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Health perceptions of adults living in a transitional housing setting

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Introduction

Many nursing schools have moved from a *community-based nursing education* and towards a *community health nursing education*. Though both sound closely similar, the Association of Community Health Nursing Educators, summarized by Cohen & Gregory, defines *community-based nursing education* as nursing care in a non-institutionalized setting, focused on acute, rehabilitative, or chronic conditions at the individual level. The same source defines *community health nursing education* as health promotion and illness/injury prevention at the population level (as cited in Pijl-Zieber & Kalischuk, 2011). With this refocus, along with the global shortage of traditional clinical placements and faculty, there has been a shift to having more non-traditional clinical placements in order to provide public health experience for nursing students (as cited in Pijl-Zieber & Kalishuk, 2011). As a part of their curriculum of health promotion, student nurses are engaged in a community health clinical setting. These sites include, but are not exclusive, to schools, homeless and houseless shelters, and other non-profit agencies.

One setting, in which nursing students may find themselves immersed, is transitional housing, also known as recovery housing, recovery residences, sober homes, sober living, sober living housing (SLH), and, as found most commonly in literature, “halfway homes.” This type of housing is broad and unregulated as each facility offers different services and requires its residents to meet different standards. What they share in common is that this sphere of the housing continuum encourages sobriety and engagement with social services before encouraging residents to move on and find permanent housing (Winn & Paquette, 2016). In the time that residents live in the setting, they are provided opportunities to build life skills and access needed

resources for success, however they personally define that as individuals, as building blocks on their road toward stability and a stable housing situation.

In their time in nursing school, student nurses are placed in community health settings as a part of their education. Here, health promotion is encouraged and interventions such as health education sessions are implemented. Student nurses have opportunities to engage in the community health nursing process and program planning through interacting and collaborating with a variety of diverse community members (Pjil-Zieber & Kalischuk, 2011).

Nursing students selected to work with individuals who live in a transitional, recovery housing setting in general have limited to no understanding of this population prior to interacting with the group. Yet, it is the role of student nurses during their clinical time with the group to prepare health promotion education plans for members of this community setting.

Background

Over a six-week clinical experience, along with volunteer events, occurring at the transitional housing site, the student researcher and her clinical partner immersed themselves in the community and and built rapport with its members. During the six-week clinical, students get to learn about the facility, do community assessments of the apparent needs, and are also tasked with putting on health education sessions. Rapport was built with weekly health education sessions. Students were immersed in the community, were assigned to assess the environment and the needs, and offered education through discussions based on the recommended topics by peers. They were offered advice from past students and from a leader in the administration on what to provide health education on, but exactly what and exactly how was never specified. Health-teaching discussions were implemented in an open, conversational style thought to be more beneficial due to its nature of breaking down invisible, existing hierarchical dynamics

between clients and providers in training. Verbal feedback was requested in the moments of the discussions, but only short validations or silent nods back were received, which made an assumption that there was positive reception. Assuming was not a valid way of moving forward, which sparked the need for further study.

Motivation for this paper was prompted by this knowledge deficiency and moreover, an interest in discovering what health is to persons living within this specific context. With this knowledge, it is anticipated that future healthcare and social service providers and providers-in-training can address health in a person-centered, context-informed manner when talking about health, especially when teaching it. This paper aims to explain the context of the study, detail the process, explain the findings, reflect on lessons learned, and make recommendations for future providers who plan to work with the population in different capacities.

Purpose

This study seeks to answer the following question: What does *health* mean from the perspectives of adults living in a transitional housing setting? In answering this question, it is assumed that health is a lived experience shaped by one's contextual experiences and temporally-bound. Through reflecting upon and/or accessing one's lived experiences of health, it is possible to identify and articulate opportunities and/or ideals, specific to one's health, for the future. As such, the specific aim of this study is to describe what the meaning of health is from the perspective of adults who are living in this setting. The following pages detail a review of the current evidence on the health of and perceptions of populations living in a transitional housing setting; health promotion methods in nursing education; and a description and interpretation of the results of this study will set the stage for a concluding discussion on how best to implement effective health promotion education within this population.

Review of Evidence

The literature review was completed by doing an initial Internet search on public databases and then a broad search on a university database.

