioning structures/cultures-for example, how they mutually reinforce or counteract one another-helps generate more comprehensive knowledge of the interconnectedness, complexity and uniqueness of those individuals' needs (Fisher, 2015).

By eliciting participants' life stories, the present study generated valuable insights into both the '*causal history*' of participants' recovery-relevant needs, *and* into their interconnectedness '*today*', in the context of temporary or transitional housing (Fisher, 2015, p. 8). For instance, the analysis demonstrates how, for several participants such as Neil, Craig and Claire, the effects of the chronic lack of adequate housing and other professional support, together with a series of adverse familial and street life events, had contributed to their self-reported negative coping, diminished sense of self-worth and a sense of social disconnectedness (See '*Chapter Seven*'). Also, the evidence of the long-term effects of street culture and of AA/NA support services on some participants' coping with SMI demonstrates the interconnectedness between substance use problems, street culture activities and mental health difficulties (Barker, 2013; Fitzpatrick et al., 2013).

While there have been efforts to conceptualise and measure SMD *quantitatively* (for example, its scale and overlap rates; Fitzpatrick et al., 2013), the *qualitative* exploration of SMD, as exemplified in the present study, enhances the understanding of the complex and subtle interconnections among different forms of disadvantage and of the potential mechanisms via which those interconnections impede individuals' mental well-being and recovery. Even further, the present critical realist analysis advances the insights generated by studies such as Kidd et al. (2014), Padgett, Tiderington, Tran Smith, Derejko and Henwood (2016) and Benbow et al. (2011) regarding the *intersectionality* of disadvantage and its impact on the experience of coping and recovery. In particular, in the context of most of the present participants' lives, homelessness should be more aptly conceptualised as a complex disadvantage created as a result of the mutually reinforcing effects of housing shortages, inadequate welfare provision, a dysfunctional family environment, adverse macro-economic events and others. Those multiple and interacting structural 'forces', in turn, create distinct experiences of self-identity, social connectedness, empowerment and other pre-requisites for recovery (Morrow & Malcoe, 2017; Llewellyn-Beardsley et al., 2019). This complexity warrants a person-centred, flexible and coordinated approach to the provision of recovery-oriented care to such multiply marginalised individuals (Fisher, 2015).

Second, the present analysis of the range of social structures/cultures having *conditioned* (rather than *determined*) participants' recovery outcomes re-establishes the importance of individual (personal) agency in the recovery process (Watson, 2012a; Yanos et al., 2007). From a theoretical standpoint, accounting for the interplay between structure and agency protects against the over-simplistic and dehumanising view that individuals passively, predictably and uniformly respond to the challenges, opportunities and contingencies presented by their objective living circumstances (Alkire, 2002; Parsell et al., 2016; Abel & Frohlich, 2012). From an emancipatory standpoint, recognising individuals' intrinsic capacities to reflect upon, challenge, resist and circumvent the effects of their social contexts is critical to empowering individuals in their unique journeys towards authentic, meaningful and productive lives (Duff, 2016; Parsell et al., 2016; Morrow & Malcoe, 2017; Watson, 2012a; Scott & Wilson, 2011). From a service provision and a social policy standpoints, fully recognising service-users' personal agency is vital for challenging practices and policies that are underpinned by coercion, paternalism, infantilisation and a '*one-size-fits-all*' mentality (Hopper, 2007; Farkas, 2007; Rose, 2014).

Crucially, however, individual-level agency-enhancing interventions-for instance, behavioural activation, counselling, peer support or strengths-based coaching-are *unlikely* to enable clients to achieve emancipatory identities without the removal of the structural impediments to their realisation. The present findings indicate that such impediments to recovery are rooted in the organisation of the housing and welfare sectors, the organisation of professional support services, in wider macro-economic processes, as well as in societal attitudes towards, and knowledge of, mental illness. Counteracting those systemic and ideological constraints on recovery is likely to require collective social justice-oriented efforts and system-level interventions.

Altogether, by exposing the web of structural influences upon participants' capacities to envision and enact a meaningful, productive and satisfying life, the present study advocates a politicised and systemic view of personal recovery (Williams et al., 2015). Instead of reducing connectedness, empowerment, hope, meaning in life and a positive self-identity to changes in internal predispositions, cognitive reappraisals, willpower and motivation, such a politicised view 'grounds' those core recovery processes in specific structural conditions and social positionalities. Those conditions fundamentally shape the access to resources and opportunities for the initiation and sustenance of recovery (Morrow & Weisser, 2012). For instance, an impaired sense of self-worth can, for some participants, be conceptualised as the emergent outcome of a dysfunctional family environment, exposure to victimisation and drug use in the community and on the streets, weak and ineffective welfare provisions for care leavers and the lack of accessible community mental health services. Analogically, for other participants, their enduring sense of being *dis*connected from others seems to be the manifestation of a *fractured* internal conversation (Archer,

1995) *in response to* the chronically unresponsive and anti-therapeutic housing policies and procedures, in combination with restricted employment opportunities and involvement in a street culture that perpetuates dependencies, lack of insight and vulnerability. Personal recovery in individuals with a history of severe forms of homelessness, therefore, is contingent upon identifying and removing the underlying structural impediments that continuously hinder individuals' capacities for insight, autonomy, self-determination and socio-emotional connectedness.

This contextualised and problematised notion of recovery amidst multiple disadvantage obviates individualised, reactive and paternalistic professional views and models of recovery (Harper & Speed, 2012). Institutional systems and the distribution of social, economic and political capital, power and opportunity, not manualised interventions, treatment modalities or programmes, create the fundamental conditions for actualising recovery. Accordingly, while mental health recovery is often framed within a discourse of a *personal* transformation (Lafrance & Stoppard, 2006), it is social, economic and political transformations that seem to govern this process (Elliott et al., 2015). While, in theory, individuals do possess the intrinsic capacity for generating individual and social change through the exercise of their autonomous reflexivity (Archer, 1995), conditions of relentless and multiple social disadvantage often 'conspire' to impinge upon the practical opportunities for such autonomy and self-directedness (Elliott et al., 2015).

The mechanisms of structure-agency interplay by means of directional guidance, modulation of individuals' degrees of interpretative freedom, and triggering changes in individuals' reflexivity modes all help explain how the recovery-impeding influence of social structures persists and even intensifies over time (Archer, 1995). Decreases in the access to financial, interpersonal, informational and other resources, in addition to the increased exposure to chronic stress, victimisation, bereavement and separation, had all exerted negative conditioning influences upon participants' self-identity, mental well-being and the sense of 'homelikeness'. Furthermore, significant life transitions such as family breakdown, loss of employment, onset of homelessness, institutionalisation and others had often substantially undermined resources for coping and recovery. Such a theoretically-enhanced understanding of the complex causality of recovery offers a plausible explanatory model linking severe and multiple disadvantage with individuals' mental health outcomes.

The Mediatory Role of Social Relations in Recovery

As highlighted in '*Chapter Four*' (See '*Conceptual framework of the Current Study*'), Archer's morphogenetic model appears to neglect or downplay the more immediate, mediatory role of social relations in the internal conversation and the exercise of personal agency (Mutch, 2004; King, 2010). In response to such under-specification of the role of social relations, the present study elaborated upon Archer's model by delineating social relations as a distinct contextual influence (See Figure 22). This allowed for a more fine-grained and dynamic understanding of *context* in relation to recovery. The present critical realist analysis also drew upon extant work on the role of *emotions* (or *affect*) and relational agency in order to theorise the mechanisms via which social relations possibly influenced participants' reflexive deliberations about recovery (Burkitt, 2016; Archer, 2000; Helm, 2010).

Beyond simply highlighting the importance of social relations in recovery, the morphogenetic model provided a mechanistic account of *how* those relations possibly shaped recovery. Examples of such mediational mechanisms include the emotional elaboration of participants' concerns and projects, as well as the co-creation of shared understanding, plural goal-directedness and collaborative action. Thus, the present study addressed the often-neglected theoretical question of how the relational context shapes individual health-related outcomes (Cornish, 2004). The analysis managed to go beyond providing superficial, largely descriptive accounts of social relations as merely a 'background' for participants' thoughts, feeling states and actions. Rather, it attempted to reveal '[…] *how the context is structured and how the key agents under study fit into it-interact with it and constitute it* […]' (Sayer, 2010a, p. 167). In particular, the analysis demonstrated the possible interlacing of external conversations and encounters, the relational by-products of those encounters such as hope, sense of togetherness and shared purpose, and participants' internal conversations regarding rehousing and recovery.

Specifically, the abductive-retroductive analysis discerned several types of interpersonal relationships that seemed to provide the most salient relational influence upon participants' internal conversations (At stages T2-T3; See Figure 22 in '*Chapter Seven'*): interactions with service providers; past and present relationships with family and with significant others; and daily interactions with fellow shelter residents (See '*Effects of Social Relations*' in '*Chapter Seven'*). Those social relations appeared to constrain or expand participants' capacities to envision and enact recovery. One of the key findings from this analytic phase concerns the enabling function of empathetic and humanising practitioner interactions, which, in some cases, appeared to lead to the emotional elaboration of participants' recovery-oriented concerns and commitments. To demonstrate, such conducive practitioners interactions seemed to help some participants override their initial feelings of hopelessness and powerlessness and more productively deliberate upon, and discern, the possibility for recovery (e.g. '*She will just break me out-I even forget that I was depressed.'* (Edward). In other words, such enabling professional support and relationships tended to facilitate participants' reflexive deliberations upon recovery. In this mediatory process, certain affective states emerging from client-practitioner interactions-such as feeling human, feeling heard and feeling equal-seemed to be particularly important.

The present analysis of the pervasive influence of social relations further challenges accounts of personal recovery as an individualistic process, whereby '[…] *the onus of recovery rests on the individual, while the social, material and political contexts of recovery are largely obscured*.' (Price-Robertson et al., 2017b, p. 410; Harper &

Speed, 2012; Rose, 2014; Woods et al., 2019). The findings thus support a relational view of personal recovery and expand the understanding of the relational antecedents of recovery for persons with a history of homelessness and SMI occupying temporary and transitional accommodation (Price-Robertson et al., 2017a; Tew et al., 2012). The current study also offers evidentiary support to the proposition that interpersonal relationships '*suffuse*' virtually all aspects of recovery such as hope, empowerment, identity and self-determination (Price-Robertson et al., 2017a, p. 108). Rather than an abstracted collection of intra-psychic experiences of changing one's beliefs, goals and attitudes as dominant models of personal recovery tend to imply (Leamy et al., 2011; De Ruysscher et al., 2017), recovery should be more aptly understood as the manifestation of complex, dynamic and situated interactions, relationships, encounters and affective transactions (Robertson-Price et al., 2017a; Duff, 2016).

Individualistic notions of recovery, such as those underpinned by a neoliberal ideology of individual self-responsibility and by Anglo-American views of the independent, self-sufficient person (McWade, 2016; Price-Robertson et al., 2017a), cannot possibly account for the myriad of relational practices that '[…] *give rise to the emotional and cognitive states that are seen as comprising recovery* […] (Price-Robertson et al., 2017a, p. 112). As the present study indicates, relationships with family members, significant others, service providers and peers represent crucial relational enablers of participants' autonomous reflexivity, which, in turn, is instrumental in recovery. The analysis, therefore, reinforces the idea that understanding recovery involves '[…] *recognising everyday life as the central arena for change* […] *while acknowledging structural factors and underlying social-psychological dynamics* […]' (Brekke et al., 2018, p. 54).

Importantly, however, social relations do not operate in a vacuum. Instead, they operate within, and are structured by, the macro-level (politico-economic, ideological, cultural and discursive) context (Corus & Saatcioglu, 2015). Healthcare exchanges in settings such as the U.S. and Scotland, for example, are likely shaped by the prevailing inequities in mental health and housing, which disproportionately marginalise persons with a history chronic homelessness and multiple needs (Fitzpatrick et al., 2013; Culhane et al., 2011; Padgett et al., 2016). Those structural inequities tend to translate into unresponsive, inaccessible and anti-therapeutic services, hostile or insensitive provider attitudes, the medicalisation of client concerns, among others (Vandekinderen et al., 2012). Understanding the mechanisms via which clients' relationships with professionals impede or facilitate their recovery requires a critical examination of the 'invisible' yet fundamental social structures that shape the complexities of service provision and, therefore, clients' well-being (Corus & Saatcioglu, 2015; Voronka et al., 2014; McNeill & Nicholas, 2019).

Personal Reflexivity and Recovery

By operationalising and analysing human agency as a major component of the morphogenetic model, the present study sheds light onto how the participants navigated and negotiated their circumstances and contexts to enable better well-being and recovery (RQ4). Accounting for the causal efficacy of individuals' human agency is vital for constructing a process-based model of personal recovery, whereby the structural/cultural conditioning and relational contexts shape, but do not determine, individuals' recovery-relevant outcomes (Watson, 2012a; Archer, 1995). The present study represents one of the few empirical attempts to conceptualise human agency in relation to personal recovery and analytically disentangle the effects of human agency from those of social structures and relations (Yanos et al., 2007; Mooney, 2016; Tang, 2018).

By drawing upon Archer's theorising about personal reflexivity and the internal conversation, together with Emirbayer and Mische's (1998) agency modes (See '*Conceptual Framework of the Current Study'* in '*Chapter Four*'), the critical realist analysis explicated participants' '*complex capacities for agency*' (Smith, 2015, p. 61), via which they endeavoured to alleviate and circumvent the distress and suffering engendered by their circumstances. Rather than as '*passive internalisers*' (Mooney, 2016, p. 377) of the constraints and resources associated with their life histories, social positioning and institutions, the critical realist analysis revealed participants as active agents who were '*purposeful, thinking, feeling, emotional, reflective, relational, responsive to meaning*' (Cassell, 2010, p. 50).

The findings that several participants demonstrated autonomous reflexivity indicate that exercising recovery-promoting agency *is* possible-even amidst the severely disempowering conditions of homelessness and shelter living. Collectively, the majority of participants engaged in a range of manifestations of this enhanced autonomous reflexivity-including both circumventing the challenges of the present by, for example, '*focusing*', '*holding on*' and '*adapting*', *and* by imagining or '*envisioning*' their emerging recovery projects as a viable future alternative. The emergent outcome of this strategic navigation was the greater degree of discernment of, deliberation upon, and dedication to recovery-relevant goals, behaviours and reflective practices. The safety offered by their temporary accommodation, the accessibility of appropriate formal support, opportunities for occupational engagement and the availability of meaningful and gratifying social relationships-were all among the conditioning structures and relations that appeared conducive to this reflexivity mode.

Those findings resonate with those from other empirical investigations demonstrating acts of coping, perseverance and resistance by individuals who are homeless, including those with mental health difficulties (Isaak et al., 2019; Meanwell, 2012; Paul et al., 2018; Finfgeld-Connett, 2010). The present findings also seem consistent with Barker's (2013, p. 367) conclusion that acts of agency against the constraints of homelessness may be not only the explicit acts of resistance but also the seemingly insignificant '*mundane and less exciting everyday acts*' such as pursuing small goals and '*staying strong*' despite the multiplicity of structural challenges. The present study extended those insights by offering a theoretically-informed account of how participants' reflexive deliberations enabled them to choose, enact and sustain certain recovery-promoting strategies, as well as the contexts that triggered and influenced those reflexive deliberations.

Crucially, however, the conditioning contexts-demarcated by the confluence of housing, organisational policies, welfare support, services landscape and occupational opportunities-imposed significant constraints upon participants' autonomous reflexivity and recovery-oriented agential actions. This tended to result in frustration, forced passivity and the perception of recovery as unstable, contingent and elusive, which undermined those participants' abilities to autonomously enact and negotiate recovery-oriented concerns and practices.

The other major finding regarding how participants navigated the socio-structural conditions of living concerns some participants' manifested tendencies for *fractured reflexivity*. Those participants' internal conversations did not lead to productive action and tended to intensify their distress and existential disorientation. As a result, they could not identify viable routes out of homelessness and into a life in recovery. Fractured reflexivity seemed to have emerged from the interlacing of cumulative structural and relational adversity, including trauma, institutional uncertainty, the inadequate access to positive affective resources and relationships, and in some cases, their invocation of self-destructive behaviours (such as excessive drinking). This configuration of structural, relational and agential antecedents had ultimately led to those participants' feeling chronically disempowered and hopeless-the antipodes of recovery. This reflexivity mode appears useful in accounting for several participants' seeming inability to form, exercise and sustain meaningful recovery-oriented life projects. Fractured reflexivity may be an important mediatory mechanism that could explain the pervasive adverse effects of chronic structural disadvantage on individual identities, health-related behaviours and recovery outcomes (Scambler, 2013). And yet, it has remained underexplored in the context of health inequalities and mental well-being.

