

**“I have unsolvable problems”: An analysis of on-site mental health counselling in
Permanent Supportive Housing**

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Background, literature, and study population

It is estimated that 30-40% of people experiencing homelessness have a mental illness (Canadian Observatory on Homelessness, 2024). Even so, systemic barriers such as low income, substance use issues, lack of service availability, and exclusionary criteria can prevent adults experiencing homelessness from accessing mental health services (Kerman, Gran-Ruaz et al., 2019). Further, the impact of homelessness on mental health is undeniable. The Mental Health Commission of Canada's (2012) *Mental Health Strategy for Canada* states, "Specific initiatives are needed to assist those who are already homeless" (p. 72). Due to the complexities of the homeless experience, such as a history of loss and trauma (Liu et al., 2020; Padgett et al., 2012), increased likelihood of substance use (Canadian Observatory on Homelessness, 2019), and extensive co-occurring challenges such as traumatic brain injury and fetal alcohol syndrome (American Psychological Association [APA], 2009), providing mental health support to adults who are experiencing homelessness is a complicated task.

Housing is one of the cornerstones of mental health recovery (Homeless Hub, 2025). The focus on survival required of homelessness shifts to one of personal health and wellbeing after stable housing is enacted (Kirst et al., 2014; Piat et al., 2015). Still, housing alone does not necessarily improve the mental health of formerly homeless adults (Aubry et al., 2015; Goering et al., 2014; Padgett et al., 2016; Sylvestre et al., 2018), as "providing housing without addressing the psychosocial factors that influence homelessness is insufficient to remediate the problem" (APA, 2009, p. 29). Integrated service delivery, including those of housing support and mental health intervention, is crucial to address the complex needs of homeless adults (Abdel-Baki et al., 2019; Brown et al., 2018; Polcin, 2016; Ponka et al., 2020; Young et al., 2014). Further, to facilitate access, mental health support delivery must be substance-use accepting

(Kerman, Gran-Ruaz, et al., 2019; Polcin, 2016), consumer choice-based (Aubry et al., 2015; Carver et al., 2020), trauma-informed (Milaney et al., 2020), non-judgmental and compassionate (Carver et al., 2020; O’Carroll, 2019; Kerman, Gran-Ruaz et al., 2019).

Even with this understanding of the need and complexities for mental health support for homeless adults, little research has been done to determine what factors contribute to effective mental health treatment for individuals experiencing homelessness or as they transition into housing (Carver et al., 2020; O’Carroll, 2019; Kerman, Gran-Ruaz et al., 2019).

Context

On-site counselling in Canadian Mental Health Association (CMHA) Kelowna Permanent Supportive Housing (PSH) sites provides clinical counselling and case management supports to residents. As explored above, community-based services can be difficult for PSH residents to access due to personal health and ability limitations, transportation challenges, systemic barriers, discrimination, and/or previous histories of negative service provider interactions. On-site counselling is designed as a flexible, accessible, client-centered service that is integrated within existing PSH supports. Counselling uses a flexible appointment and/or walk-in model depending on needs in the specific PSH site. Counsellors and clinicians in PSH sites have adopted the following philosophies of care in supporting PSH clients: Housing First (Homeless Hub, 2025), harm-reduction, client-centered care, recovery orientation, trauma-informed practice, and intersectionality.

Counselling at PSH sites largely avoids typically cited external barriers such as inability to pay, discrimination against substance users, physical distance, wait-times, rules of service (O’Carroll, 2019), and lack of accessibility or eligibility (Kerman, 2019). However, housing

counsellors are only available two days a week. Therefore, our investigation of facilitators and barriers to accessing in-house counselling services emphasized internal considerations, with the addition of one theme on the external barrier of ease of access.