Search Strategy

This first search for what existed included a Google search of "health perceptions in transitional housing academic literature." With keywords "health", "perception*," "transition*," "housing." After this initial Google search, with the assistance of experts in literature searches, a University database search was conducted. This search session started on CINAHL. Under the category "CINAHL Subject Headings," the population of interest "transitional housing" most matched the mesh heading "Halfway Houses", described by the scope: "Specialized residences for intellectually disabled individuals, or for psychiatric, drug or alcohol rehabilitation patients, who no longer need hospitalization or institutionalization but who are not yet fully prepared to return to their communities." With the Boolean "MH Halfway Houses," the expander of including related articles, and the limiters of English language, peer-reviewed research articles between the years 2010 to 2019, 32 articles were returned between 2010 and 2017. The next database visited was MEDLINE. Under the category "MeSH 2018," the population of interest "transitional housing" most matched the mesh heading "Halfway Houses," described by the scope: "Specialized residences for persons who do not require full hospitalization, and are not well enough to function completely within the community without professional supervision, protection and support." With the Boolean "MH Halfway Houses," the expander of including related articles, and the limiters of English language and between the years 2010 to 2019, 41 articles were returned between 2010 and 2018. The last database visited was SOCIndex. Under the category "Subject Terms," the population of interest "transitional housing" most matched the

category “SOBER living environments,” described by the scope note: “Here are entered works on transitional group housing intended for recovering substance abuse addicts.” With the Boolean “DE SOBER living environments,” the expander of including related articles, and limiter of peer-reviewed, 9 articles returned between 2014 and 2018.

To narrow the scope, articles were filtered out of the scope of this project by first assessing the titles to see if they were relevant to the population, and then abstracts were assessed for relevance. Through reading articles, different terms in the literature appeared, prompting continued review. A search was rerun with mesh headings for “recovery housing” and “halfway houses (CINAHL, Medline). When rerun in CINAHL Subject Headings for “community living” (defined as “living in the community as opposed to living in a facility”) and subheading of “sober” with limiters of peer-reviewed, English language, and between the years 2009 and 2019, one article returned. When rerun with Medline MeSH 2018 for “community living” AND “community integration” (defined as “policies and programs which ensure that displaced persons and chronic illnesses receive the support and social services needed to live in their communities”) AND subheading of “sober” with limiters of English language and between the years 2007-2016, the search returned two articles. When rerun SOCIndex headings “psychology” OR “awareness” OR “self-perception” OR “social perception” OR “worldview” OR “attitude” AND “health” AND “sober” with limiters of peer-reviewed and between the years 2009-2019, eight articles were returned. Articles that were focused on women’s health, parenting, and focused on formerly-incarcerated populations were omitted, as the population of study consisted of those who identified as male and from various backgrounds.

Overview of Evidence

In total, this review included 15 articles. Findings from this review overall reveal that the state of the science on this topic of interest remains in need of development. This exploration found there exists knowledge on the relationship between substance use disorder and houselessness and how society responds to it; health expectations and needs for this specific populations; the role of stigma and stakeholders in health outcomes of this population; and health promotion and nursing student involvement in community settings. Before reviewing the relevant science, it is first important to discuss the challenges in accessing it.

Barriers to Finding Evidence on Experiences of Addiction Disorders & Houselessness

The primary barrier in gathering an evidence base specific to the research topic herein were the numerous and misleading generalizations that have been attributed in previous writings to persons experiencing addiction issues and/or houselessness. Upon systematic literature review, caution is necessary when critiquing the quality and reliability of the prior knowledge produced specific to people experiencing houselessness and substance use disorders (Polcin, 2016).

When conducting a literature review, it was also difficult to find a cohesive definition for "transitional housing," the term used for this study. Though the nature of these housing programs share fundamental regard for facilitating support, housing, and sobriety during a time of transition, each program is unique and exists by many names, including "sober housing," "sober living homes," "halfway houses," "recovery housing," and "recovery residence" (Winn & Paquette, 2016). In databased literature, the term "halfway house" best fit the goals of the target facility, while the term "recovery residence" not only defined the facility goals, but was also inclusive and reflective of the goals of the target population. Recovery residences (RRs), also known as SLHs, are sober, safe, and healthy living environments that promote recovery from

substance use disorder and their associated problems (The Society of Community Research and Action, 2013). These facilities are key factors in long-term improvement for individuals and have a positive impact on the community as a whole, through service and collaboration.