The present findings about the processes via which the participants exercised their agency carry significant theoretical implications for unravelling whether and how recovery is envisioned and enacted amidst health and social inequalities. To enable such theoretical advancements, personal recovery should be conceptualised as the emergent outcome of the interplay between social structure and human agency (Yanos et al., 2007). In this process, human agency is the causal force mediating between the effects of structural/cultural conditioning and observed recovery-relevant outcomes. The present IPA and critical realist analyses reveal that personal recovery is initiated and enacted as a result of the activation of an autonomous mode of reflexivity, which manifested itself as the enhancement of iterative, practical-evaluative and projective temporal orientations (Emirbayer & Mische, 1998). Personal recovery should be understood as contingent upon the activation of various forms of individual agency, in the context of structural, cultural and relational enablements. Future investigations of personal recovery should adopt a pluralistic and dynamic conception of human agency and continue to explore the various ways in which different types of agency are implicated in the recovery process (Yanos et al., 2007).

Limitations of the Study

The following methodological and theoretical limitations of the present study likely affect the transferability and credibility of the findings. Those relate to the sample, the use of self-report, narrative methods and the analytic strategies of choice.

Sample Size and Representativeness

Only 18 participants were recruited in the current study (10 in the U.S. and eight in Scotland; See ‘*Demographic Characteristics of the Sample*’ in ‘*Chapter Five*’). As an idiographic approach to qualitative data analysis, IPA benefits from relatively small samples, whereby the idiosyncrasies and nuances within each participant’s account can be adequately examined (Smith et al., 2009). However, the restricted sample size and diversity inhibit the transferability of the findings of this study. Specifically, recruiting participants from a wider range of accommodation provider types (such as single-room occupancies, night shelters, family shelters and permanent supportive housing) and geographical settings would have allowed for a more comprehensive analysis of the range of socio-economic, socio-cultural, institutional and biographical factors affecting recovery.

Overall, while the demographic composition of the present sample seems to reflect national estimates according to several characteristics, notable sample limitations remain the underrepresentation of women, young adults, families and Caucasian Americans. Therefore, the findings of the present study are not generalisable to the wider population of interest and should be interpreted with caution.

The male-female ratio in the present sample is 7:2, which reflects the marked overrepresentation of men in both the American and the Scottish *single homeless* populations (U.S. Department of Housing and Urban Development, 2017; Scottish Government, 2018b). According to national estimates of *homeless families* (including lone parents), however, the gender ratio is rather even in both Scotland (Scottish Government, 2018b) and in the U.S. (U.S. Department of Housing and Urban Development, 2018). Furthermore, across both jurisdictions, single men remain overrepresented among the unsheltered (including street homeless) and among the chronically homeless populations (U.S. Department of Housing and Urban Development, 2018), which is reflected in the current sample.

Given the growing evidence base demonstrating that homelessness is a gendered experience (Whitzman, 2006; Bonugli et al., 2013; Gonyea & Melekis, 2017; Bird et al., 2017; Benbow et al., 2011), the underrepresentation of women's voices limits the transferability of the present findings. For instance, more qualitative research is warranted to examine how gendered forms of structural disadvantage and discrimination such as gender-based violence and income inequality intersect and interact with housing instability and mental health difficulties to shape those individuals’ recovery trajectories (Benbow et al., 2011).

Further recovery research is also needed focusing on homeless youth with complex needs (Cronley & Evans, 2017; Crosby et al., 2018; Farrugia, 2011). Rather underexplored in the current study remain the effects of the symbolic burden of homelessness-for example, stigmatisation and disempowering discursive practices-on youth’s reflexivity, identities, mental well-being and recovery (Farrugia, 2011). Examining manifestations of personal agency in young homeless persons-such as resilience, street culture activities, survival skills and others-has the potential to facilitate the understanding of the recovery process in this sub-population (Cronley & Evans, 2017).

Finally, the ethnic profiles of the homeless population vary dramatically when comparing Scotland and the U.S. This is reflected in the differences between the ethnic characteristics in the Scottish and the American sub-samples in the present study (See ‘*Demographic Characteristics of the Sample*’ in ‘*Chapter Five*’). The Scottish sub-sample was made up entirely of Caucasians, which is consistent with national estimates (Scottish Government, 2018b). The U.S. sub-sample consists of 40% African-American, 30% Hispanic, 20% Asian and 10% Caucasian participants. This ethnic profile does seem to reflect the overall percentage of African-Americans who are homeless in the U.S. but underrepresents Caucasian (or white) people who are homeless in the country (U.S. Department of Housing and Urban Development, 2017). Further research should be carried out with larger, more demographically and geographically representative samples, including with individuals that are street homeless and otherwise disconnected from health and social care services.

Limitations of Narrative Research

A number of conceptual and methodological caveats stem from the inherent challenges and limitations of narrative research (Polkinghorne, 2007). Polkinghorne (2007) discusses several such limitations including the inability of language to convey the complexity and intensity of participants' biographical experiences. Furthermore, individual differences in the participants' level of articulation, reflective capacity and narrative competence are unavoidable (Kirkevold & Bergland, 2007). Those threats to the credibility of the narrative data were partially mitigated by the use of the minimally structured life story interview and by the use of participant-generated images and the mobile phone diary, which all facilitated participants' opportunities for self-reflection and self-expression.

Other inherent limitations of self-report narrative research remain the potential lack of credibility of the information shared by the participants, as well as participants' susceptibility to social desirability bias (Polkinghorne, 2007). The present study did not verify participants' accounts by interviewing their case managers or conducting field observations. Additionally, participants' testimonies about their life experiences are invariably dependent on their memories of those events and on their willingness to share those with the Researcher. Those limitations undermine the trustworthiness of the present study insofar as it cannot be verified whether participants' accounts represent complete and accurate reflections of their life stories. It is hoped that the rapport-building procedures, including the multiple interviewing and the participatory elements of this study, helped generate honest, authentic yet understandably incomplete accounts of participants' lives (See '*Ethical Considerations and Researcher Reflexivity and Positionality*' in '*Chapter Five*').

Reflections on the Data Analysis and Potential Caveats

The depth and richness of data in a phenomenological analysis are largely dependent on the participants' degree of disclosure, level of engagement with the interview questions, and on the interviewer's empathetic and listening abilities (Smith et al., 2009). It must be noted that not all participants engaged equally well with the interview questions. Two participants, in particular, Liam and Henry, seemed reluctant to divulge details about their personal experiences. Unsurprisingly, neither of them was interested in partaking in the mobile phone diary phase of the study. Similarly, only nine (50%) of the participants opted to complete the mobile phone diary and their level of output varied substantially (See '*Mobile Diary Participation Data*' in '*Chapter Five*'). Those uneven participation rates undermine the coherence of the data and mean that certain participants' experiences were better represented in the analysis than other participants'.

All qualitative research is concerned with *subjectivity*- the participants' and the researcher's (Smith et al., 2009). Therefore, alternative thematic structures and explanations of the findings are, indeed, possible and should be critically considered by the consumers of research. For instance, the IPA themes reflect the Researcher's own meaning-making and interpretative repertoire and are only one way of representing participants' complex recovery experiences (Smith et al., 2009). To enhance the credibility and authenticity of the findings, that is, ensuring '[…] *the data accurately represent the reality of the participant* […]' (Yeh & Inman, 2007, p. 387), the Researcher maintained self-reflexivity throughout the research process by reflexive journalling, memo notes, peer debriefing and 'bracketing' (Jootun et al., 2009; Yeh & Inman, 2007; Somekh & Lewin, 2005; See '*Ethical Considerations and Researcher Reflexivity and Positionality*' in '*Chapter Five'*). The credibility and authenticity of the findings would have been further increased by the use of data triangulation methods such as member checking, field notes, participant observation and interviews with other relevant informants such as case managers, which, however, were not carried out in this study.

A final set of limitations of the current study concerns the use of critical realism as an underpinning meta-theoretical framework. For one thing, the abductive and retroductive analytic phases reflect the analyst's subjective interpretations, preferences-theoretical and value-based, and interpretative repertoire. While those thought operations afford flexibility, creativity and explanatory value to the analysis, they also make the analysis highly susceptible to researcher bias. The Researcher attempted to mitigate some of those credibility concerns by utilising '*a multiplicity of theorizations'* (Timmermans & Tavory, 2012), p. 181), which included Archer's (1995) concepts of human reflexivity and the internal conversations, Emirbayer and Mische's (1998) typology of human agency, in addition to other sociological constructs. This allowed the Researcher to analyse the data using different theoretical lenses thus increasing the rigour of the analysis (Danermark et al., 2005).

Furthermore, because of the nature of abduction and retroduction, the explanatory theorising in a critical realist study is never finished or exhaustive but always partial and iterative. A critical realist analysis is necessarily selective. As discussed by Hedström and Ylikoski (2010, p. 53): *'A mechanism-based explanation describes the causal process selectively. It does not aim at an exhaustive account of all details but seeks to capture the crucial elements of the process by abstracting away the irrelevant details.'.* This means that the explanatory analysis proceeded by abstracting some aspects of social structures and contexts that seem to hold the highest explanatory power, and not others. Therefore, it is possible that some potentially relevant entities remained undertheorised.

Some of the common theoretical criticisms against critical realism highlighted in '*Chapter Four*' (See '*Critique and Limitations of Critical Realism*') are also worth discussing insofar as they may compromise the trustworthiness of the present findings. Specifically, with its emphasis on how individuals engage in (conscious) reflexive deliberations as the vehicle for individual and collective agency, critical realism seems to neglect the individual's '*capacity for pre-reflexive and pre-conscious actions*' (Akram, 2013, p. 45; Elder-Vass, 2007). Akram (2013) notes that allowing for such pre-reflexive action does not contradict the notion of the autonomous and deliberating agent. Reflexivity, instead, should be more accurately viewed as a continuum ranging from more habitual to more deliberate and creative action (Akram, 2013; Atkinson, 2010). The present analysis, however, did not account for any possible automated, subconscious responses displayed by the participants. Neither did it incorporate the notions of dispositions or internalisation to explain the effects of social structures on recovery-relevant outcomes (Elder-Vass, 2007). Further empirical work should assess the utility of combining critical realism with a more dispositional view of human action in efforts to understand the full spectrum of structural effects upon individual agency (Elder-Vass, 2007).

In addition, Archer's strong emphasis on the internal conversation as mediating the effects of structure on outcomes has been criticised for neglecting the external conversations individuals have with others as an important mediating mechanism (Mouzelis, 2007). Mouzelis (2007) calls this point of contention the debate between the externality and internality of enablements and constraints. Accordingly, due to its heavy focus on tracing *intra-active*, internal changes in participants' agential orientations, the present study may have failed to capture some of the changes in participants' *interactive* processes. Although the present study elaborated on the classic morphogenetic model by examining social relations as a distinct causal entity, the morphogenetic model's ability to comprehensively account for their influence upon individuals' internal conversations remains contested and necessitates further conceptual and empirical development (King, 2010; Mutch, 2004).

Finally, an additional challenge in conducting empirical analyses of qualitative self-report data of the potential role of social structures remains individuals' possible reluctance to discuss the wider systemic and structural influences upon their well-being and life choices (Elliott et al., 2015). Indeed, some prior studies with marginalised populations have reported participants' uneven discussions of individual and structural causes of health inequalities-often favouring the former group of determinants (Putland et al., 2011; Piat et al., 2015). Similarly, the present study found varying degrees of emphases on contextual and structural factors displayed by the participants. For example, explicit discussions of the effects of poverty, mental health stigma, gender relations, education, social integration and other evidence-supported social determinants of health were relatively rare in the present study. This could be a result of either the data gathering techniques employed in the present study (for example, the interview schedule), or of more fundamental processes relating to how the structural conditions of existence may shape individuals' awareness of those very conditions (Elliott et al., 2015). Therefore, this remains an open empirical question for future research.

Future Research Directions

The present study hopes to catalyse further research into personal recovery and multiple disadvantage along several broad lines of enquiry. Such promising avenues for future empirical and theoretical developments are proposed in the following sections. Those include elucidating the complex and contingent causality and cross-cultural variation in recovery; understanding the relationship between dual recovery and homelessness; as well as the role of relationality in recovery-relevant agency.

Advancing the Recovery Research Agenda

The present study hopes to inform and inspire the critical theoretical engagement with the personal recovery concept in future research. Such research should seek to expose the socio-structural constraints rooted in oppressive and stigmatising discourses, systems and ideologies that impede multiply marginalised individuals' efforts to exercise self-directed choices and realise their authentic, emancipatory identities (Morrow & Malcoe, 2017; Harper & Speed, 2012). Such research should be underpinned by the assumption that personal recovery is characterised by a contingent causality, which requires the multi-level theorising of the various causal layers and entities shaping observed recovery outcomes (Mooney, 2016; Angus & Clark, 2012). Such sophisticated theoretical models should account for the confluence of social structures (the macro-level), interpersonal relationships (the meso-level) and the individual (the micro-level; Steinert & Pilgram, 2007; Taket et al., 2009). As Taket and colleagues (2009, p. 28) posit:

> '[…] *in order to understand the dynamics of exclusion and connection across different layers of human action and interaction, it is important to reflect on how these concentric spheres* [the macro- , meso- , and micro- levels] *influence each other and the common pathways that run through them.*'

Relatedly, Clegg (2016, p. 501) argues, *'Social theory needs to wrestle with understanding the multiple determinations of the concrete by employing necessary abstraction and accounting for the unseen.'.* Future theoretical endeavours should aim to advance this exploration of the complexity of contextual influences upon mental health and recovery by generating explanatory accounts linking socio-economic, cultural, political, organisational, familial and other types of effects (Bhaskar & Danermark, 2006).

The present study demonstrated the feasibility of critical realism for theorising personal recovery in the context of multiple disadvantage by generating a nuanced, multi-stage and contextualised account of how individuals make sense of, navigate and negotiate their recovery. The present study challenges the reductionist, unidimensional understanding of personal recovery and encourages future empirical investigations attempting to unpack the '*complex causal chain*' of recovery for different underserved populations (Wynn & Williams, 2012, p. 798). With its elaborate arsenal of conceptual tools such as the stratified notion of reality, mediated knowledge, social morphogenesis, theoretical pluralism and others, critical realism is well-positioned to overcome the '*restricted conceptual repertoire*' associated with dominant models of personal recovery and help illuminate '*the social and political links between distress and structural injustice'* (Harper & Speed, 2012, p. 10; Bhaskar, 1989; Archer, 1995; 2003; Danermark et al., 2005; Craig & Bigby, 2015).

Potentially fertile areas for future critical realist-informed recovery research include examining the effects of some of the under-examined social structures in the current study such as capitalism, exploitation, poverty, stigmatisation, gender relations, and others, on individual well-being, autonomy and recovery (Wainwright & Forbes, 2000; Bergin et al., 2008; Bonnington & Rose, 2014). Understanding how exclusionary social arrangements affect individuals' recovery, and the coping strategies that they deploy to negotiate those, is likely to inform anti-oppressive interventions that could eventually remove the structural constraints to human emancipation and flourishing (Bhaskar, 1989; Houston, 2001; McNeill & Nicholas, 2019; Olivet, 2012). Examining how various social structures, processes and pathways differentially affect individuals' chances to achieve recovery is likely to advance an equity-based agenda in mental health and health inequalities research (Östlin et al., 2011). Such an agenda, in turn, can directly inform policies and programmes that counteract those inequality-generating mechanisms and promote equitable access to recovery-enhancing resources.

Simultaneously, mental health researchers should continue advancing creative participatory research methodologies involving persons with lived experience, especially those who are multiply marginalised (Kramer-Roy, 2015; Elliott et al., 2015). Hybrid qualitative methodologies such as the mobile phone diary, digital ethnography and participatory-action research with those deemed 'hard-to-reach' have an important role in meeting the emancipatory aims of mental health research (Kramer-Roy, 2015; Bartlett & Milligan, 2015; Aldridge, 2014).