O'Carroll (2019) identified six internalized barriers that operate through cognitions or emotions that can impact homeless people's health service usage. These include fatalistic cognitions, where participants believe that they will not live for much longer or that it is too late to change, and therefore it is not worthwhile to begin treatment; denial cognitions, where participants do not believe they need support; presumption of poor treatment; presumption of discrimination; self-blame, where participants believe that their health is their own fault and that they do not deserve treatment; and competing priorities where survival practices, getting money, attending appointments, etc., were prioritized over receiving healthcare. Other reasons participants avoided accessing care were general fear, hopelessness, embarrassment, and low self-esteem (O'Carroll, 2019). While this study was conducted based on accessing physical health services, we used the above information to inform the creation of our investigation into the barriers of accessing within-housing counselling services. Kerman (2019) identified facilitators of accessing mental health services among currently and formerly homeless adults. These included having mental health staff perceived as qualified, considerate, nonjudgemental, dependable, and truly wanting to support clients; perceiving other service users as safe, and like the self; and quality and atmosphere of the physical space (Kerman, 2019).

Method

Participants

Kelowna has five CMHA PSH sites, four of which offer counselling services. We recruited six participants from each of the four housing sites that offer counselling, three participants who have accessed counselling and three who have not. All 24 participants were aged 25 or above. Slightly different versions of the survey follow, based on whether they have ever accessed housing counselling previously. Per Bornstein et al (2013), we utilized a convenience sampling method based on housing residents' availability during the time of data collection. It is common for the residents of supportive housing to have low literacy rates and/or diverse abilities and needs. Therefore, the researcher assisted participants with completing the survey. This also allowed for the capture of commentary from the participants, for inclusion within the qualitative analysis portion of the results. We also tracked the number of residents who declined to answer the survey – see full participation breakdown in Figure 1.

At the beginning of the survey, participants answered basic demographic questions, including age range, gender identity, how long they have lived in CMHA Supportive Housing, and whether they have accessed housing counselling before. Information about the 24 participants can be found in Table 1, along with their randomly assigned three-digit participant number.

Table 1

Participation breakdown

Site	Total Reached	Accepted – Have	Accepted – have not	Declined	Accepted – already fulfilled sector
Ellis Place	8	3	3	2	0
McCurdy Place	11	3	3	3	2

Heath House	8	3	3	2	0
Willowbridge	9	3	3	3	0

Participant information

The primary researcher surveyed 24 participants over four CMHA Kelowna permanent supportive housing sites. Each site provided six participants, three who had accessed counselling and three who had not. Gender distribution included 50% male (n = 12), 46% female (n = 11), and 4% gender diverse (n = 1). These gender labels are trans-inclusive, i.e., participants were able to choose their own gender marker and for example, trans women were able to choose the marker “female”. 17% of participants were aged 25 to 35 (n = 4), 29% aged 36 to 45 (n = 7), 17% aged 46 to 55 (n = 4), and 38% were over 55 years of age (n = 9). No participants were less than 25 years of age. 75% of participants had lived in CMHA PSH for more than two years (n = 18), 4% for 12 to 24 months (n = 1), 13% for six to 12 months (n = 3), and 8% for three to six months (n = 2).

Based on study design, 50% (n = 12) of participants had never accessed counselling in their PSH site. Of the 12 that had accessed counselling, 67% had accessed more than five times and access on a regular basis (n = 8), 17% had accessed more than five times but only occasionally (n = 2), and 17% had accessed between one and five times (n = 2).

Survey Process and Data Analysis

Following the recruitment of participants, 16 scale-based and four interview questions were asked on participants using the outline found in Appendix. Verbal consent to continue with the survey was received before proceeding. To get a full picture of participants’ lives and opinions, informal commentary made throughout the survey process was included in qualitative analysis. Based on low literacy rates and/or diverse abilities and needs of participants, the

researcher assisted participants with completing the survey, answering clarifying questions or rewording questions for maximum participant understanding and engagement. Surveys were filled out by the researcher on paper, and notes were taken of qualitative responses. Per Babbie, Edgerton and Roberts (2021), having an interviewer directly involved results in fewer incomplete questionnaires and is more effective for complicated issues. It does take more time and effort than self-report surveys. Survey responses were later typed onto a secure drive, along with the randomly assigned three-digit participant code for later analysis. Details were reproduced as authentically as possible.