Intersection of Substance Use Disorder, Houselessness and/or Supported Housing Programs

Since the 1980s, high mortgage interest rates drew people out of homeownership and into rental housing **(**Joint Center for Housing Studies of Harvard University**,** 2018**)**. However, rent also remained high, and inversely, the number of low-cost rentals declined, driving lower-income households to spend outside of their allocation of household income to housing, of which U.S. public policy states that exceeding 30 percent of income to be an indication of housing affordability problem (Linneman & Megbolugbe, 1992). As of January 2017, there was a national estimate of 553,742 people experiencing homelessness or houselessness, with 360,867 of people living in a shelter or transitional housing (National Alliance to End Homelessness, 2017). As stated by the U.S. Substance Abuse and Mental Health Services Administration, several factors lead to homelessness, such as the availability of affordable housing, poverty, personal history of trauma or violence, personal characteristics, and mental and/or substance use disorders (SAMHSA, 2019). It is a stereotype in society that the homeless population is comprised of alcoholics or drug abusers, rather than seeing substance addiction as an illness that needs support to overcome (National Coalition for the Homeless, 2009). Substance use disorder and homelessness do not have an established order, of one condition necessarily precipitating the other. People who are experiencing houselessness with co-occurring mental illness or substance use disorder is a population hard to reach and is vulnerable to poorer health outcomes, especially with a part of this population not having health insurance (Shinn et al. 2001; National Coalition

for the Homeless, 2009). The supported housing programs offer social services, access to mental and physical health care, and peer support (National Coalition for the Homeless, 2009). For those who are able to enter housing that uses this linear approach, which requires abstinence from substances, sobriety is a goal and permanent stable housing is the end goal (Kertesz *et al.*, 2009; Ridgway & Zipple, 1990; Polcin, 2016). If unable to find permanent housing, these residents are vulnerable to relapse and reoccurrence of houselessness (Kertesz, *et al.*, 2009).

Societal Stigma

One of the biggest perceived barriers for support of SLHs is the social stigma of drug and alcohol problems (Polcin, Henderson, Trocki, Evens, & Wittman, 2012). One factor in this is professionals' and stakeholders' misunderstandings or misperceptions of the situations of residents of RRs and the benefits they already bring and can continue to bring with continued support. In Oregon and in other states, there is a Homeless Youth Continuum, but there is a call for recovery efforts to have its own space within the sphere of service continuum (Multnomah County, 2019).

Stakeholders & Current Recommendations from the Literature

There is a need for support from legislators and local stakeholders, like universities that place their students in the community settings. From past studies, positive outcomes are predicted best by the support individuals receive in recovery-oriented communities (Winn & Paquette, 2016). It's a fact that nursing schools are placing their students more and more in non-traditional clinical sites, which is probably not the vision a lot of nursing students had when entering school. This is occurring because of the global shortage of traditional placements and a global shift from *community-based nursing education* which focuses on acute care at the individual level to *community health nursing education* which focuses on the prevention and

promotion at the population level. It is acknowledged in academic literature that students may not see the value of non-traditional placements, as the practice is less hands-on and focused on more abstract and broad application of population health concepts. This includes process-oriented, population-centered health promotion and program planning, collaboration with community members in developing relationships, addressing the social determinants of health, enactment of the principles of primary health care, development of leadership skills and cultural humility and sensibility, and facilitation of group synergy and process (Pjil-Zieber & Kalischuk, 2011). These skills and concepts can be implemented into a non-traditional clinical placement experience, but there is no standard to how a student will experience them, as each population and the support and leadership onsite differ with each placement.

The Society of Community Research and Action and the National Association of Recovery Residences (2013) have cited that research scientists wishing to study recovery residences face considerable funding challenges given that funding efforts towards the neuroscience of substance use disorder take precedence. Residence facilities' regulations differ with each state and local governments (Jason, Mericle, Polcin, & White, 2013). They all have their own unique missions and visions, which allow them room to do the work they want to do, but it also makes it harder for communication and collaboration among the facilities, which means that partnerships with stakeholders, like schools of nursing with their partners, can carry significant impact.

A small, but growing, body of literature exists showing the significance of these residential facilities in recovery outcomes within the community health continuum. As such, there is empirical data available showing the numbers of sober and housed outcomes of individuals who lived in these settings. However, a gap remains in the literature with regard to

understanding what health actually means from the perspective of persons who are in these transitional housing and recovery circumstances and in what education is desired by them given their lived experience of health. This gap is significant because, ultimately, health takes precedence—after all, what is humanity without health?

Study Design

A qualitative descriptive methodology was chosen in order to allow room for interpretation. The basic ontological assumption relevant to this methodology is that human beings interpret and co-construct knowledge and shared meanings that are shaped by their individual subjectivities and historical and current contextual experiences. Epistemologically, knowledge can only be obtained via processes of human interaction. This means that the researcher and/or members of the research team are primary human instruments necessary in data collection, analytic, and interpretive processes of this research.