Dual Recovery and Homelessness

The findings of the present study make a valuable contribution to the literature on *dual recovery* in the context of homelessness. The present findings are somewhat consistent with Green et al.’s (2015) findings regarding the central importance of individuals’ knowledge about the effects of alcohol and substances, and about the effects of the environment (*‘people, places and things’*) on one’s recovery. Those findings therefore concur with the present findings of the importance of insight, self-knowledge, mental health literacy and positive coping. The present findings also corroborate Green et al.’s (2015) conclusions regarding the importance of peer support, flexible interventions and empathetic staff responses. Green et al.’s sample, however, consisted overwhelmingly of Caucasian participants who had been receiving behavioural health services for at least 12 months and who had made substantial progress with their recovery. In contrast, the current sample was considerably more diverse in terms of ethnicity, geographical settings, housing circumstances and the relationship the participants had with their recovery. The present study, therefore, expands the knowledge of the dynamics of dual recovery for a more diverse group of service-users-those facing multiple forms of socio-structural disadvantage and health inequalities.

Future empirical enquiries should focus on exploring how various temporary housing models facilitate or hinder dual recovery, as well as whether integrative intervention models based on dual recovery could be effectively implemented within homelessness services (Davidson et al., 2008; Ness et al., 2014). Achieving such a degree of integration between mental health and substance use intervention techniques requires, however, overcoming the ‘silo’, fragmented approach to healthcare services, as well as minimising the iatrogenic harm of certain types of treatment (e.g. drug substitution therapy) to recovery outcomes (Drake, 2007; Ness et al., 2014). Notably, although the majority of the present study’s participants had had co-occurring mental health and substance use problems, few discussed in detail their experience with substance use treatment and its relationship with their mental health treatment. Given the commonly reported difficulties individuals with dual diagnosis tend to report with navigating multiple and often uncoordinated services, future research is warranted investigating those barriers to effective care among homeless populations (Ness et al., 2014).

Relationality, Professional Practice and Recovery

By the creative and pluralistic application of theoretical concepts such as relational agency, affect and emotional elaboration (Helm, 2010; Archer, 2000; Holmes, 2010; Burkitt, 2016), the present critical realist analysis attempted to elucidate the diversity of relational mechanisms that possibly shaped participants' recovery-relevant reflexive deliberations and agential actions. Accounting for the relational context within which the capacities for recovery emerge is crucial to understanding the role of interpersonal relationships in enabling or constraining individual and collective agency in community and institutional settings (Topor et al., 2018; Brekke et al., 2018; Price-Robertson et al., 2017b). Further research exploring provider perspectives and the client-provider interactions using naturalistic methods such as participant observation and institutional ethnography is warranted to advance the insights into the connection between relational practice, organisational context, client agency and recovery (Brekke et al., 2018; Topor et al., 2018). The concept of *relational agency* and its significance for recovery, in particular, should be investigated as it relates to the nature, dynamics and consequences of individuals' interactions with providers, fellow clients and significant others (Burkitt, 2016).

Further research is also required to investigate the co-creation and accumulation of emotional resources in relationships and institutions that define the homelessness experience, as well as the relationship between emotional capital and personal recovery (Tew, 2013). Zschau and colleagues (2016, p. 24) define emotional capital as the circulation, exchange, transformation and accumulation of emotional resources that are '[…] *network-specific resources that capture the capacity of the networks to provide positive emotional feedback and support.'.* They also posit that emotional capital subsumes resources such as '*empathy/sympathy, acceptance, willingness to listen, validation, compassion, and the capacity to counsel or give advice.'* (p. 24), in addition to the resources needed to sustain emotional intimacy (Zschau et al., 2016). Research on emotional capital and its role in the lives of people who are homeless offers potentially fruitful avenues for theoretical expansion and contextualisation of the concept of (mental health) *recovery capital* as applied to this population (Tew, 2013). Defined as the resources that enable one to achieve self-efficacy and a range of social capabilities (Tew, 2013), recovery capital should also account for the more fluid, relational resources that constitute an individual's emotional capital.

Ultimately, future research should attempt to explicate the various constituents of recovery, which are rooted not only in individual psychologies but also in affective encounters, interpersonal relationships, institutional practices and socio-political contexts. As Cameron Duff (2014, p. 118) concludes:

> *'Recovery, as such, ought to be construed as part of the affective, relational and intensive fabric of everyday life, expressed in moments of self-efficacy, connection and rapport; in the growing realisation of a body's power of acting. Recovery is an affective and relational achievement in this sense.'.*

Cross-Cultural Differences in the Recovery Experience

Although socio-cultural variations in how recovery is perceived, experienced and achieved have been recognised by several authors, cross-cultural investigations into recovery have been rare (Adeponle et al., 2012; Leamy et al., 2011; Brijnath, 2015). The present study's transatlantic, multi-site data collection strategy was innovative insofar as it represents one of the few qualitative empirical investigations on personal recovery in different geospatial and cultural settings. Although the systematic between-country comparison in participants' recovery experiences was *not* a major aim of the present study, the transatlantic focus arguably increased the capabilities of the present study for exploring the contextual embeddedness of recovery.

The present findings of the greater significance of religiosity, spirituality and cultural values ascribed by the African-American and Hispanic participants in the U.S. sub-sample (See '*Cross-Country Comparison of the IPA Findings*' in '*Chapter Six*') are consistent with the large body of literature documenting the vital role of faith, religiosity and religious participation in the psychological, social and emotional lives of African-American and other ethnic minority communities (Karadzhov & White, 2020). Those findings also highlight the vital importance of integrating cultural sensitivity, including communal values such as collective responsibility, interdependence and harmony, into the recovery-oriented mental health care for persons with complex needs (Jones et al., 2007). As argued by Jones and colleagues (2007), in order to deliver a truly *strengths-based* approach to mental health care, service-providers should be cognizant of how clients' cultural background is likely to shape their recovery-oriented goals, self-concept, access to community supports and engagement with treatment.

In addition, the findings stress the need for expanding the scope of recovery research by exploring the needs and experiences of culturally and racially diverse populations (Jones et al., 2007; Leamy et al., 2011). For instance, further research into the unique experiences of African-American and BME clients holds promise for advancing the knowledge of how those individuals mobilise individual and communal strengths, resilience and other resources to enable recovery in the face of structural adversity such as discrimination, health inequalities and oppression (Jones et al., 2007). Unpacking the subtle but profound ways in which culture influences recovery is also likely to help challenge the still-dominant individualistic, psychologised views of recovery that tend to favour individual responsibility, self-management and self-sufficiency (Harper & Speed, 2012).

Notably, however, as Jones and colleagues (2007, p. 263) note, '[m]*easuring the influence of culture on recovery will be of limited use if the populations being studied are not aware of recovery concepts*.'. Indeed, the present findings of some participants' greater familiarity with substance use recovery than mental health recovery warrant further qualitative investigations attempting to distil the relationship between different types of recovery for socially marginalised client groups, as well as clarify those individuals' understanding of the core attributes of mental health recovery.

Another potentially important cross-cultural difference detected in the present sample in how recovery is envisioned and enacted concerns the American participants' greater emphasis on their self-efficacy and a stronger adoption of a culturally-specific conception of the '*good life*'-achieving the '*American Dream*' (See '*Cross-Country Comparison of the IPA Findings*' in '*Chapter Six*'). Those cultural nuances observable in the American participants' narratives could reflect America's hyper-individualistic culture and its emphasis on personal responsibility and individuation. As argued by Adeponle and colleagues (2012, p. 117): *'[…] from the perspective of individualism, recovery is expressed through the person's capacity to identify and pursue their own goals […]'.* It could be speculated that for some individuals, the ideal of the '*American Dream*' may offer a recognisable symbolic and discursive resource that could help in designing one's recovery journey. For others, however, this cultural symbol may represent an unachievable societal expectation for productivity, conformity and financial independence. The relationship between multiple disadvantage, the values of individualism, neoliberal policy regimes and individuals' subjective constructions of recovery remains an open empirical question (Adeponle et al., 2012).

The observed tentative cross-cultural nuances in conceptions of prosperity, meaning in life and recovery in the present study support Adeponle and colleagues' (2012) recommendation that personal recovery is a culturally-mediated phenomenon that should be analysed at various level-including at the discursive, socio-cultural and socio-political levels. The present findings of cross-cultural variations in some of the barriers to and facilitators of recovery echo the multinational study conducted by Davidson and colleagues (2005), whereby the authors identified cross-cultural differences in the social and cultural factors supporting or inhibiting their participants' personal recovery, including material resources and informal and formal health systems.

Future recovery research should specifically examine cross-cultural and cross-country differences in the experiences and facilitators and barriers of personal recovery (Brijnath, 2015; Davidson et al., 2005; Myers, 2010). Comparative research designs, in particular, hold promise for disentangling the effects of cultural norms and discourses, the mental health and welfare systems, policy practices, housing and poverty and other supra-individual factors shaping the recovery process (Leamy et al., 2011; Slade et al., 2012).

Implications for Practice and Policy

The following sections discuss the implications of the present findings for mental health and social work practice and policy, with a focus on person-centred care in homeless service settings and on structural interventions.

Implications for Service Design and Delivery: Humanising and Person-Centred Care

The present study underscores the importance of offering humanising and person-centred care as integral to the provision of a *truly* recovery-oriented care to clients who are homeless and have complex needs (Gillis et al., 2010; Le Boutillier et al., 2015). The present findings of the lived experience and the structural and relational antecedents of recovery generate actionable insights into how to translate the recovery philosophy into concrete institutional practices and policies.

The findings of the participants' conceptualisations of recovery indicate that health and social care providers should demonstrate a sensitivity to the diverse and often subtle ways in which individuals contemplate, make sense of, and relate to their recovery. As argued by Bonney and Stickley (2008) in their review, '[r]*ecovery does not stand still but is an ongoing process of personal discovery* […]' (p. 149). Clients should be provided with opportunities to develop an authentic conception of recovery, well-being and 'the good life', even if this entails the implicit or explicit disidentification with organisational models of recovery. Service providers should also be prepared to respond with empathy and encouragement to some clients' reluctance or inability to articulate recovery in definitive, concrete, positive, purposive and future-oriented terms. As part of their commitment to delivering recovery-oriented and narratively competent care, homeless service providers should demonstrate awareness of the complex ways in which chronic homelessness and experiences with service provision may shape clients' attitudes towards recovery (Conlon et al., 2015).

The findings regarding the recovery-enabling function of *insight* warrant increased efforts by service-providers to create *insight-facilitating conditions* aimed at expanding clients' access to information and awareness of alternatives (Levitt et al., 2004; Lysaker et al., 2009). What Rapp and Goscha (2011, p. 31) recommend is that providers should understand '*who this person was before coming to services'* as well as what the factors that affect clients' abilities to '*recover, reclaim, or transform their life'* are. Although the present study identified commonalities among the participants' experiences of insight, the routes to insight were unique for each participant and could not be understood independent from participants' life stories. This also underscores the importance of service-providers' demonstrating *narrative humility* in their engagement with their clients (Shapiro, 2011). Narrative humility entails a compassionate, respectful and empathetic stance towards clients' personal narratives, which may appear ambiguous and even contradictory but which carry profound significance for the narrator's sense of coherence and self-mastery (Shapiro, 2011). In this sense, participants' life story narratives may be conceived as the 'vehicles' for insight and self-empowerment and as such, they should be listened to and validated.

Therapeutic techniques based on existential theory such as the theory of self-transcendence have the potential to assist clients in the '[…] *expansion of one's boundaries inwardly in various introspective activities, outwardly through concerns about others and temporally, whereby the perceptions of one's past and future enhance the present*.' (Nygren et al., 2005, p. 355, citing Reed, 1991). Such interventions have the potential to facilitate individuals' reflective engagement with their own life stories and the identification of alternative routes to recovery that are aligned with individuals' own values and biographies.

The implications of the present study resonate with Lal's (2010) recommendation against the rigid, decontextualised and uncritical application of the concept and framework of personal recovery to historically underserved service-user groups. Indeed, as argued in '*Chapter Three*', and consistent with Lal's (2010) arguments, understanding the meaning, process and antecedents of recovery across diverse populations and across levels of service delivery is integral to overcoming the '*translational gap*' associated with the recovery approach (Le Boutillier et al., 2015, p. 430). Specifically, providers of services for clients who are homeless and have complex needs should be cognizant of the pervasive influence of homelessness and chronic life adversity on clients' capacities to envision and enact recovery. As the present study demonstrated, participants' ambiguous relationships with the recovery idea, difficulties establishing a sense of 'homelikeness', depleted sense of emotional connectedness and the complex challenges of achieving dual recovery necessitate co-designing with the clients the most meaningful and viable routes to recovery (Lawless et al., 2009).

Even further, personal narratives should take centre stage in each client's recovery planning so that the client's unique values, priorities, strengths and aspirations can be understood as embedded in a dynamic set of biographical, relational and socio-structural contexts (Slade et al., 2015). Placing emphasis on clients' personal narratives also helps devise a care plan that is flexible, non-prescriptive, collaborative and strengths-oriented (Slade et al., 2015; Rapp & Goscha, 2011). It is also likely to protect against 'modelling' recovery into rigid sets of practices and expected outcomes (Kogstad et al., 2011).

Relatedly, a *humanising approach* to care gives primacy to '*what it means to be human'* (p. 68-69) and aims to nurture clients' agency, uniqueness, togetherness, sense of personal journey and sense-making (Todres et al., 2009, p. 68-69). The super-ordinate theme, *feeling* '*wanted, accepted and needed'*, and particularly the sub-theme, *family experiences, vulnerability and deprived socio-emotional needs*, underscore the potentially cathartic, *humanising* and therapeutic role of reflecting upon, and coming to terms with, one's inherent (human) *vulnerability*. Indeed, in their life stories, participants often reflected upon their sense of vulnerability and loss of innocence in early life as a result of family breakdown and other adversity, which some had aimed to compensate by developing a false sense of invulnerability (e.g. '*false strength'*; Benjamin) by using drugs, for instance. As a result, some reported '*pushing to the side*' their deprived needs for love and belonging. The interviews were an opportunity for those participants to reflect on coming to terms with their inherent human vulnerabilities in a way that was cathartic and even empowering. Those findings resonate with Entwistle and Watt's (2013) recommendation that support services should both nourish clients' personal strengths and capabilities *and* acknowledge and respond to '*their potential to suffer in characteristically human ways—including emotionally and psychologically via threats to their self and identity'* (p. 35).

Case managers and counsellors working in homeless service settings should develop working relationships with clients that are built upon the recognition of their '*shared humanness*' as the foundation for mutual respect and empathy (O'Keeffe et al., 2018, p. 639). Such an orientation is likely to help minimise the risk of client shame and self-blame, retraumatisation and the entrenchment of their feelings of alterity and deviance-major barriers to collaborative recovery-oriented practice (O'Keeffe et al., 2018).

According to Dahlberg and colleagues (2009), a humanising philosophy of care can inform institutional policies and practices that are *'authentically person centred'* (p. 265). The authors argue that models of care that overemphasise *'personal or collective agency and self-authority'* (p. 266) are inadequate for fully accounting for the complexity of human experiences of well-being and illness as they de-emphasise the view of clients as *'vulnerable'* or '*exposed'* to suffering, harm and adversity (p. 266). According to the lifeworld-led care model Dahlberg and colleagues (2009, p. 267) put forward, '[b]*oth the vulnerabilities of being human and the possible freedoms of being human are acknowledged as fundamental dimensions that are in creative tension with one another* […]'. Applying this philosophy of care to the concept of recovery and recovery-oriented care, it could be proposed that personal recovery entails realising, coming to terms with, and navigating both one's vulnerabilities and freedoms and personal agency (Dahlberg et al., 2009).