Findings from the scalar questions can be found in Tables 2 and 3. Qualitative responses were analyzed using a thematic content analysis approach (Braun & Clarke, 2006), identifying major themes, sub-themes, and codes within each theme. An inductive method was used, staying as close to the participants' original language as possible.

Ethical considerations

The major ethical consideration with this project is the researcher's own alignment with the counselling program, which may influence responses from survey participants. The primary researcher completing surveys with participants was a student counsellor, and while she was therefore not an employee of the counselling program, she was affiliated with the counsellors and had completed counselling sessions with some participants. Participant responses could also be skewed based on researcher involvement in the survey process, although the research team felt this was best to support participants in responding.

Results

Survey responses

Results from the survey questions are outlined in Table 2 and Table 3 below, separated by those who have and have not accessed counselling, respectively. For readability, responses that received zero endorsements are omitted.

Table 2

Survey results: Participants who have accessed counselling

Survey question	Pleasant or positive endorsement	Unpleasant or negative endorsement	Neutral or unknown
The counsellor treated me...	Well 92% (n = 11)		Neutral or unknown 8% (n = 1)
I find the counsellor to be...	Respectful etc. 92% (n = 11)		Neutral or unknown 8% (n = 1)
I find the counsellor to be competent, qualified, and knowledgeable	Yes 83% (n = 10)		Neutral or unknown 17% (n = 2)
The gender/ sex of the counsellor is an important factor.	Agree 33% (n = 4)	Disagree 66% (n = 8)	
I think that the counselling room is clean, warm, and comfortable.	Yes 92% (n = 11)		Neutral or unknown 8% (n = 1)
The days of the week that the counsellor is available work for me.	Yes 92% (n = 11)	No 8% (n = 1)	
The counsellor is available enough days of the week.	Yes 75% (n = 9)	No 25% (n = 3)	
It is... to make an appointment for counselling.	Easy 92% (n = 11)	Hard 8% (n = 1)	
Would you still access counselling if it was not available on-site?	Yes 50% (n = 6)	No 42% (n = 5)	Neutral or unknown 8% (n = 1)
If I wanted off-site counselling, I know where to go to get it.	Yes 50% (n = 6)	No 50% (n = 6)	

The housing staff judge me for accessing counselling.	Disagree 92% (n = 11)	Agree 8% (n = 1)	
I only use counselling to address specific issues as they arise.	Agree 42% (n = 5)	Disagree 58% (n = 7)	
I don't like meeting one on one with the counsellor.	Disagree 92% (n = 11)		Neutral or unknown 8% (n = 1)
I go to counselling to address substance use, mental health, or emotional concerns.	Agree 92% (n = 11)		Neutral or unknown 8% (n = 1)
Counselling helps to support me in ways I'm not supported elsewhere.	Agree 100% (n = 12)		
The counsellor helps me with casework.	Agree 92% (n = 11)		Neutral or unknown 8% (n = 1)

Table 3

Survey results: Participants who have not accessed counselling

Survey question	Pleasant or positive endorsement	Unpleasant or negative endorsement	Neutral or unknown
I think the counsellor would treat me...	Well 67% (n = 8)	Poorly 8% (n = 1)	Neutral or unknown 25% (n = 3)
I find the counsellor to be...	Respectful etc. 50% (n = 6)		Neutral or unknown 50% (n = 6)
I find the counsellor to be competent, qualified, and knowledgeable	Yes 50% (n = 6)	No 8% (n = 1)	Neutral or unknown 42% (n = 5)
The gender/ sex of the counsellor is an important factor.	Agree 33% (n = 4)	Disagree 58% (n = 7)	Neutral or unknown 8% (n = 1)
I think that the counselling room is clean, warm, and comfortable.	Yes 75% (n = 9)		Neutral or unknown 25% (n = 3)
The days of the week that the counsellor is available work for me.	Yes 92% (n = 11)		Neutral or unknown 8% (n = 1)
The counsellor is available enough days of the week.	Yes 83% (n = 10)		Neutral or unknown 17% (n = 2)