Setting, Participants, & Recruitment Process

The participants were residents of a transitional sober-living housing facility in the Pacific Northwest known to accommodate vulnerable populations including adults who are socioeconomically disadvantaged, underinsured, and/or those with certain chronic medical conditions. Adults 18 years of age or older were sought for recruitment via a convenience and purposive sampling method. The case manager of the building served as a key informant and provided permission to conduct the study. The study was also approved via the University of Portland's Institutional Review Board.

Qualitative Survey

A survey of 6 questions was created by the author. The survey questions, grounded in the literature, offered participants the opportunity to respond to open-ended questions about their perceptions of health. Some examples of questions included:

- Please describe your ideal of health. How did you come to think about health this way? (e.g. *How were you taught about health or what is healthy?)*
- Describe a time when you felt most healthy. Describe the things that were going on in your life that made you feel that way?
- Explain the ways that your environment impacts your health? (e.g. *What's helpful or harmful? How so? What opportunities or barriers exist to making changing in your environment to optimize your health?)*

Upon permission of the residence's case manager, the printed copy of the survey, as well as a link to an online version of it, was slipped under residents' unit doors. Notification flyers about the study were posted thereafter in high-traffic hallways in the residential building.

Ethical Considerations

Participation in the study was made clear to be 100% voluntary. To ensure against the possibility of coercion or obligatory participation, prospective participants were informed that participation and non-participation would not influence the professional relationship between student and community member, nor their residential status. A small monetary incentive was of a $5 Rite Aid gift card was offered to each participant who completed the survey, as a token of appreciation for their time. Data collection was fully anonymous. The case manager of the residence collected the surveys in sealed envelopes in exchange for the incentive. The case manager returned the envelopes to the student researcher via U.S. post mail.

Results & Analysis

Demographics

There was a sample size of nine, with one outlier set of answers that had responses of one letter for the fill-in questions on the online survey, so eight were truly analyzed. All were living in the same transitional housing site, a majority identified as male, all were from the U.S. Five

were from the west coast, two from the east coast, and one from the Midwest. They all indicated English as their native language.

The results showed that residents were at different phases in their understanding of health, with some perceiving health as only healthy diet and exercise, others reflecting that they saw it more holistically, with themselves in the center. Another depicted it as a sense of despair when talking about health at all. Given the varying backgrounds of the residents and answers, to adults living in a transitional housing setting, health *is* security. Knowing that they have the tools to remain safe and sober offers this sense of security, those tools include social support teams, healthcare teams, access to physical activity, and having options for healthy food. With the data overall, four main themes were interpreted using the analysis techniques of Colaizzi's existential phenomenological method and Hsieh's conventional content analysis.

Perception of health as a balance

Participants described that health is an accessible holistic balance, consistent with one's life plans and those that the transitional housing programs encourage. Self-discernment and the ability to access health services, specifically mental health, were elemental in successful health management to this population. Diet and mental wellness were equally mentioned strongly.

Models of health as their old self & modes to health as supported sobriety

When asked about models and modes of health, people commonly referred to their past selves or someone who has accomplished physical feats, i.e. iron man marathons, living to 100+ years, and superheroes. Sobriety and social support, specifically a partner and family, were explicitly mentioned as elements in healthy times.

Polar environment perceptions: mutual struggle vs. self-sustained standards

Each person came from different histories before being in the shared space in which they were living together. The way that people saw others in their environment was partisan—some found that being around others who struggle mutually helped with resiliency, while some found that being around others living with unhealthy behaviors, such as nicotine dependence and living on the streets, pushed them away, despite the possibility of a shared story.

Life as a health teacher and a call to upgrade the teaching game

Most people learned about health not through classes or health visits, but through scheduled programing and experiences. There was an interest in different methods and phases of learning about health: focused classes, itemized pamphlets, group discussion, and individual reflection. It seemed that self-study was desired, but the overlying theme is that they wanted structured, informative information provided directly.

Discussion & Recommendations

From the survey responses returned and the themes interpreted, the answer to the question "What is heath from the perspectives of adults living in a transitional housing setting?" is that health is having a sense of security.