The dangers of the decontextualised and idealistic approaches to independence, autonomy and self-sufficiency in the context of mental health and social care services and policies have been recognised by several authors (Fineman, 2008; Entwistle & Watt, 2013). The current findings support the view that services for people who are homeless and have complex needs should both recognise and enable clients' autonomy and self-determination, *and* be responsive to, and nurture, clients' vulnerability-both their intrinsic (human) vulnerability and their situational vulnerability (e.g. interpersonal, institutional; Fineman, 2008; Varcoe et al., 2014). The findings concur with Fineman's (2008, p. 12) assertion that '[c]*ontemplating our shared vulnerability it becomes apparent that human beings need each other, and that we must structure our institutions in response to this fundamental human reality.'.* Indeed, collectively, the participants in the present study reflected on their homelessness (and co-occurring disadvantage) as '*an experience of being human*' (Gwinner et al., 2013, p. 108). In the words of one of the American participants, George, '*I'm trying to figure out the same thing you're trying to figure out-what is it that I'm searching for* […]'. This reframing of homelessness as a deeply human experience should underpin approaches to health and social care and oppose the commonly dominating 'othering', marginalisation and objectification of those who have been homeless (Rolnik, 2010; Zufferey, 2016).

In addition, the present findings concur with Greenfield et al.'s (2014) study findings regarding the importance of being listened to, heeded and respected as major relational enablers of recovery. The participants in the present study underscored their difficulties with making sense of, communicating, and coping with the multiple sources of adversity they experienced ('*I feel bombarded with so many different issues…'* (Matthew). Those participants therefore appreciated being provided with the physical, psychological and emotional space necessary to help them reflect on, find meaning in, and develop viable solutions to their concerns. The current participants seemed to value providers' competencies relating to listening, compassion and empathy more than providers' abilities to provide technical, short-term and reductionist solutions to the clients' concerns. These findings concur which Greenfield and colleagues' (2014, p. 8) conclusion that when clients' physical (e.g. security), psychological and emotional needs are unsatisfied as a result of unhelpful staff attitudes and organisational practices, clients can feel '[…] *invisible, unheard, unimportant, ignored, patronized and overlooked; feeling treated as a set of clinical symptoms instead of a whole person; as a 'number' instead of a named person* […]'.

The present findings also indicate the need to incorporate a trauma-informed approach into the provision of recovery-oriented care in homeless services (Duncan, Oby, & Larkin, 2019; McKenzie-Mohr et al., 2012). Several participants' life story narratives revealed their experiences of acute and cumulative traumatic events-from domestic violence to the chronic stress caused by housing instability. For them, receiving appropriate psychotherapeutic support with making sense of, and positively reconstructing, those adverse life events seemed instrumental in developing their capacities for insight, symptom management and positive self-identity (See '*Formal Support Services as Key Enablers of Positive Coping and Self-Management*' in '*Chapter Six*'). The diversity and pervasiveness of the impacts of traumatic and other adverse life experiences on participants' recovery capabilities necessitate enhanced trauma awareness and trauma responsiveness by service-providers (Duncan, Oby, & Larkin, 2019). Trauma-informed care for clients with complex needs in homeless services should involve not only the minimisation of retraumatisation by ensuring physical, psychological and emotional safety, but also the creation of the conditions that allow clients to meaningfully process their trauma and enact their evolving agency and empowerment in a healing manner (Bransford & Cole, 2019). The awareness of, and responsiveness to, the pervasive impact of trauma should suffuse all components of service provision and policy-from the initial assessment of clients' needs and goals through to recognising the signs of trauma in clients' responses to the service provision and ensuring clients have access to trauma-informed psychological services (Bransford & Cole, 2019). This may involve, for instance, aptly reframing clients' seemingly diminished interest in socialising, difficulties in trusting others, use of drugs and alcohol and feelings of helplessness as common responses to traumatic experiences (Hopper et al., 2010).

Given the current participants' experiences of the shelter as a '*boundary situation*' (McGraw, 1995), as a critical transitional space that can be both disruptive and illuminative psychologically and existentially (See '*Dilemmas of Meaning*' in '*Chapter Six'*), service providers in temporary accommodation settings have the opportunity to contribute to long-lasting positive change in clients' journeys to autonomy, empowerment and healing (Hopper et al., 2010). Admittedly, implementing trauma-informed care with a high degree of fidelity in homelessness services is likely to be challenging due to high client and staff turnover, overcrowding, overburdened staff and other organisational constraints (Hopper et al., 2010; Olivet et al., 2010). However, because managing trauma and trauma-induced mental illness and co-occurring conditions is instrumental in exiting homelessness, the principles of trauma-informed care should be seen as an integral part of the day-to-day service provision in those institutions, rather than as an added bureaucratic burden (Hopper et al., 2010; Padgett et al., 2016). Those principles can be embodied and operationalised by redesigning homelessness services so that they prioritise trauma-informed policies and procedures, relationality and the awareness that ‘difficult’, ‘unruly’ or ‘chaotic’ client behaviours may, in fact, be common reactions to traumatic experiences and the resultant sense of powerlessness and ‘unhomelikeness’ (Hopper et al., 2010).

Beyond the provision of individual-level interventions aiming to reduce the negative effects of trauma, social policies should be implemented to increase the availability and accessibility of community resources that can promote positive adaptation, recovery and social inclusion post-trauma for all-regardless of housing or socioeconomic status (McKenzie-Mohr et al., 2012). As argued by Burstow (2003, p. 1306), ‘[…] *trauma is inherently political*.’. According to such a politicised view of trauma, the experience of, and recovery from, trauma should be viewed as emerging from concrete societal and institutional conditions, practices and attitudes (Burstow, 2003). Trauma-responsive interventions, therefore, should integrate violence reduction, poverty alleviation, family and community resilience strengthening, and other socio-structural interventions aiming to mitigate the risk of acute and chronic trauma (McKenzie-Mohr et al., 2012).

Future interventions research should explore how the service provision could enhance clients’ *recovery capabilities*-that is, enabling clients’ agency and freedom to attain valued achievements in all of the core recovery dimensions distilled in this study: achieving insight and envisioning recovery, regaining a state of security and ‘homelikeness’, learning positive coping and negotiating a positive self-identity, finding meaning and purpose in life and having social and emotional connectedness to others. Viewing recovery as a complex set of interrelated capabilities, whereby no one capability should be prioritised to the neglect of others, can help pin down what responding to clients' *complexity of need* requires in practice (Tanekenov et al., 2018; Abel & Frohlich, 2012; Dobson, 2019). A recovery-oriented philosophy of service provision should be underpinned by the understanding that clients' complex needs are '[…] *the results of cumulative and intersecting biographical and societal problems, which manifest in personal needs, issues and experiences*.' (Dobson, 2019, p. 12). This, in turn, necessitates coordinated, holistic, humanising and *agency-enhancing* interventions, programmes and policies. Such an institutional response to complex needs in homelessness is fundamentally opposed to the commonplace *agency-limiting* organisational policies and practices such as service fragmentation and the resultant institutional 'cycling', the medicalisation of problems, an over-emphasis on rigid notions of 'housing readiness', negative discourses surrounding clients with complex needs as 'service resistant' and 'chaotic', and others highlighted in '*Chapter Two*' and '*Chapter Three*' (Abel & Frohlich, 2012; Dobson, 2019; Watts et al., 2018).

Transforming the Shelter Space

The present findings seem to carry actionable implications for transforming the homeless shelter space in support of clients' personal recovery and permanent rehousing. Creating shelters that are conducive to clients' safety, empowerment and self-determination has been a major commitment of the NYC Government in its 2017 action plan to address the homelessness and housing crises in the city (NYC Government, 2017). Similarly, the Scottish authorities have recognised the importance of improving the temporary accommodation provision by creating facilities that are '*sustainable and holistic, person centred and needs led response to homelessness in place'* (Glasgow City Health and Social Care Partnership, 2016, p. 56; Watts et al., 2018). The present findings can inform the design of 'enabling' spaces in the service provision for clients with complex needs who are homeless. The findings that temporary accommodation and the day centre can have both recovery-promoting and recovery-impeding functions highlight the need for a more detailed investigation of what makes accommodation services *asset-conferring* (Fineman, 2008, p. 16) or *asset-depriving institutions* (Bowpitt et al., 2014). The present findings are consistent with other research findings about the contradictory nature of services for persons experiencing multiple disadvantage, including accommodation services (Bowpitt et al., 2014; Dobson, 2011). Bowpitt et al. (2014), for instance, discuss the contested nature of the 'sanctuary' service model as both '*a place of safety and a place of confrontation'* (p. 1256).

The present findings of the various components of the shelter space that shaped the participants' recovery-both therapeutic and anti-therapeutic-can instruct future efforts to design shelter and other temporary and transitional housing facilities as *enabling spaces* (Duff, 2010). The present findings identified a range of enabling processes and resources with regards to expanding the participants' opportunities for autonomous reflexivity and recovery. Examples are the material (e.g. private room; safe premises) and social and psychological (e.g. therapeutic support) resources that facilitate a state of 'homelike' being-in-the-world as well as insight as changing awareness, self-knowledge and personal growth (Levitt et al., 2004). The findings of the enabling properties of the shelter (or other temporary housing) and the relationships and encounters that it affords, therefore, resonate with Cameron Duff's proposition that *place*, especially in a therapeutic or other service provision context, is more aptly conceptualised not merely as a collection of material and physical features but rather as '[…] *a social and relational production involving diverse material, social and affective elements.*' (p. 338). According to Duff (2010), such a dynamic and pluralistic conceptualisation of place and space expands the methodological and theoretical possibilities to unravel how the therapeutic and other potentials of places and spaces can be harnessed in the delivery of effective public policies and programmes.

Applied to the homeless shelter, such theorising can help identify and strengthen the material, social and affective resources that are facilitative of clients' personal recovery. It can also help emphasise how the 'everyday work' of recovery is initiated, negotiated and maintained amidst the often-precarious conditions of homelessness (Duff, 2012). The present findings of the differential impact of shelter life on participants' recovery (e.g. '*an open prison'* (Henry) versus *'a chance for a complete turnaround'* (Conor) indicate that the roles of the shelter and its facilities are not fixed and universal for all clients but rather depend on the extent to which they afford '*discrete enabling resources'* (Duff, 2012, p. 1388) that support clients' recovery *in the context of clients' evolving recovery-relevant goals*. Furthermore, the current study's themes about the importance of occupational engagement, self-management and coping by *'doing things',* and about the role of being active and productive for participants' positive sense of self and connectedness to others underscore the centrality of material (physical, tangible), social and affective '*movements*' and exchanges among clients', providers, the shelter space and the wider community in recovery. Under such a relational, socio-affective and material, and processual conception of recovery, it is '[…] *the activity of working on one's own recovery that is critical […]'* (Duff, 2014, p. 119). In the context of shelter living or transitional housing, however, those recovery-relevant activities, movements and exchanges, are shaped or structured by the physical and normative constraints engendered by the relevant policies and physical infrastructure that co-create the shelter and the housing sector.

The present findings indicate the need to design safe havens and other types of temporary and crisis accommodation in a way that promotes the *affective engagement* of service-users with fellow service-users and with service-providers. This includes improving the quality and atmosphere of communal and private living spaces so that they instil moods and feelings that positively shape one's mental well-being and recovery (Duff, 2012; Kerman et al., 2019; Burns, 2016). As argued by Price-Robertson et al. (2017b, p. 413), recovery is contingent upon '[…] *the specific encounters, events, processes and relations by which assemblages gain (and lose) capacities to affect, and be affected by, other entities (human and nonhuman) in the everyday experience of becoming well […] '.* Maximising opportunities for positive social interactions in the shelter, while preserving each client’s sense of safety, privacy, control and autonomy, should be at the core of strategies to adapt the temporary housing provision to the needs of clients with SMI and other co-occurring conditions (Burns, 2016).

The present study’s findings about the importance of safety, security and constancy and about the psychologically damaging effects of boredom indicate the need for further research into clients’ dynamic relationship with place and into the affective atmospheres of shelter living (Piat et al., 2017). Theoretical insights from ethnography, mental health geography and anthropology can generate understanding of the ‘*emplacement*’ of recovery for individuals who reside in accommodation for the homeless (Hodgetts et al., 2007; Piat et al., 2017; Burns, 2016). For instance, Burns’s (2016) empirically derived theoretical model for ageing homeless adults’ experiences of housing in the Canadian context, ‘*oscillating in and out of place*’, appears to provide a fertile ground for future empirical investigations of the relationship between housing conditions, interpersonal relations, experiential dimensions of place (such as comfort and control) and well-being.

The literature on psychologically informed environments (PIEs) in the homeless services provision is steadily expanding. PIEs can be defined as ‘[…] *an attempt to meet the fundamental needs of residents by providing psychological safety and rebuilding damaged attachment relationships through the provision of a professional home and family.’* (Phipps et al., 2017, p. 30). The nature and effects of PIEs on personal recovery amidst homelessness, however, still remain underresearched and undertheorised (Piat et al., 2017; Duff, 2010; Johnson & Haigh, 2010). Several major challenges to the optimal utilisation of PIEs to support the personal recovery in homeless clients with complex needs persist. Those include difficulties in operationalising the principles of PIEs in day-to-day practice, as well as supporting clients’ autonomy, resilience and self-determination rather than catering primarily to clients’ deficits and illness symptoms (Woodcock & Gill, 2014; Phipps et al., 2017).

Provider Competencies for Responding to Complex Needs

In the context of increasing workload pressures and complexity of cases facing frontline homeless providers, ensuring providers are adequately trained and supported in the provision of trauma-sensitive, client-centred and recovery-oriented practice remains vital (Maguire, 2012). The present findings carry implications for the competencies and attitudes required from health and social care providers in order to respond to the complex needs of clients with SMI who have been chronically homeless. Translating the recovery ideal into concrete care practices has been challenging (McCranie, 2010; Le Boutillier et al., 2011; Khoury & del Barrio, 2015; Vandekinderen et al., 2012). Defined as '*a complex of ideas'*, recovery has faced critique for its susceptibility to professional co-optation, which can lead to its core values not being adequately translated into institutionalised norms and practices (McCranie, 2010, p. 472; Le Boutillier et al., 2015).

While it remains important for practitioners to understand they cannot '*recover*' people, counsellors, clinicians, case managers, support workers and other frontline staff remain the vital agents for creating the conditions that enable recovery (Le Boutillier et al., 2015; Le Boutillier et al., 2011; Roberts & Boardman, 2011). Becoming a recovery-oriented practitioner in homeless service settings, however, likely poses numerous organisational, cultural and professional challenges (Gillis et al., 2010). Some of those include encouraging clients' autonomy and self-direction in the context of pervasive structural discrimination and disempowerment; situating clients' seeming resistance to engage in services within clients' biographical and socio-structural contexts; and upholding a commitment to recovery in the face of austerity and other complex organisational impediments (Roberts & Boardman, 2011; Gillis et al., 2010). An essential ingredient of effective recovery-oriented working relationships is practitioners' responsiveness to clients' potential uncertainty and ambiguity in relation to the possibility of recovery in their lives. Such an ethos of care seems integral to supporting '[…] *emergent recovery processes—a potentially challenging process of looking beyond immediate distress and impairment to envisioning what a better life might actually be like* […] (Tew et al., 2015, p. i84). The helpfulness of this relationship is contingent, in part, on practitioners' empathetic and creative engagement with the clients' lifeworlds in order to gain an informed understanding of what it is really like to have undergone chronic and complex trauma and what this means for how health and social care is delivered. In line with the recovery vision, such provider competencies and practices should be underpinned by therapeutic optimism, as well as by the beliefs that individuals can find meaning even when confronted with seemingly unresolvable hardship, and that '[a] *person's life offers meaning in every moment and situation.'* (Smith & Liehr, 2008, p. 24).

Providers of homeless services should be empowered and trained to optimally fulfil a dual recovery-the role of providers of therapeutic, pastoral, case managing and coordinating support, and the role of advocates for social justice in homeless health (Conlon et al., 2015). While justice-centred professional values such as the commitment to challenging inequalities have been incorporated in policies and guidelines on the mental health service provision in both the U.K. and the U.S. (Conlon et al., 2015), it has remained less clear what forms and dimensions of inequalities service providers-such as mental health nurses, social workers and case managers-should be trained to recognise and advocate against. Providers' engagement with, and knowledge about, clients' life histories, concerns and social contexts allow them to understand deprivations in what domains of well-being and recovery most profoundly affect clients' recovery outcomes (such as occupational and social exclusion; restricted emotional and identity capital, etc.). Such knowledge is instrumental in empowering providers to engage in *informed advocacy* aimed at increasing the awareness of, and ameliorating, the observed inequalities (MacKinnon & Moffitt, 2014). Informed advocacy starts with providers' learning about how intersecting structural factors shape the needs, engagement with services and service outcomes in homeless populations (McNeil et al., 2013). Informed advocacy is critical to challenging healthcare practices that pathologise psychological distress, which is often a product of inequalities and structural violence and discrimination (McNeil et al., 2013; Pickett & Wilkinson, 2010).