It is... to make an appointment for counselling.	Easy 33% (n = 4)	Hard 17% (n = 2)	Neutral or unknown 50% (n = 6)
Would you access counselling off-site?	Yes 58% (n = 7)	No 42% (n = 5)	
If I wanted off-site counselling, I know where to go to get it.	Yes 33% (n = 4)	No 66% (n = 8)	
The housing staff would judge me for accessing counselling.	Agree 17% (n = 2)	Disagree 66% (n = 8)	Neutral or unknown 17% (n = 2)
I would be open to counselling, but only for specific issues as they arise.	Agree 83% (n = 10)	Disagree 8% (n = 1)	Neutral or unknown 8% (n = 1)
I would be open to counselling, but I don't like meeting one on one.	Disagree 92% (n = 11)	Agree 8% (n = 1)	
I believe I have substance use, mental health, or emotional concerns that could be addressed in counselling.	Agree 42% (n = 5)	Disagree 42% (n = 5)	Neutral or unknown 17% (n = 2)
I feel I'm already well-supported and do not need counselling.	Agree 42% (n = 5)	Disagree 42% (n = 5)	Neutral or unknown 17% (n = 2)
I believe the counsellor could help me with casework.	Agree 66% (n = 8)	Disagree 17% (n = 2)	Neutral or unknown 17% (n = 2)

Qualitative responses

Responses to qualitative questions, as well as commentary made throughout the survey process, were categorized into several categories and specific codes using an inductive coding approach. Tables 4 and 5 summarize the major qualitative findings. For readability and generalizability, only the highest frequency (most endorsed) codes are included. Some categories are designated as facilitators, aiding participants' access to counselling, or barriers inhibiting their access.

Table 4

Qualitative results: Participants who have accessed counselling

Category	Highest frequency codes	Notable Quote(s)
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Counsellor's gender	Participant would prefer to have a female counsellor (n = 2)	"Me as a guy, it's easier to talk to a man"
	Participant would prefer to have a male counsellor (n = 1)	
Perception of the counsellor	Other specific positive endorsement (good listener, calm, accepting, reliable, likable, client-centered, open, respected) (n = 8)	"[They] allow me to go at my own pace"
	Counsellor is noted as a good person (n = 4)	"I feel like I am [their] equal"
	Counsellor is noted as good at their job (n = 3) Counsellor is perceived as being 'here for me' (n = 3)	
Resources	Participants were connected to or familiar with 12 independent agencies, the most common being: CMHA Main Office at 504 Sutherland Ave. (n = 6) Interior Health/ 505 Doyle Ave. (n = 6) Housing staff inside the PSH site (n = 3)	
Housing staff	N = 3 participants mentioned specifics regarding housing staff's judgements or perceptions of residents that access counselling. N = 2 of those participants endorsed positive relationships with staff as facilitating their counselling experience.	"Staff wouldn't necessarily judge me negatively, but maybe as 'more willing to help themselves' -- looking down on those that do not access counselling"
Perceptions of counselling	Counselling has helped them (n = 7) Counselling is a good time (n = 2) Counselling is comfortable (n = 2)	"Counselling is one of my favourite times"
Why counselling is used	To address emotional concerns or mood (n = 5) To open up or be listened to (n = 5) For case management (n = 4) To gain life purpose, motivation, or confidence (n = 3)	

	To get an outside view of the self (n = 3)
	To address specific mental health or mental illness symptoms, diagnoses, or behaviors (n = 3)
Privacy and one-one-one	Like meeting one-on-one (n = 9)
	Would not participate in group counselling due to concerns about privacy (n = 3)
	Concern about other residents knowing I go to counselling (n = 3)
Facilitator: accessibility	I like that counselling is right on site (n = 6)
	It is generally easy to access counselling (n = 6)
	It is easy to book appointments (n = 4)
	Appointment times are flexible (n = 2)
Barrier: Scheduling	I would like counselling to be available more days of the week (n = 5)
	The counsellor is not always available when needed (n = 2)