Participants found access and crisis plans were important to them to be healthy. Their answers demonstrated resiliency and a high standard they are setting up for themselves to reach their goals. Relationships and the social environment regarding recovery were especially important to them feeling like they could reach their health goals. There is stigma around substance use disorder, houselessness, and mental health. And it was definitely felt within this population. When asked "What impacts your health?" One participant replied, "societal acceptance of substances and lack of public awareness…and knowledge about mental care

resources." What people wanted to learn most about health was specific to coping and maintenance and they wanted to learn in ways that were hands on and classroom group settings, rather than the open discussion based setting that had been offered.

Today, the U.S. is in an opioid crisis, and there is a call for public awareness of substance use disorder and their causes, which includes lack of education of their dependent effects (U.S. Department of Health and Human Services, 2019). Today, the U.S. is also facing a shortage of affordable housing. According to the National Low Income Housing Coalition in their 2018 review, for every 100 low-income renters needing housing the U.S., there are only 35 affordable housing options available. Knowledge of these existing social issues along with nonjudgmental, proactive conversation can make for a better social environment and reduce felt stigma around housing issues and substance use disorder. It is imperative that health and human care providers and providers-in-training remember that they can change the culture of a place through their interactions. Milieu can change and morph. It is maintained by policy and history, and it is people of today that change the history. It is important to check one's own thoughts and feelings whenever working with a certain population. Being self-aware is necessary to recognize attitudes and behaviors that are adding to the stigma or efforts that are working to fight against and rise above it. Those who live in recovery are the experts on what they need to be healthy, and so figuring out the best way to get a population what they need to be healthy is key. In this case, verbal inquiry in front of the whole class group did not give a full sense of what they needed from the health sessions, but allowing them to write freely, on their own time and anonymously invited more responses. Thus, it is recommended that providers find tailored ways that to give their clients a voice to advocate for themselves.

The participants in this study indicated that mental health was just as important as

physical health. This is a noteworthy shift in expressions of health today, especially given current media messaging and the stigmatization present within US society, with adults with drug dependence being one of the two most consistently stigmatized of groups (Parcesepe & Cabassa, 2013). Another interesting finding of this study, was that there were scant responses regarding spiritual health. This is also noteworthy, as spiritual well-being is considered to be the fourth dimension of health and addressing this aspect of health in health promotion activities may be a beneficial aspect to the wellness of this population (Koenig, 2012).

Finally, it may benefit this population to learn about social determinants of health. To be able to discuss privilege and to have a sense of their position within society's sphere of privilege could offer clarity, inspire change, and potentiate emancipation, voice, visibility, and ultimately self-produced, positive, health outcomes..

Recommendations

Conversations with populations, given all their mixed pasts and varied presents, asking what they want to learn and what they think about health can be best approached using cultural humility. Cultural humility is a lifelong commitment to self-reflection to respond to existing power imbalances so that all parties can develop mutually beneficial and advocacy partnerships with communities on behalf of individuals and populations (Tervalon & Murray-Garcia, 1998). Culture lives in a place with its people—it does not have to cross oceans or borders, it is globally applicable. The main takeaway from trying to identify commonalities amongst persons living in a single transitional housing setting is that the residents in these facilities want to maintain their health and that they are all in recovery and at their own stages. To generalize beyond this would be to wrongly assume. All participants had various goals in life, as evidenced by their survey responses. From business owner to returning to school to more; each response was a person, a

human being, with a dream.

Limitations

The number of participants was very limited, and the study was conducted in only one transitional housing setting. Comparative studies with larger samples from similar settings in different locations that offer similar resources should be done before these themes can be generalized to populations that live in transitional housing settings, focused primarily in sober-living housing that help individuals transition from being houseless to being housed. The surveys were completed on paper or electronically, and recruitment strategies were passive. Open-ended surveys, when compared to in-person interviews, do not offer the opportunity for follow-up questions and instant member checking in the form of read-back. In addition, the principle investigator was a student who had completed a clinical rotation in the setting, which may have given the impression that responses could affect their relationship or status with residency within the setting. Another significant limitation is that the handwritten surveys were given to the setting's case manager to be passed (via a sealed envelope) to the student researcher. As a result, the participants may have been worried about breach of confidentiality and related personal risks of such. The surveys were written in English, which may have posed barriers too for residents who could not read and/or whose first language was not English. Another limitation is that there was no collection of official testimonials from other nursing students in the setting, only comments heard and conversations had that led to the development of this study. The research time frame was limited, as the student researcher had a one-semester period to find, design, and implement the study. Due to the time limitation, an official member-check was not conducted. The main limitation to note is that this study is only a snapshot of the population at one point in

time, as the goal of these residences is to be a temporary spot for people to grow in their recovery journey.