Structural competency-defined as the awareness of the roles of structural and cultural factors in shaping health-related behaviours-is another valuable orientation in the provision of effective mental health and social work support to clients with lived experience of homelessness (Metzl & Hansen, 2014). The critical realist analysis in this study indicated not only a multiplicity of such inequality-generating forces but also the incremental and often-subtle mechanisms via which they come to deplete individuals' capacities for good health and recovery. This highlights the necessity for the thoughtful assessment of clients' *structural vulnerability* as an integral aspect of case management and recovery planning and as a way to enhance providers' structural competency (Bourgois et al., 2017). Structural vulnerability encompasses the individual's increased susceptibility to poor health outcomes due to their disadvantageous social positioning in relation to power hierarchies, policies and institutional norms (Bourgois et al., 2017). Structural competency, therefore, is an important component of recovery-oriented practice with homeless clients with complex needs that is both individually-focused *and* responsive to organisational and structural issues (Khoury & del Barrio, 2015).

Last but not least, integrating *peer support* into the care package for clients transitioning out of homelessness is another organisational innovation that is likely to enhance the recovery-promoting potential of housing services (Barker & Maguire, 2017; Corrigan et al., 2015). Few of the current study's participants shared they had received peer support services, especially as part of the mental health provision (See '*Formal Support Services as Key Enablers of Positive Coping and Self-Management*' in '*Chapter Six*'). The participants' emphasis on occupation, including group-based recreational activities, as well as their reported struggles to make sense of their mental illness and recovery, restore a positive self-identity and to feel socially and emotionally connected to others, appears to indicate the need for more accessible peer support services for clients in temporary accommodation. Embedding peer support as an essential component of the provision of mental health support in homelessness services is not without its challenges, however, and merits further research evaluating its goals, feasibility, implementation and role within the multiprofessional support system for clients with complex needs (Barker & Maguire, 2017). Rigorous investigations of peer support in homeless populations have been scarce (Barker et al., 2018). One of the few such studies, Barker and colleagues' (2018) qualitative England-based study with 29 clients, has demonstrated the promising potential of peer support for helping clients build meaningful and trusting relationships.

More broadly, service-user involvement at all levels of service and policy planning, delivery and evaluation should be encouraged and sustained in order to 'infuse' organisational and systemic interventions with the authentic core values of the recovery movement such as humanity, dignity, respect and empowerment (Voronka et al., 2014; Deegan, 1988; Nelson et al., 2016; Beresford, 2000). The diverse experiential knowledges offered by service-users are likely to challenge professionalised, medicalised discourses and practices in homeless services, increase the transparency of organisational policies and practices, and also aid those individuals in validating their complex experiences of suffering and injustice, and in regaining valued identities (Voronka et al., 2014; Nelson et al., 2016). User-provider collaboration is rife with ideological, political and practical challenges, however (Nelson et al., 2016). For instance, barriers to sustainable partnerships include the high staff turnover, bureaucratic demands and the difficulties clients with complex needs tend to experience with navigating multiple fragmented services (Kerman et al., 2019; Meanwell, 2012). Ensuring sustained support from user-led and other third-sector advocacy organisations, establishing shared values and minimising professional and public stigma towards homelessness and mental illness are among the preconditions for fruitful, transformational collaborations (Nelson et al., 2016).

The Need for Structural Interventions

Recovery-oriented interventions, including case management, should not overemphasise clients’ motivations, adherence to treatment and attitudes by neglecting the structural, cultural and relational factors conditioning clients’ responsiveness to treatment, self-identity and personally defined goals (Lawless et al., 2009; Kerman et al., 2019). Individual-level interventions should go hand-in-hand with organisational and wider structural interventions aiming to optimise the provision of better coordinated care, more accessible and appropriate occupational opportunities, and the spaces that help clients foster ‘homelikeness’, privacy and emotional connectedness.

System-level interventions should target the fundamental causes that marginalise those who are homeless by creating inequitable opportunities for housing, employment, income, social inclusion, health and other vital domains of life. An explicit political focus on restoring health equity in this population is likely to promote a system-wide response encompassing living conditions, health care, poverty, multimorbidity, substance use and neighbourhood safety (Duncan, Howard, & Streeter, 2019; Karban, 2017).

The multiplicity of socio-structural influences upon mental well-being and recovery identified in this study underscores the need for multi-sectoral interventions in both institutional/programmatic and community settings to sustainably optimise the mental health and social outcomes of individuals with complex needs (Castillo et al., 2019; Altena et al., 2010). For instance, as part of a core package of homeless assistance, clients should be offered opportunities to engage in life skills, mental health literacy and vocational programmes as a route to empowerment, social inclusion and socio-economic security (Altena et al., 2010; Helfrich & Fogg, 2007). At the heart of such interventions acting upon the social determinants of multiple disadvantage and exclusion should be expanding individuals' capabilities for informed personal choices, independent living, community participation and vocational and/or educational realisation (Helfrich & Fogg, 2007; Piat et al., 2015). Furthermore, well-coordinated health and non-health sectors have an important role to play in mitigating the exclusionary and recovery-impeding effects of significant life transitions such as deinstitutionalisation, leaving foster care, entries in shelter-type housing, separation and others (Piat et al., 2015). Those sustained intersectoral efforts are likely to positively contribute to the provision of equitable and tailored support to multiply marginalised individuals and thus prevent their further entrenchment into social exclusion (Piat et al., 2015).

Fundamental policy priorities in the housing sector remain minimising shelter stays and facilitating clients' routes into permanent accommodation (Padgett, Henwood & Tsemberis, 2016; Wusinich et al., 2019). Access to affordable and appropriate housing should be increased and homeless outreach should increase its capacities and effectiveness so that the duration of homelessness and 'institutional cycling' is minimised and the agency- and recovery-impeding effects of homeless shelters-counteracted. Aftercare for recently rehousing clients should also be optimised in order to ensure clients' various psychosocial, mental and physical health needs are met. The deleterious psychological effects of chronic boredom, social isolation and substance use evidenced in the present study vividly demonstrate the need to increase recently rehoused clients' access to recovery-enabling social and economic capital, as well as to mainstream support services.

Client-centred and rights-based supportive housing approaches such as Housing First represent such evidence-based structural interventions that connect clients with complex needs to valued housing, welfare, healthcare and relationship-based resources that are integral for regaining autonomy, empowerment and social recognition (Padgett, Henwood & Tsemberis, 2016; van den Berk-Clark, 2016; Kirst et al., 2014; Castillo et al., 2019). Controlled evaluation studies assessing the impact of Housing First on a range of physical health, mental health, substance use and social outcomes in an ever-expanding diversity of client demographics have shown promise for the continued embrace of this model (Stergiopoulos et al., 2016; O'Campo et al., 2016; Piat et al., 2015).

At the level of civic society, cross-sectoral, community-wide initiatives such as Thrive NYC have demonstrated the feasibility of harnessing political and community resources to provide a comprehensive, value-based public health response to the mental health crisis, including action on the social determinants of mental health (Belkin & McGray, 2019). Some of the target areas of Thrive NYC with distinct and acute relevance to the homeless population in the city include counteracting structural racism and collective trauma, promoting community cohesion and collective self-efficacy in mental health, and housing and income stability programmes (Belkin & McGray, 2019).

From Recovery to Citizenship

The findings from this study have direct policy relevance insofar as they indicate the need to promote citizenship-oriented care post-rehousing. *Citizenship* can provide a comprehensive, human rights-oriented framework for supporting clients post-rehousing (Rowe & Davidson, 2016; Vandekinderen et al., 2012; Clifton et al., 2013). As the present findings highlight, the provision of own, permanent housing is necessary but insufficient in enabling clients to fulfil personally meaningful and socially valued roles and responsibilities, or to sustain their autonomy and self-directedness. Therefore, citizenship-oriented interventions should focus on creating the conditions to enhance individuals' civic participation in a manner that is aligned with, and promotive of, their unique recovery journeys. This will include, among other structural interventions, reducing professional and public stigma towards those with a history of SMI and homelessness, and increasing the access to vocational and other occupational opportunities for such individuals in community settings. This study's findings regarding the importance of both material (e.g. stable housing, access to medication) and socio-affective resources (e.g. hope, sense of shared purpose) for recovery indicate the need for citizenship-oriented interventions to also attend to the affective aspects of individuals' social connectedness and participation (Rowe et al., 2009; Ponce & Rowe, 2018; Ponce et al., 2012).

Importantly, citizenship subsumes a collectivist, relational perspective on mental health rehabilitation, service use and empowerment in marginalised groups (Quinn, Bromage, & Rowe, 2020). Arguably, in order for individuals with a history of multiple disadvantage to actualise and sustain their recovery in the community, the conditions should be present that allow them to attain the '*civic-social-participational aspects of citizenship*' (Quinn et al., 2020, p. 363; Hamer et al., 2014). Those include having equitable access to citizenship-promoting resources and relationships and being recognised as equal by others. This, in turn, mandates the exercise of political and societal responsibility aimed to eliminating the structural and cultural barriers to social inclusion and recognition for all. Potentially impactful acts of such collective responsibility are involving persons with lived experience in decision-making at the organisational and policy levels and developing peer specialist workforces in the mental health and social care sectors. Citizenship is also promoted by creating a humanising discourse surrounding homelessness and co-occurring disadvantage by foregrounding voices of lived experience in policy-making and creative storytelling in the media; investing in community mental health services; strengthening community resilience, and many others (Ponce & Rowe, 2018; Harper et al., 2017; Vandekinderen et al., 2012; Hamer et al., 2014).

Conclusion

Homelessness is a politico-economic and public health challenge of rising magnitude and complexity in leading developed countries (Aldridge et al., 2018; Shinn, 2010; Somerville, 2013). A multi-determined phenomenon, homelessness is said to be the consequence of persistent health and social inequalities, structural discrimination, sectoral inefficiencies, reductionist policy responses and others (Watson et al., 2016; Zufferey, 2016; Shinn, 2007). Those facing chronic or long-term homelessness tend to experience disproportionately adverse physical health, mental health, disability, employment and rehousing outcomes, which tends to not only create a vicious circle of institutionalisation and housing instability but also severely impede those individuals' quality of life (Aldridge et al., 2018; Watson et al., 2016; Homeless Link, 2014; Fitzpatrick et al., 2013). The high rates of mental health and substance use problems among the homeless, particularly the chronically homeless, populations in both the U.S. and Scotland pose complex challenges to the provision of effective and comprehensive health and social care services (U.S. Department of Housing and Urban Development, 2017; Scottish Government, 2018b).

While personal recovery entails therapeutic optimism and the belief that each person has the intrinsic right to achieve self-directed, authentic, meaningful and productive lives, the realisation of recovery amidst homelessness and co-occurring disadvantage tends to be severely impeded by a plethora of economic, institutional, cultural and individual factors (Tew et al., 2012; Hopper, 2007). An entrenched form of social exclusion, homelessness poses serious challenges to the realisation of the recovery ideal-both in terms of individual life projects and in terms of mental health system transformation (Gillis et al., 2010; Cornes et al., 2014; Padgett, Henwood, & Tsemberis, 2016).

This transatlantic qualitative study makes a multifaceted contribution to understanding the meaning, enablers and barriers of personal recovery in individuals with SMI experiencing chronic homelessness-an underresearched and multiply marginalised client group. To understand the influence of severe forms of homelessness and accompanying health inequalities on mental well-being and recovery, the present study recruited 18 clients of various temporary accommodation providers in New Yok City and Glasgow, Scotland. The study was underpinned by the assumption that in order to understand how recovery happens for this population, one must unravel (a) what recovery means to individuals with lived experience, and (b) how the processes of recovery are shaped by the confluence of socio-structural, relational and individual (agential) factors. By foregrounding the lived experience of adults with complex needs who might not consider themselves to be '*in recovery*' or '*recovered*', the present study expanded the knowledge of the diversity of recovery experiences. The elicitation of the recovery experiences from a historically disenfranchised group within a qualitative, participatory research paradigm is instrumental in helping those individuals regain *epistemic authority*-their credibility as possessors of valuable knowledge and the ability to redefine themselves by rejecting imposed, dominant labels or categories (Fisher & Freshwater, 2014).

The findings from this study illuminate the complexities of the recovery experience as the participants attempted to make sense of their past, navigate their precarious present and '*envision*' a future post-rehousing. While some participants were hopeful about attaining a '*quote-unquote somewhat normal life*', becoming '*in charge of*' their lives and regaining a sense of '*homelikeness*', '*completion*' and self-directedness, others saw '*no way out of being homeless*' and had '*no one*' to offer them '*an inkling of hope*' that an alternative life was feasible. For many, chronic homelessness was a profoundly disruptive experience-psycho-emotionally, socially and existentially-which had hindered their capacities to envision and enact their authentic conceptions of the '*good life*'.

To facilitate personal recovery, temporary accommodation services should be organised as enabling institutions and spaces that offer clients the physical, psychological and relational preconditions to engage in recovery, as well as to connect effectively with professional support services and meaningful occupational opportunities. Service-providers and policy-makers alike should recognise how incremental and situational systemic, cultural and biographical factors (such as poverty, adverse childhood experiences, unemployment and stigma) may diminish clients' recovery-promoting personal agency. Amidst the paternalism, client infantilisation, conditionality and other restrictive policies and practices endemic in homelessness and mental health services, it is vital to develop intervention strategies to uphold and sustain clients' intrinsic capabilities for self-determination and autonomy.

Understanding the process of agency in those groups is instrumental in recognising the extent to which individuals can capitalise upon the resources offered by health and social care services (such as welfare support, housing, case management, psychotherapeutic help, recovery planning); understanding how meaningful those supports are *in relation to* individuals' unique values, goals and strengths; and assessing whether the formal service provision is indeed sufficient to reduce the suffering and inequalities and promote recovery (Fitzpatrick et al., 2007). Ultimately, empirical insights into the dynamics of agency in the transition from chronic homelessness can inform strategies to counteract the agency-diminishing effects of policies and practices and encourage agency-promoting policies, practices and relationships (Bowpitt et al., 2014). Health and social care services and policies should be designed and implemented in ways that are supportive of clients' contemplative, imaginative, creative and critical, emotional and spiritual capacities to rebuild their lives. Understanding what enables and constrains individuals' capacities and resources to '[…] *survive, grow, and mature*, […] *resist adversities, endure suffering, and experience a good life in spite of harsh conditions.*' (Lundman et al., 2010, p. 252) is essential for informing recovery-oriented and person-centred services, and ultimately, achieving health equity and social justice (Rapp & Goscha, 2011; Lundman et al., 2010; Phipps et al., 2019). As Manuel (2006, as cited by Norris et al., 2010, p. 196) states, '[…] *good* *public policy takes stock of where people are located, where they want to be (the good life), and how the good society can build bridges to help them get there.'.*

Recovery researchers should be equipped with the emancipatory sensibilities, as well as with an elaborate and pluralistic theoretical repertoire, in order to unravel both '*the impingements of structure on individual health and well-being'* and *'the tactics devised by individuals to deal with these very impingements.'* (Angus & Clark, 2012, p. 3). A research agenda that endeavours to foreground the voices of those most marginalised in society is likely to continue to substantially expand and critique the conceptual bases, universality and applicability of personal recovery (Lal, 2010; Kerman et al., 2019). The present study concurs with Houston (2010b, p. 76), who argues that '[…] *it is only by understanding the deep causes of oppression that we can develop ways of dismantling it'.* By examining agential processes that are located within a wider socio-structural order, researchers can enhance the understanding of how and under what conditions emancipatory identities can be achieved, reinforced or transformed, and how structural forces such as health inequalities are implicated in those processes (Edwards et al., 2014; Archer, 2000; O'Mahoney & Marks, 2014). More studies into clients' conceptualisations and experiences of recovery in different organisational settings, such as homeless services, are needed in order to develop a contextualised understanding of recovery-as-experience and harness this knowledge to inform care policies, organisational norms and ethos (Smith-Merry et al., 2011; Le Boutillier et al., 2015).