Table 5

Qualitative results: Participants who have not accessed counselling

Category	Highest frequency codes	Notable Quote(s)
Counsellor's gender	Would rather meet with a woman (no female counsellor available) (n = 3)	
	Would rather meet with a man (no male counsellor available) (n = 1)	
Resources	Participants were connected to or knew about seven independent agencies, the most common being:	
	Interior Health / 505 Doyle Ave. (n = 3)	
	Housing staff inside the PSH site (n = 2)	

	Assertive Community Treatment Team (ACT) (n = 2)	
Perceptions of counselling	Endorsement of a one-on-one format as good or preferable to a group setting (n = 8)	
	Counselling could be good for me under the right circumstances (n = 5)	
Why counselling is not used	My concerns cannot be addressed in counselling or counselling could harm me (n = 7)	“It would be a waste of [the counsellor]'s time. I have unsolvable problems and [the counsellor] would not be able to help me.”
	I can or want to deal with issues myself (n = 6)	
	I don't want to or am afraid to open up (n = 6)	
	Time-based barriers such as procrastination, time management concerns, or impatience (n = 3)	“It would make me think about the things that have happened and make it like it's happening again – if I can just forget it, it's in the past. Counselling would bring all of that stuff up.”
	Would rather access counselling offsite (n = 3)	
	Privacy concerns such as worry about other residents knowing their business or concerns that the counselling room is not private enough (n = 3)	
	Counselling is for other people, not for me (n = 2)	
Unaddressed needs or reasons why counselling could be used	Casework such as errands, making phone calls, making appointments, or assistance accessing healthcare (n = 5)	“Counselling is generally not a fit for me – I don't need ‘thoughts and feelings’ help, I need real physical help, like antibiotics and getting a backpack”
	Support addressing substance use (n = 3)	
	Therapeutic needs such as someone to confide in, addressing my childhood, or addressing behavior patterns (n = 3)	

Discussion

Investigation of results data identified four main themes related to housing counselling: accessibility, clinical-intervention support, social-emotional support, and internalized barriers. Different participant groups interacted with these themes in overlapping and varying ways.

These themes are discussed below. Also included is a dedicated section on endorsement of facilitators and barriers based on O'Carroll (2019) and Kerman (2019).

Accessibility and having counselling on-site

Overall, counselling inside PSH sites was rated as highly accessible across the two groups, with days of the week for availability, ease of access, and comfort of the room rated positively at or above 75% in all cases. Participants widely disagreed that housing workers negatively viewed them for accessing counselling. Barriers around time-management could be potentially addressed with alternate booking systems for those who need more support.

Of the participants who had accessed counselling in their PSH sites, both “off-site counselling” questions (A - “I would access off-site counselling”, and B - “I would know where to go to access off-site counselling”) had 50% positive endorsement. However, these were largely different participants – A was endorsed by participants 101, 103, 202, 203, 302, and 406; while B was endorsed by participants 101, 202, 203, 405, 304, and 306. Therefore, only 25% (n = 3) of these participants (101, 202, and 203) both were willing to access off-site counselling and knew where to go to get it. All other participants (75%, n = 9), despite accessing counselling in their PSH sites, would face a barrier (either willingness, or ability, or both) to accessing counselling off-site. This emphasizes the important gap that counselling offered within the houses fills.

83% of those that have not accessed counselling felt that two days a week for counselling was enough, compared to 75% of those who have accessed counselling. Those who use the service want it to be more readily available. Connected to increased availability is the 33% of each group that felt gender/ sex is an important factor in determining their counselling access.

Given that only one counsellor is available per house, clients could potentially benefit from having more counsellor access in order to choose a counsellor that is in alignment with their gender preferences.

The current format of one-on-one counselling was widely endorsed by participants, with many stating that they would not attend group counselling, especially to avoid perceived privacy breaches. Privacy was a main concern in general, brought up by both those who have and have not accessed counselling. It is true that others knowing one accesses counselling is a difficult barrier to address, due to the placement of the counselling room in the houses. Of those that have not accessed and have privacy concerns ($n = 3$ total), $n = 2$ were from Heath House and $n = 1$ was from Willowbridge.