Conclusion

Critical self-reflection is an important part of nursing role development. As such, it is a regular expectation of nursing students to engage in reflection throughout their journey through nursing school. Upon reflection of this research process, four main conclusions were revealed. (1) Nurses and other healthcare professionals can work collectively towards fixing societal power imbalances and the stigma associated with mental illness, including addiction. This starts by actively listening, being aware of body language, owning what is not known, knowing boundaries, and knowing when to ask for help. All parts of a system can aspire to create partnership, not only from the system's administrative level, but also at the individual level, building rapport and gaining key informants. Persons who are positioned at the margin by society's sphere of privilege are not "*those* people" and our narrative must stop being that social issues are "not *our* problem" because in any and all ways, people who work to benefit the lives of other people are human care providers.

(2) The messaging in the nursing profession around public health and community health nurses requires a cultural shift. It needs to be presented to nursing students as a valuable endeavor and one that is key to healthy populations. All student nurses need to know that they are studying to become public health nurses, because health starts in the home, it starts in the community. Without the collaboration of community members, community leaders, and teams of health care providers across the continuum of care, steps of health can be missed, which could send community members to the emergency department and perhaps to an unnecessarily shortened life. So, it makes sense financially as a system: more preventative care and education

will lead to less hospital admits. That is why the wellness resources and especially the education about wellness and health risks are crucial to provide as a system and as a community.

(3) Schools need to have and share a better understanding of what public health nurses do, which not only encapsulates policy changes, but also individual and family health education and promotive care. Illness care and supportive care, like acute settings, should remain a priority, but putting more emphasis and support into community health and preventative care would start a cultural shift in society from healthcare to *wellcare*, bringing healing to places where people live, work, and play.

And lastly, (4) Nursing schools should prepare graduates to have a clearer general understanding of primary care principles, roles, and psychomotor skills that community nurses can practice. Students are change agents and should be praised and pushed to take pride and privilege in their roles in global communities in a manner that allows room for collaboration, mutual growth, and health promotion.

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Table 1. Direct Quotes

Question Focus	Answers
1. Ideal of health & how you have come to think about health this way	• physical activity: "cross country days" • diet: "eating healthy" • home: "balanced diet", cultural influence on diet (i.e. rice) • mental health: "in check", "skills to handle hiccups" • spiritual: "question and search" • "not too much candy or smoking" • "feelings about myself" • "never taught about health"
2. Model of health & how you can achieve this/how you achieved this	• "a superhero" • "impossible" • "compare myself to my youth" • "working out 3x a week" • living a long time: "102 years old" • "no sweets" • "no opportunities", "no answer sorry" • physical feats: "Iron Man" • "dedication", "work", "financial support"
3. A time you felt most healthy	• "making good money", "working" • "woman at my side" , "finding my wife" • "socially involved and supported" • "drugs and alcohol were recreational & were socially acceptable and enlightening" • "sports", "training", "all star", "in shape" • "at [transitional housing site], sober & exercising" • "never"
4. How you address health concerns	• "emergeny-c, dietary supplements bought on food stamps" • "matters what level of concern" • "tough it out", "get some rest" • "ask my mom about everything" • "go to [community clinic]", "blood work" • "church for mental health" • "if there is a problem go to the doctor" • "safety plan", "friends and family", "groups", "therapist", "PCP" • "find the underlying motion"
5. How does your environment impact your health	• "being in a spot where you're surrounded by others struggling" • "societal acceptance of drugs, alcohol, and tobacco" • "access to low cost health care" • "lack of public knowledge/awareness of mental care

	resources” • “ease of existence” re: habits & addictions • “street people are dirty…like plague rats” • “[transitional site] has great food and gym…health is convenient, accessible, and entirely possible” • “smoker…I hate them they stink”, “I keep my distance” • “bad place to live or relationship is bad” • “without active job” • “indoors is helpful”
6. What do you want to learn about health & how do you best learn/how would you like to learn	• “self study” • “Canadian health care” • “my addiction in my past” • “meditation”, “nutrition” • “informative classroom environment” • “hands on” • “the past”, “handle on my sobriety” • “reading”, “verbal”, “I am down to learn” • “past and current health” • “PCP”, “factual/itemized pamphlet/journal” • “team and multi-support systems”, “organic influence” • “classes”, “group discussion”, “individual work” • “videos”, “alone instead of group classes”