Recovery *is* possible-even for those that have endured severe and multiple disadvantage; however, it is contingent upon enabling and humanising institutional, cultural and relational practices, encounters and processes.

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Appendices

Appendix 1: Methodology of the Critical Literature Review

Search Strategy

A systematic review approach was deemed inappropriate and unfeasible for several reasons. The diverse and often-incommensurate study designs and epistemologies make much of the recovery literature difficult to systematically search, appraise and synthesise without the risk of over-privileging one epistemology over another (Tew et al., 2012). In addition, the extremely limited number of empirical investigations in areas such as recovery and co-occurring homelessness necessitated a more flexible and inclusive engagement with the relevant theoretical and empirical scholarship. Furthermore, concepts such as ‘recovery’, ‘homelessness’ and ‘social exclusion’ tend to be contested terms, with no universally accepted definitions (Hsieh, 2016; Morgan et al., 2007; Slade et al., 2012). Therefore, relying on a pre-planned, restricted set of search terms is likely to exclude potentially relevant sources (Tew et al., 2012).

Comprehensive searches were conducted in several electronic databases, including Scopus, PsycINFO, MEDLINE, CINAHL Plus and Social Services Abstracts. This selection of electronic databases reflected the interdisciplinary focus of the literature on recovery and homelessness, which includes the psychiatric, psychological, sociological, social work, nursing, health policy and other literatures. Broad-based, free-text search terms were used (e.g., ‘recovery’, ‘experience’; ‘homeless/ness’; ‘mental’), in addition to relevant methodological filters (e.g., ‘qualitative’, ‘mixed*’, ‘ethnograph*’, ‘interview*’, ‘randomised’, ‘trial’ and others; Shaw et al., 2004). To maximise the retrieval of potentially useful sources, bibliographic searches and citation searches were also carried out. To identify the most influential concepts in relation to the review objectives, the theoretical literature was also searched (Huff, 2008; Booth, 2016). Qualitative and quantitative, empirical and non-empirical evidence, and primary and secondary types of evidence were considered. The search process was iterative and took place between October 2016 and July 2019.

Quality Appraisal

No formal quality appraisal of the articles discussed in this review was conducted. Evidence sources were critically evaluated as part of the remit of the review based on their methodological and conceptual contributions to the empirical and theoretical topics that form the review objectives (Grant & Booth, 2009).

Evidence Synthesis and Reporting

The evidence synthesis focused around pertinent conceptual, methodological and philosophical issues (Huff, 2008). Specifically, the evidence on the core tenets and principles of personal recovery, and on the influence of different forms of structural disadvantage, including homelessness, was critically evaluated. The findings of the critical review are presented using narrative and tabular formats.

Overview of narrative reviews and syntheses examining the structure and characteristics of, and influences on, personal recovery (N = 15)

Review (Author(s); Title	**Aims**	**Study Composition**	**Main Themes/ Key Findings**
Cluster I: Generic reviews of recovery dimensions and components, and of factors influencing recovery			
Bonney & Stickley (2008); Recovery and mental health: A review of	‘[…] *to examine the British literature relating to recovery in mental health. […] to examine the*	N = 170; British papers published between 2002-2008	The main themes were: identity, the service provision agenda, the social domain, power and control, hope and optimism, risk and responsibility.

the British Literature	*various ways the respective stakeholders conceptualize the notion of recovery in mental health.'* (p. 140)		The social domain theme includes one's reintegration into leisure, work and other social opportunities, regaining 'equality' in society and overcoming social exclusion, stigma, civil rights restrictions and others.
Drake & Whitley (2014); Recovery and severe mental illness: Description and analysis	To understand people's views of their recovery as reported in autobiographical and other qualitative studies; To ascertain the proportion of people living in recovery from the evidence from quantitative studies; To identify interventions and approaches that are consistent with the evidence form primary studies on recovery.	N - Not reported. Autobiographical accounts; qualitative studies; quantitative studies	The review briefly reports evidence that individuals with severe mental illness tend to experience various forms of inequities, including **homelessness**, lack of access to affordable housing, victimisation and stigma (e.g. Padgett et al., 2008). **Housing** and employment, among other socio-structural factors, are discussed as vital for recovery. From their review of quantitative studies, the review authors conclude that '[…] *recovery aspirations and recovery realities remain discordant for many people with SMI.'* (p. 240).
Jacob et al. (2017); Mental health recovery: A review of the peer-reviewed published literature	To analyses views of recovery held by consumers, carers and service providers; To understand the factors influencing recovery	N = 26; Peer-reviewed qualitative, quantitative and mixed-method studies	Recovery was commonly viewed as: (a) a personal transformation and a future orientation; (b) a cure; and (c) an impossibility. Other key themes include engaging in meaningful activities, having meaning in life, self-acceptance and self-control, transformation of the self; inner wellbeing;

			multidimensional process; absence of symptoms. Factors facilitating recovery and factors impeding recovery relating to mental health systems are reviewed. The review highlights the importance of understanding consumers' meanings of recovery. The review found that '[…] *recovery from mental illness is a multidimensional process and the concept cannot be defined in rigid terms.'* (p. 54).
Leamy et al. (2011); Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis	*'To synthesise published descriptions and models of personal recovery into an empirically based conceptual framework.'* (p. 445)	N = 97; Qualitative studies, narrative literature reviews, book chapters, consultation documents reporting the use of consensus methods, opinion pieces or editorials, quantitative studies	The CHIME conceptual framework of personal recovery was developed consisting of five core recovery components: connectedness, hope and optimism, identity, meaning-making and empowerment.
Onken et al. (2007); An analysis of the definitions and elements of recovery: A review of the literature	To analyse the '*definitions and dimensions'* of personal recovery by using *'an ecological framework to take the individual's life context into account while*	N - Not reported; Not reported	The review authors identify a range of 'person-centred' (e.g. hope, agency, self-determination), 're-authoring' (e.g. personal narratives, narrative engagement with dominant discourses), 'exchange-centred' (e.g. social roles, power, choice), and

	emphasizing both the reestablishment of one's mental health (i.e., first order change) and the mitigation of the oppressive nature of barriers imposed by the greater community (i.e., second order change) […]'		'community-centred' (e.g. social connectedness/relationships, social circumstances/opportunities including basic needs such as **housing**, stigma and integration) elements of recovery.
Slade et al. (2012); International differences in understanding recovery: A systematic review	To validate the CHIME framework of personal recovery (Leamy et al., 2011) by reviewing recovery research in several countries; To compare conceptualisations of recovery in different countries	N = 115; Published qualitative research, non-systematic literature reviews and position papers	The CHIME framework was found to be largely valid, although limited to Western countries only. Several evidence gaps were noted including empirical evidence on changes of recovery over time and evidence on the role of mental health services in supporting recovery.
Stickley & Wright (2011b); The British research evidence for recovery, papers published between 2006 and 2009 (inclusive). Part Two: A review of the grey literature	'[…] *to analyse the contemporary British literature related to recovery in mental health.'* (p. 298)	N = 39 information sources; Grey/non-peer reviewed literature: books, book chapters, papers, policy documents, publications from voluntary sector organizations	The main themes identified were**:** social, historical and political critique; philosophy of hope for the individual; individual identity and narrative; models and guidance for mental health practice. '*Recovery is a complicated and multifaceted concept with no universal definition. It spans individual, professional and policy domains.'* (p. 305). The relevance of humanistic philosophy for recovery is

including book chapters and policy documents			emphasised.
Stuart et al. (2017); What we talk about when we talk about recovery: A systematic review and best-fit framework synthesis of qualitative literature	*‘To carry out a review and synthesis of qualitative research to answer the question: ‘‘What do we know about how service users with severe and enduring mental illness experience the process of recovery?’* (p. 291)	N = 15 (12 used in the best-fit framework synthesis) Peer-reviewed qualitative studies	The review found that while influential models of recovery (such as CHIME; Leamy et al., 2011) are a relatively good fit for the extant evidence on recovery, a significant proportion of the data (30%) has remained unaccounted for by those models. Among the themes not accounted for by the CHIME model was ***‘Difficulties’***, which includes **disempowerment**, financial concerns, struggling, suffering and ambivalence, losses, and others.
Cluster II: Reviews primarily focusing on the social aspects of recovery			
Tew et al. (2012); Social factors and recovery from mental health difficulties: A review of the evidence	To examine ‘[…] *the role that social factors can play in enabling (or impeding) recovery.*’ (p. 443)	N = 71; Not reported	**The main themes are**: ***‘empowerment and control over one’s life****;* **connectedness** *(including both inter-personal relationships and* ***social inclusion****); and* ***rebuilding positive identities*** *(often within the context of* ***stigma and discrimination****)’* (p. 443) Within the theme of power relations and empowerment, the review authors discuss the issues of oppressive social situations, injustices, abuse, and equitable and reciprocal social relationships and

			community participation. Within the theme of identity, stigma and discrimination, the review authors discuss the exacerbating impact of stigma based on minority status on mental health and recovery. The intersection of housing and occupational exclusion and mental health is briefly highlighted. The internalisation of stigma is offered as a possible mechanism for the influence of structural discrimination. The review authors discuss the importance of social inclusion and social capital. **Income, housing and employment** are mentioned as barriers to social inclusion.
Topor et al. (2011), Not just an individual journey: Social aspects of recovery	To describe *'aspects of recovery that involve the contributions of others, the social environment and society'* (p. 90)	N - not reported; Not reported	Social aspects of recovery discussed are relationships, **adequate material conditions** and responsive services and supports. Among the material and social conditions discussed are **home,** money and occupations, the recovery discourses, and the recovery orientation of mental health services.
Cluster III: Reviews focusing on the experiences of recovery in specific sub-populations of mental health service-users			
Ness et al. (2014); Facilitators and barriers in	***Dual recovery***; '[…] to *identify and discuss what persons with co-*	N = 7; Peer-reviewed qualitative and mixed-method	**Facilitators of dual recovery**: meaningful everyday life; focus on strengths and future orientation; re-establishing a

dual recovery: a literature review of first-person perspectives	*occurring mental health and substance use problems describe as facilitators and barriers in their recovery process as revealed in the literature.'* (p. 107)	studies containing first-person accounts of persons with lived experience of recovery	social life and supportive relationships. **Barriers to dual recovery**: lack of tailored help; complex systems and uncoordinated services. The review concludes that: '*Persons in dual recovery report inefficiency of complex systems and how problematic this is for their health and health care.'* (p. 114). The review authors also highlight the need for better coordinated care, a stronger recovery orientation of services, '***a strong focus on humanity and common human life issues'*** (p. 114), and the identification and elimination of structural inequalities (e.g. inclusive work environments, stigma).
Shepherd et al. (2016a); Personal recovery within forensic settings– Systematic review and meta-synthesis of qualitative methods studies	'[…] *to develop a model of the personal recovery processes for people needing forensic mental health services'* (p. 59)	N = 5; Qualitative studies	The main themes are: safety and security as a necessary base for the recovery process, the dynamics of hope and social networks in supporting the recovery process and work on identity as a changing feature in the recovery process.
Shepherd et al. (2016b); Personal recovery in personality	'[…] *to review the existing qualitative methods literature in relation to the*	N = 3; Peer-reviewed qualitative studies	Three main themes were identified: **Safety and containment** as a prerequisite to recovery, **social networks** and

disorder: Systematic review and meta-synthesis of qualitative methods studies	*experience of personal recovery in personality disorder.'* (p. 41)		**autonomy** in the recovery process and **identity construction** as a process of change.
Cluster IV: Other reviews			
Doroud et al. (2015); Recovery as an occupational journey: A scoping review exploring the links between occupational engagement and recovery for people with enduring mental health issues	To understand '[…] *the links between occupational engagement and recovery for people with enduring mental health issues.'*	N = 17; Peer-reviewed quantitative, qualitative and mixed-method research	**Main findings**: '[…] *recovery is an ongoing occupational process that seems to involve experiences of gradual re-engagement, engaging within the stream of everyday occupational life, and full community participation. Engaging in meaningful and valued occupations appears to support recovering through fostering connectedness, hope, identity, meaning, and empowerment; establishing structured routines and assisting people in managing illness.'* (p. 378). The review authors briefly mention studies exploring the role of the wider social and physical contexts on recovery. Further research is required on the '*nature, processes, mechanisms and underlying factors'* (p. 389) via which occupational engagement influences recovery (e.g. Sutton et al., 2012).

Stickley & Wright (2011a); The British research evidence for recovery, papers published between 2006 and 2009 (inclusive). Part One: a review of the peer-reviewed literature using a systematic approach	'[…] *to analyse the theoretical development of the recovery concept and highlight future directions for recovery in mental health services.'* (p. 247)	N = 12; Peer-reviewed research: theoretical papers, empirical research (qualitative and quantitative), and literature reviews (Bonney & Stickley, 2008; Cleary & Dowling, 2009)	**Main emerging themes**: hope and optimism; meaning to life; activities promoting recovery; definitions and discourses; and implications for mental health practice. The review identifies critical theoretical work on the importance of **structural factors** (e.g. racism, poverty, unemployment) for achieving recovery (e.g. Pilgrim, 2008). The roles of communities and of **addressing the wider social determinants of inequalities** are highlighted. '**Recovery is a complex concept**, *not clearly defined and in need of further debate and clarification* […]' (p. 253). Tensions are highlighted between personal narratives of recovery and evidence-based medicine, and between humanistic values and the biomedical model of mental illness. A growing body of critique advocates a conceptualization of recovery as a collective (not solely individual) responsibility. The relevance of humanistic theory for conceptualizing and implementing recovery is underscored. However, the review authors argue there is insufficient attention to this link between humanism and recovery in the literature.

Appendix 2: Study Overview Emailed to Prospective Gatekeepers

This project has received funding from the European Union's Horizon 2020 Research and Innovation programme under the Marie Sklodowska-Curie grant agreement No 690954.

Transatlantic Research Study: Homelessness, Mental Health Difficulties and the Navigation of Recovery

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Background. Personal narratives of the experience of multiple disadvantage such as co-occurring homelessness and mental illness have been neglected and yet an important source for in-depth and contextualized understanding of health inequities. Specifically, little is known about how *mental health recovery* is navigated by individuals facing intersecting disadvantage based on their gender, race, ethnicity, age, income *and* health status. It is hoped that creative and participatory research methodologies can empower individuals to articulate the complexities of their experiences, and in turn, inform the development of more responsive, inclusive and person-centered policies and practices.

Research objectives. This participatory qualitative study aims to explore the experiences and/or visions of mental health recovery, the challenges to maintaining a positive self-identity, the sources of coping and resilience, the perceptions of neighborhood context and services, and the storied critical life experiences of *homeless* *adults with serious mental illness (SMI) with/without co-occurring substance use problems.*

Participants. Between 6 and 10 participants currently receiving services from a housing/homelessness service provider will be asked to participate. To be eligible, participants will have to have a history of a diagnosis of SMI, be currently homeless (houseless or roofless), be over 18 y.o.a. and have a fluent level of English language.

What will be asked of participants. Participants will be asked to take part in two one-to-one in-depth interviews with the Researcher. Participants will then be asked to complete an interactive mobile phone diary over a period of seven days and come back for a final (third) follow-up interview. The mobile phone diary involves the participants using a smartphone to respond to unintrusive automated prompts about their everyday lives with text or multi-media messaging (including images). Participants will be offered one shopping voucher worth £15, per interview, as a compensation for their time.

Ethical standards. This study was granted approval by the University of Strathclyde's University Ethics Committee on July 28, 2017 (UEC17/42 Weaver/Karadzhov/Quinn). Procedures are in place to ensure confidentiality and anonymity, protect the safety of participants, and create an equitable, open and respectful researcher-participant relationship.

Implications and Potential Impact of this Study on Individuals, Organizations and Communities:

- This study will offer a space for participating individuals to document and reflect on their everyday life, their strengths, and their concerns, and be listened to. Homeless participants in similar prior studies have reported enhanced reflexivity, insight and self-efficacy;

- The results of the study will potentially inform person-centered, recovery-oriented practice and the coordinated provision of services addressing the psycho-social needs of homeless clients;

- The collated, anonymized findings may be shared with partnering agencies to inform their service delivery;

- Participant-generated photo images during the study may be used to target policy-makers and/or engage the wider public by organizing photo exhibitions, talks and other awareness-raising and stigma-reduction events;

- Participating organizations will contribute to the cross-national fertilization and dissemination of knowledge on health inequalities, social inclusion, citizenship and recovery.

Thank you for your time and consideration!

Appendix 3: Background Questionnaire

Background Questionnaire

Participant No:	*(this is to protect your identity*)	Date:

Instructions: Please answer the questions below as accurately as possible by ticking the answer that best describes you. You may refuse to answer any question without explanation. All information you provide will remain anonymous.

What is your country of birth? ___________________ What is your city of birth? ___________________ About how many years have your lived in this city for? __________________	What is your native language? _________________ How old were you on your last birthday? __________________ What is your biological sex? ○ Female ○ Male
What race/ethnicity best describes you: ○ White or Caucasian ○ Black or African American ○ Asian ○ Hispanic ○ Native American ○ Other *(Please specify)*	What is your gender identity? ○ Female ○ Male ○ Trans male/Trans man ○ Trans female/Trans woman ○ Gender non-conforming ○ Other (*Please specify)* ○ *Prefer not to answer*
What is the highest level of school you have completed or the highest degree you have received? ○ Less than high school degree ○ High school degree	

○ Some college but no degree ○ Bachelor degree ○ Graduate degree ○ Other *(Please specify)*	
What best describes your current employment status? ○ Employed full-time ○ Employed part-time ○ Unemployed, looking for work ○ Unemployed, NOT looking for work ○ Retired ○ Disabled, not able to work ○ Other *(Please specify)*	What is your current marital status? ○ Married ○ Separated ○ Divorced ○ Widowed ○ Never married ○ *Prefer not to answer*
Do you have any children or dependants? ○ Yes (*Please specify how many*)______ ○ No ○ *Prefer not to answer*	Are you currently living with someone in a marriage-like relationship? ○ Yes ○ No ○ *Prefer not to answer*
How would you rate your overall physical health? ○ Excellent ○ Very good ○ Good ○ Fair ○ Poor ○ Don't know ○ *Prefer not to answer*	How would you rate your overall mental health? ○ Excellent ○ Very good ○ Good ○ Fair ○ Poor ○ Don't know ○ *Prefer not to answer*
Is your physical health now better, worse, or about the same as it was one year ago?	Is your mental health now better, worse, or about the same as it was one year ago?

○ Better ○ Worse ○ Same ○ Don’t know ○ *Prefer not to answer*	○ Better ○ Worse ○ Same ○ Don’t know ○ *Prefer not to answer*

Appendix 4: Structured Residential History Interview Schedule

Brief Residential History Interview Schedule:

For how long (in months) have you been a client of….?
Answer:

Please select one of the following that best describes your *current* housing situation:

○ Without accommodation or roofless (e.g. sleeping on the streets/sleeping rough or staying in a night shelter);

○ Living in temporary accommodation or houseless (e.g. transitional housing, supported accommodation, homeless hostel, women's shelter; squatting);

○ Sharing accommodation (e.g. temporarily with family/friends, facing eviction) or living in unfit and/or insecure housing (e.g. temporary structure, mobile home, overcrowded place) AND are at risk of becoming literally homeless (roofless);

○ *Other (please specify):*

When was the first time you were without a place to stay? How old were you then?
Answer:

Since the first time you (were homeless/had no place to stay), how many times have you lived in your own room, apartment, or house for a month or more?
Answer:

When was the last time you lived in your own room, apartment, or house for a month or more (excluding times you stayed with friends or family)? *Please tick:*
○ Less than 2 weeks ago
○ Between 1 and 6 months ago
○ Between 6 and 12 months ago
○ More than 1 year ago

Adding up all the months or years in your life that you spent without a regular place to stay, how long was this altogether?
Answer:

What has been the longest period of time you have been homeless/without a place to stay?
Answer:

How old were you the first time you stayed in a shelter or other temporary facility?
Answer:

How many nights in the past 12 months did you stay in a shelter or other temporary facility?
Answer:

On how many different occasions have you ended up homeless/not having a place to stay in your lifetime?
Answer:

Since the first time you were homeless/had no place to stay, have you ever lived with family or friends for a month or more? *Please tick:*

○ Yes
○ No

In how many different shelters have you stayed overnight during the past year? *Please tick:*

○ 0
○ 1
○ 2
○ 3+

In how many other cities have you lived during the last 5 years?
Answer:

How many times did you have to move neighborhood in the past year? *Please tick:*

○ 0
○ 1
○ 2
○ 3+

Where did you stay last night? *Please tick:*

○ In a shelter
○ On the streets
○ In a park
○ In a cheap motel/hotel
○ In a friend's home
○ In your family's home
○ In a tunnel or abandoned building
○ In a bus/train station
○ In hospital
○ In jail
○ In your own apartment or home
○ In your partner's home

○ Anywhere else (*please specify)*

Where else have you stayed overnight in <u>the past month</u>? *Please tick all that apply:*

○ In a shelter
○ In a transitional housing programme
○ On the streets
○ In a park
○ In a cheap motel/hotel
○ In a friend's home
○ In your family's home
○ Anywhere else (*please specify)*
○ In a tunnel or abandoned building
○ In a bus/train station
○ In hospital
○ In a detox facility
○ In jail
○ In your own apartment or home
○ In your partner's home

Where else have you stayed overnight <u>in the past year</u>? *Please tick all that apply:*

○ In a shelter
○ In a transitional housing programme
○ On the streets
○ In a park
○ In a cheap motel/hotel
○ In a friend's home
○ In your family's home
○ Anywhere else (*please specify)*
○ In a tunnel or abandoned building
○ In a bus/train station
○ In hospital
○ In a detox facility
○ In jail
○ In your own apartment or home
○ In your partner's home

<u>In the past year</u>, which one of these places was your <u>usual</u> sleeping place? *Please tick one or two that apply the most:*

○ In a shelter
○ In a transitional housing programme
○ On the streets
○ In a park
○ In a tunnel or abandoned building
○ In a bus/train station
○ In hospital
○ In a detox facility
○ In jail

○ In a cheap motel/hotel
○ In a friend’s home
○ In your family’s home
○ Anywhere else (*please specify)*
○ In your own apartment or home
○ In your partner’s home

People don't have a regular place to stay for many different reasons. I'd like you to think back to the very first time you ever found yourself without a regular place to stay. What was the main reason:

○ Unemployment, loss of job, problems paying the rent or mortgage, eviction, or having no money
○ Family conflict or other family breakup reasons
○ A health problem, a hospital discharge, emotional problem, or mental illness
○ Alcohol or drug reasons
○ Divorce or separation or breaking up with a boyfriend/girlfriend
○ Another reason *Please specify):*

Please tick any other reasons that apply:

○ Unemployment, loss of job, problems paying the rent or mortgage, eviction, or having no money
○ Family conflict or other family breakup reasons
○ A health problem, a hospital discharge, emotional problem, or mental illness
○ Alcohol or drug reasons
○ Divorce or separation or breaking up with a boyfriend/girlfriend
○ Another reason *Please specify):*

I'd like for you to think about your present situation. What is the main reason you don't have a regular place of your own to live right now?

○ Unemployment, loss of job, problems paying the rent or mortgage, eviction, or having no money
○ Family conflict or other family breakup reasons
○ A health problem, a hospital discharge, emotional problem, or mental illness
○ Alcohol or drug reasons
○ Divorce or separation or breaking up with a boyfriend/girlfriend
○ Another reason *Please specify):*

Please tick any other reasons that apply:

- ○ Unemployment, loss of job, problems paying the rent or mortgage, eviction, or having no money
- ○ Family conflict or other family breakup reasons
- ○ A health problem, a hospital discharge, emotional problem, or mental illness
- ○ Alcohol or drug reasons
- ○ Divorce or separation or breaking up with a boyfriend/girlfriend
- ○ Another reason *Please specify):*

Appendix 5: In-depth Qualitative Interview Schedule

Life story, significant events, critical/transition periods, life lessons, a 'grand narrative'
(Any initial prompts to stimulate recall and engagement with the past) Preamble (McAdams, 1995): When looking back at our lives, many of us tend to think about our lives as a story or as a timeline. So I'd like to ask you to imagine that right now. Every story has events or a string of events, people, time and place and so on. And every story has ups and downs, and many different parts or stages.

Growing up, family, community and social networks. Begin by telling me where you grew up and what growing up was like. *Prompts: What did your family do at the time? Did you get on with them? Did you have friends you used to hang out with? Did you like your neighbourhood? In comparison with others, were your family and neighbourhood poor, well-off or average? How did your relationships with the significant other in your life change after that? How did that influence you? What was the best/worst part of the neighbourhood you grew up in?*

Then, what happened? How did your life unfold after that? Tell me about what happened with your school, family, siblings, etc. *Prompt: If you think about it in episodes or stages, what were the next few episodes that came about?*

If those were the first chapters of your life so far, what are the next ones?
What important events for your story took place? Can you describe them for me? Where were you? Who else was involved? What significant events took places within those episodes? How did they affect you? What were you thinking and feeling at those times? Why were they important events? What impact did they have on you as a person and on your life as a whole? Why does this stand out for you?

Onset, antecedents, and causes of hardship (or 'trigger points')
When did your current problems begin? *(Allows for the primary event of interest to emerge naturally from the account)*
Probes: How did that come about? Will you tell me more?
How has your life changed since you began experiencing homelessness?
Has homelessness or not having a place to stay impacted you? And what about your well-being/health?

Low/critical points. Transition points
From what you shared so far, which do you feel has been the biggest hardship or the biggest turning point in your life? ***Of course, I'd like to remind you that it is completely***

up to you how you answer this, if you'd wish to answer at all. Universal probes. How did you face/handle/deal with this experience? What impact has it had on your life/on? And what, if anything, do you regret the most in your life so far? Why?
And what, if anything, do you think was the best thing that happened to you? Anything that you cherish or are proud of? Tell me how this came about.
Now think about a time or an event that led to a lot of change in your life-what I like to call 'turning point'. This can be either positive or negative. While those points do not necessarily define us, I feel they are important for other to understand what we have been through. *Prompts:* ***And what about a positive/negative turning point?*** *E.g. in your family life, relationships, health, job, housing situation.*

Life now:
Tell me about your life now. Where do you live? What does your typical day look like? What people do you encounter in your day-to-day life?
What is the hardest thing about your life right now? Do you think you are doing better or worse than a month ago? Why/how?
What satisfactions can you find in your life? OR Are there any advantages to living the way you do now?
Who, if anybody, do you count on the most for support when you are struggling? E.g. In terms of people close to you and/or social service agencies.
Now tell me about what the past week has been like for you, e.g. where did you spend most of your time, did you meet with anyone.
What in your life in the past and in your life ***now*** a) helps you improve things; b) prevents you from getting better?
Can you remember the most recent time when something good/positive happened to you?

Are there any times in your life that you remember more vividly than others? Why?
How often do you think about the past? When do you usually do that? Why?
What did you wish you had known when you were young?

What do you think are the reasons you continue to struggle/be unwell/ have mental health problems (if acknowledged)/have substance use problems (if acknowledged)? Why do you think this has been the case?
What do you think could have been done to prevent your experience of homelessness?
What kinds of things make it hard for you to do well?

Source of coping, strengths and skills. Personal priorities. Hopes and goals

What or who in your life ***so far*** has helped you get better; b) has made it difficult for you to get better? Why/How? What happened? Does this continue to be the case in your life now? What about recently? What do you think needs to happen for you to see those changes for the better? What can support these changes? What can get in the way of making this a reality?
What skills do you have that help you get by in your situation? What challenges do you encounter? How have you overcome challenges? Are there challenges you have not been able to overcome?

(From Nott & Vuchinih, 2016) What does it mean in general to have a good life? Prompt: What do you need to get there? What do you need to get that life? Steps to get there? Prompt: Now thinking about you specifically, what matters most to you in life?
What is the most important thing for you to be **well**?
What is the most important thing for you to have a stable home?

When you think about our future, how far into the future do you usually think about? Prompts: *A year from now? Day-to-day?* Why? How often think about the future? Why?
How do you think your life will be different one year from now?
Start asking about the immediate future and then probe into the longer-term future:
What is now head of you next? Prompt: What are the most important things that will happen next week, this month, next month? And what about further into the future? If you have to imagine your life a year from one, what will it be?
What are your concerns about the future?
What in your life needs to change for you to be better off, do you think? (*impersonal construction)* What in your life do you need to change to be better off, do you think? *(personal construction)* What can other people and organizations do to help achieve this?

Well-Being and Personal Recovery

What does '*being well'* mean to you?
Have you ever heard of the term 'recovery' before? If yes, when?
What does recovery mean to you, if anything?
Would you say you are in recovery now? Have you been in recovery before? If yes, tell me a bit more about what happened.
How do you feel about being/not being in recovery? Does that affect how you see yourself?

Would you like to recovery/be in recovery? How would your life be different if you were?
(If in recovery) Thinking back, can you pinpoint any time or event that started your recovery? What happened? How easy/difficult was it? What led to this point? What made it easy/difficult? Why did you want to recovery (stop using drugs, etc.)? How has your life changed since then? How long was it since you last had a poor episode of mental health/used drugs?
Would you do anything different if you could go back?
How easy is it to keep feeling well/stay in recovery nowadays?

Reflections on structural conditions of existence:

How do you think poverty has impact your life? What led to poverty in your life?
Has the housing you have been in been good for your needs?
What have your experiences been with service-providers, such as this one?
What have your experiences been with doctors, nurses, medical staff, emergency services, if you have had any?
Have you ever spent time at the hospital? I know it is very personal but will you be willing to share what your experience was?

What have your experiences been with service-providers, such as this one?
What do you like and don't like about this particular service?

When you are in the public, how do you think other people see you? Can you tell me a very positive and a negative encounter with a stranger out in the public? What happened? Did this affect you personally?
Tell me one particular occasion when you were treated unfairly?
Tell me one particular occasion when someone did something good for you?

Have you had any close encounters with the police? How did they treat you?

Closing questions:
What advice would you give to someone else in your situation?
What are some of the most important lessons that you have learned in your life so far?
What, if anything, are you looking forward to in the future?

Appendix 6: Elicitation Interview Questions

Post-Diary Feedback: Participant situated reflexivity (methodological reflections; Riach, 2009):

Can you tell me about your experiences of completing the mobile phone diary?
Which part did you enjoy the most and which-the least?
Did you encounter any difficulties?
Was the mobile phone diary helpful for communicating different aspects of your life?

What made you decide when to make a diary entry and when not to?

Questions about 'non-data' (Palen & Salzman, 2002; Hodgetts et al., 2007):

Do you ever wish you had made diary entries which you didn't make? What would they look like?
Is there a photograph that you wish you had taken but you never did? Why?

Photo elicitation questions (Hussey, 2001, as cited by Horwitz, 2012; Andonian & MacRae, 2011):

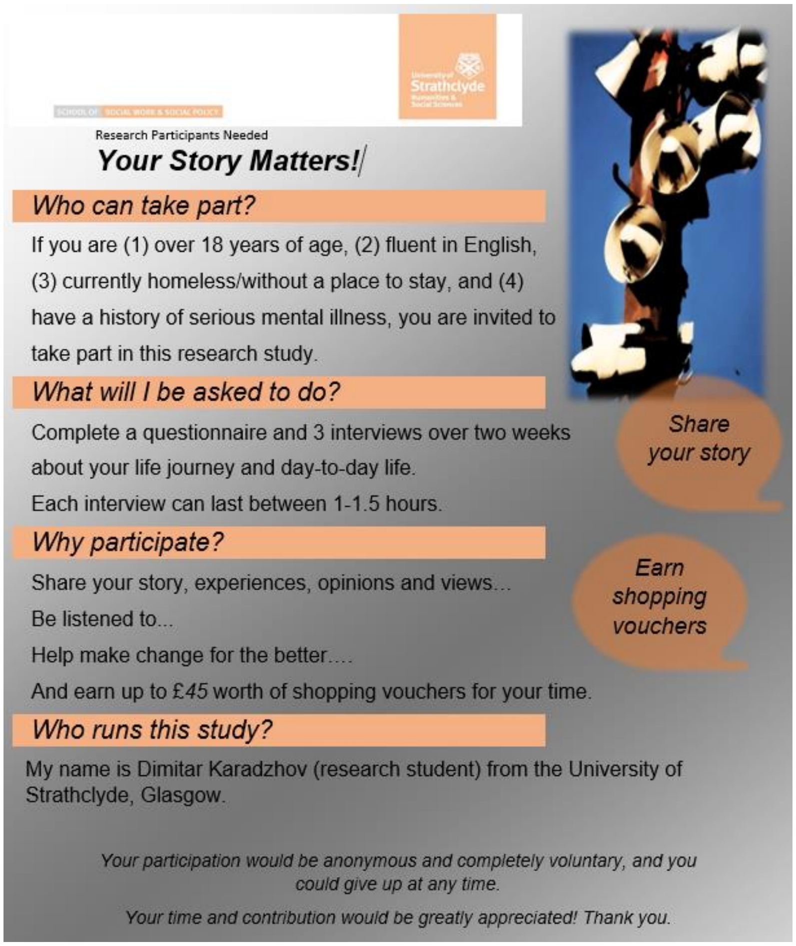
Describe Your Picture;
What is Happening in your picture?;
Why did you take a picture Of this?;
What does this picture Tell us about your life?;
How can this picture provide Opportunities to improve your life?

Do you remember what you were thinking or doing when taking this image?
What does this photo mean to you?
How does this photo relate to your recovery (if applicable)?
Anything else you would like to add…?

Appendix 7: List of Transcription Symbols Used

Symbol	Usage
(…)	Pause of more than .5 second (unless precisely timed)
=	Overlap
[ ]	Show where speech overlaps
( )	Unclear word
(did)	Guess at unclear word
[clears throat]	Non-lexical phenomena, vocal or non-vocal, which interrupts the lexical stretch
Underlining	Emphasis
CAPITALS	Word said loudly or shouted
(( ))	Contextual information where no symbol of representation was available; author’s descriptions
(h)	Laughter, denoting humour
:::	Elongated speech, a stretched sound
↑	Rise in intonation
↓	Drop in intonation
> <	Show where speech has quickened
< >	Show where speech has slowed down
I:	Interviewer
P:	Participant
.hhhh (…)	An inbreath
hhhh (…)	An outbreath
/	Unfinished sentence
worri/ concerned	Word doubling, discontinuation
uh-huh, mhm, yeah, um	Affirmative noises

Appendix 8: Study Leaflet



SCHOOL OF SOCIAL WORK & SOCIAL POLICY

University of Strathclyde
Humanities & Social Sciences

Research Participants Needed

Your Story Matters!

Who can take part?

If you are (1) over 18 years of age, (2) fluent in English, (3) currently homeless/without a place to stay, and (4) have a history of serious mental illness, you are invited to take part in this research study.

What will I be asked to do?

Complete a questionnaire and 3 interviews over two weeks about your life journey and day-to-day life.

Each interview can last between 1-1.5 hours.

Why participate?

Share your story, experiences, opinions and views…

Be listened to…

Help make change for the better….

And earn up to *£45* worth of shopping vouchers for your time.

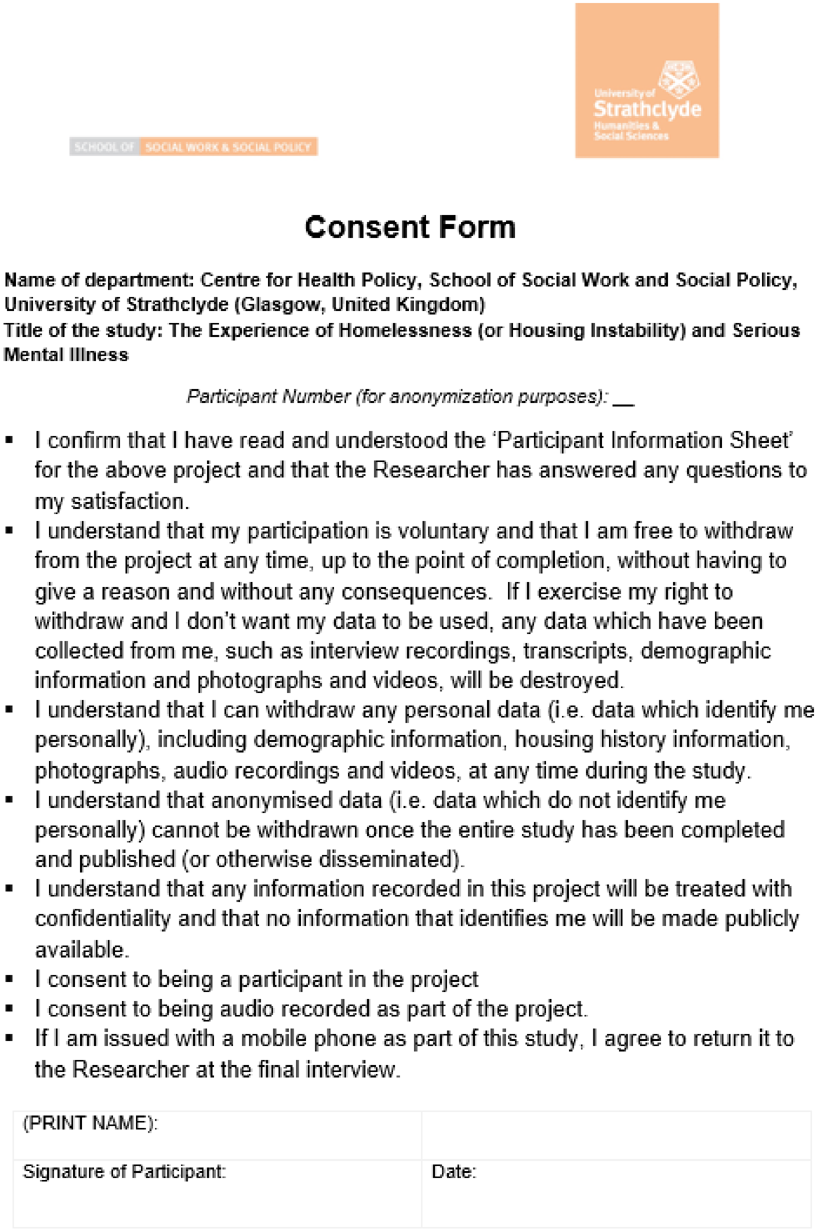
Who runs this study?

My name is Dimitar Karadzhov (research student) from the University of Strathclyde, Glasgow.

Your participation would be anonymous and completely voluntary, and you could give up at any time.

Your time and contribution would be greatly appreciated! Thank you.

Appendix 9: Consent Form



SCHOOL OF SOCIAL WORK & SOCIAL POLICY

University of Strathclyde
Humanities & Social Sciences

Consent Form

Name of department: Centre for Health Policy, School of Social Work and Social Policy, University of Strathclyde (Glasgow, United Kingdom)
Title of the study: The Experience of Homelessness (or Housing Instability) and Serious Mental Illness

Participant Number (for anonymization purposes): __

- I confirm that I have read and understood the 'Participant Information Sheet' for the above project and that the Researcher has answered any questions to my satisfaction.
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time, up to the point of completion, without having to give a reason and without any consequences. If I exercise my right to withdraw and I don't want my data to be used, any data which have been collected from me, such as interview recordings, transcripts, demographic information and photographs and videos, will be destroyed.
- I understand that I can withdraw any personal data (i.e. data which identify me personally), including demographic information, housing history information, photographs, audio recordings and videos, at any time during the study.
- I understand that anonymised data (i.e. data which do not identify me personally) cannot be withdrawn once the entire study has been completed and published (or otherwise disseminated).
- I understand that any information recorded in this project will be treated with confidentiality and that no information that identifies me will be made publicly available.
- I consent to being a participant in the project
- I consent to being audio recorded as part of the project.
- If I am issued with a mobile phone as part of this study, I agree to return it to the Researcher at the final interview.

(PRINT NAME):	
Signature of Participant:	Date:

Appendix 10: Participant Information Sheet

Participant Information Sheet

Name of department: Centre for Health Policy, School of Social Work and Social Policy, University of Strathclyde (Glasgow, United Kingdom)
Title of the study: **The Experience of Homelessness (or Housing Instability) and Serious Mental Illness**

Participant Number (for anonymization purposes): __

About the Researcher: Dimitar Karadzhov, is a Doctoral student based at the University of Strathclyde, Glasgow, United Kingdom, and completing this research as his dissertation (thesis). Dimitar can be contacted at Dimitar.Karadzhov@strath.ac.uk.

What is the purpose of this investigation?
This study aims to learn more about the experience of individuals who are homeless/without a place to stay and who also have a history of a diagnosis of serious mental illness and/or substance use problems. The study aims to understand their life journey so far, their day-to-day life, hopes, struggles and sources of strength.

This study is independent from the organisation/service provider you are a client of. Your participation in this study will not affect the services you receive.

Do you have to take part?
Participation in this study is voluntary. You may refuse to answer any question and/or withdraw participation at any time without penalty and without explanation. If you wish to discontinue participation, all information held about you will be permanently destroyed.

What will you do in the project?
You will be asked to take part in two back-to-back interviews over two days,

followed by a one-week period in which you will be asked to take notes about your day-to-day life in the form of a diary with text and photographs (using a mobile phone or a notepad). At the end, you will be invited to a third and final interview to talk about what you have written in your diary. You will also be asked to complete a brief demographic and residential history questionnaire.

Each interview will take 1h-1h 30 min. At the end of each interview, you will be offered a $20 shopping voucher as a compensation for your time.

You may drop out of the study after any stage, as you wish.

What are the potential risks to you in taking part?

During the interviews, you might experience discomfort and/or distress when talking about your personal experiences. You may decide which questions to answer and which not, and this will not affect your participation or the rewards that you will receive for your time. The Researcher will treat any information you share sensitively and confidentially. The Research might share some of the information you provide only if the Researcher becomes concerned about an imminent risk to your personal safety or the imminent risk to the safety of others.

Potential problems could arise when you decide to photograph other people’s faces without their explicit permission. It is vital that you prioritise your own safety and well-being when you take photographs and send messages to the Researcher. You should only do so if you consider if it safe and convenient.

What happens to the information in the project?

All information that you share with the Researcher (including photographs, audio and video recordings) will be anonymised by using pseudonyms (fake names) and participant numbers to protect your identity and that of any other people or organisations you mention.

All information will be stored in password-protected computer and treated with confidentiality. All your personal data will be safely destroyed by March 2020, when the Researcher’s degree programme finishes. The Researcher intends to summarise the findings from this study in a research report, which the Researcher will aim to publish in academic journals. The Researcher also intends to hold learning events towards the end of the research period. In these publications and at the events, the Researcher may display photographs /quote directly from interviews but those quotes and/or photographs will be anonymous.

Thank you for reading this information – please ask Dimitar any questions if you are unsure about what is written here.

SCHOOL OF SOCIAL WORK & SOCIAL POLICY

University of Strathclyde
Humanities & Social Sciences

Researcher Contact Information:

Researcher contact details:
Dimitar Karadzhov (PhD Student/Visiting Scholar at New York University)

Dimitar.Karadzhov@strath.ac.uk / Dimitar.Karadzhov@nyu.edu.

McSilver Institute 41 East 11th Street, 7th Floor, New York, NY 10003.

Chief Investigator details:
Dr Beth Weaver

Department: School of Social Work and Social Policy. Centre for Youth and Criminal Justice. Humanities and Social Sciences.
Telephone: 01414448657
E-mail: beth.weaver@strath.ac.uk

This investigation is funded by the University of Strathclyde, Glasgow, United Kingdom.

This investigation was granted ethical approval by the University of Strathclyde Ethics Committee.

If you have any questions/concerns, during or after the investigation, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Prof. Victoria Stanhope

Silver School of Social Work
1 Washington Square North
New York, NY 10003

Telephone: (212) 998-5942
Email: victoria.stanhope@nyu.edu

Appendix 11: Release of Materials Consent Form

SCHOOL OF SOCIAL WORK & SOCIAL POLICY

University of Strathclyde
Humanities & Social Sciences

Release of Materials Consent Form & Copyright License

Study title: The Experience of Homelessness (or Housing Instability), Serious Mental Illness and/or Substance Use Problems

(Participant Number (for anonymization purposes): ___)

Instructions: Please read the statements below and mark them as you consider appropriate. Your decisions will not affect your participation in this study.

I,____________________________(please write your name in CAPITALS) ('Participant'), give the Researcher (Dimitar Karadzhov) permission (licence) to use all or part of the research project materials (interview recordings, quotes, photographs and/or recordings/videos) in the following ways (please **initial)**:

____During future project activities, at academic conferences, research publications or at workshops taught by the project Researcher. Comments or exceptions:

____At community events such as exhibitions intended to discuss and raise awareness about homelessness, poverty and mental health. Comments or exceptions:

____On other strategic communications such as social networking (such as Twitter), media forums and blogs. Comments of exceptions:

I understand that I retain my copyright and related rights in any research project materials I create (for example photographs I take). I am giving the Researcher a licence to reuse my materials without any time limit and that he can use them in other countries as well as the USA. I retain the right to also licence my materials to others if I choose. The researcher can use and reuse my project materials as the research requires including for publication. I understand that the researcher may edit or adapt the materials I create. I understand that I will be entitled to keep a physical copy of any materials that I create.

I understand that my identity will be kept confidential and unless I request otherwise, my name will not be directly attached to any materials I create when they are reused as above. I understand that my personal data will be kept securely and processed in line with the relevant legislation in the USA and the UK.

By entering into this voluntary agreement, the undersigned Participant releases and forever holds harmless the project Researcher from any and all claims, demands, damages, losses, obligations, rights and causes of action, whether known or unknown, relating in any way to this activity. The Participant acknowledges that her/his participation in the project was entirely voluntary. This Release is effective as of (‘date specified’).

Participant Signature:
Date:

Appendix 12: Privacy Notice

Privacy Notice for Participants in Research Projects

Introduction

The University of Strathclyde is committed to transparency and to complying with its responsibilities under data protection legislation. This privacy notice sets out important information regarding how we use your information and your rights under the legislation. This privacy notice relates to individuals participating in research projects conducted by researchers at the University of Strathclyde. Please note that this standard information should be considered alongside information provided by the researcher for each project, which is usually in the form of a participant information sheet, has been tailored to suit the particular project and is usually given to participants before they decide whether or not they want to participate in the research. The participant information sheet will include further details about how personal information is processed in the particular project; this will typically include information about what data is being processed, how it is being stored, how long it will be retained for, and any other recipients of the personal information.

Data controller and the data protection officer

The University of Strathclyde is the data controller under data protection legislation. This means that the University is responsible for how it uses and processes your personal data and for complying with requests from you in relation to your personal data, where appropriate under the legislation.

Any enquiries regarding data protection should be made to the University's Data Protection Officer at dataprotection@strath.ac.uk.

Legal basis for processing your personal information

If you are participating in a research project, we may collect your personal information. The type of information that we collect will vary depending on the project. Our basis for collecting this information is outlined below:

Type of information	Basis for processing
Personal information and associated research data collected for the purposes of conducting research (including the special category data-race/ethnicity)	It is necessary for the performance of a task carried out in the public interest.

Details of transfers to third countries and safeguards

For some projects, personal information may be processed outside the EU, this will only be done when research is taking place in locations outside the EU, or in some cases if personal information is published on a website. If this happens, the University will ensure that appropriate safeguards are in place, and you will be fully informed about the details of recipients of the data by the researcher, usually in the participant information sheet.

Data subject rights

For the majority of research projects, you have the right to access your personal data held by the University; you have the right to have your data erased; you are entitled to have personal data rectified if it is inaccurate or incomplete; and you can restrict the processing of your personal information. To exercise these rights please contact dataprotection@strath.ac.uk.

In some research projects, the researchers may decide that it is not possible to provide these rights

because doing so would prevent or seriously impair the achievement of the research purpose. If this is the case for the research project you are participating in, it will be explained clearly by the researcher, usually in the participant information sheet.
Right to complain to supervisory authority
You have the right to lodge a complaint against the University regarding data protection issues with the Information Commissioner’s Office (https://ico.org.uk/concerns/). If you have any concerns/issues with the way the University has processed your personal data, you can contact the Data Protection Officer at dataprotection@strath.ac.uk. You also have the right to lodge a complaint against the University regarding data protection issues with the Information Commissioner’s Office (https://ico.org.uk/concerns/).