Clinical perceptions and support

Of those that have accessed counselling, 58% stated they disagree with the claim that “I only use counselling to address specific issues as they arise”. Based on conversation with the researcher, these participants instead use counselling on an on-going basis to address their most prevalent needs regardless of intensity or of the need itself. This is in opposition to those who have not accessed counselling, with 85% agreeing that, should they go to counselling, it would only be to address issues as they arise. This suggests that perception around and relationship with counselling potentially changes over the counselling process, once rapport is built and potential positive outcomes develop.

92% of those that have accessed counselling agree that they have mental health, substance use, or emotional concerns that can be addressed in counselling, compared to 42% of those that have not. In contrast, those that have not accessed counselling were equally likely to

state that they need help with casework (n = 5) as therapeutic needs or substance use (n = 5). Those who have accessed counselling were generally more connected to other resources than those that have not.

Social-emotional perceptions and support

Across groups, social connection and emotional support were strong reasons that residents have or would access counselling. For those that have accessed counselling, their 'why' was most commonly emotional concerns or mood (n = 5) and the need to open up (n = 5). Participants also wanted to gain life purpose, motivation, or confidence (n = 3) and get an outside view of the self (n = 3). Together, these were more common than addressing specific mental health concerns (n = 3) or casework (n = 4). No participant who has accessed counselling mentioned substance use as a motivator. In addition, 100% of those who have accessed counselling agreed that counselling supports them in ways they are not supported elsewhere.

For those that have not accessed counselling, 42% (n = 5) agreed that they may have substance use, mental health, or emotional concerns that could be addressed in counselling. Of these, n = 3 endorsed needing therapeutic support such as having someone to confide in and n = 3 felt they could use support addressing substance use. The biggest barriers appear to be internal, as discussed in more depth in the next section. N = 7 participants felt their concerns were uncounsellable, n = 6 valued independence and wanted to address concerns on their own, and n = 6 felt a barrier towards opening up.

It is notable that those who have not accessed counselling perceive the social-emotional element of counselling to be a barrier, while those who have accessed counselling largely value this as the strongest benefit of counselling. This may be self-selective, e.g. those that are already

more open to social-emotional relationships are more likely to access counselling in the first place, or it may be indicative of a lack of understanding around what benefits addressing emotional needs may have.

Internalized facilitators and barriers

As outlined above, counselling at PSH sites avoids the most common external barriers to service accessibility, such as payment, wait-times, physical travel distances, and lack of eligibility. Therefore, in designing our survey, we emphasized questions relating to internal barriers, as we felt these were more likely to represent the reasons that residents do not access counselling services. Some support for external barriers was found, e.g. wanting counselling to be available more days of the week, as discussed in the section entitled ‘Accessibility’. As anticipated, though, most barriers identified were internal. This section will consider how the results from participants who have not accessed counseling compares to the internalized facilitators and barriers of accessing care identified by O’Carroll (2019) and Kerman (2019).

Support was not found for O’Carroll’s (2019) internalized barriers of presumption of poor treatment or presumption of discrimination. Similarly, Kerman’s (2019) facilitators of having staff that are qualified, nonjudgemental, and considerate; and having a physical space that is perceived as clean and comfortable were largely supported – if participants felt able to comment on the counsellor and physical space. These findings suggest that the counsellors in PSH sites are successfully countering residents’ internalized barriers that the counsellor has control over.

Support was found for denial cognitions, believing support would not be useful; self-blame and believing they do not deserve support; competing priorities like valuing casework

over counselling; and feelings of hopelessness (O’Carroll, 2019). The four most common reasons cited by those who had not accessed counselling as reasons why they have not accessed fall under those listed internalized barriers. Additionally, the most common reason (n = 5) participants felt they could use the counselling program was to gain access to casework, supporting the competing priorities barrier. The final facilitator from Kerman (2019), that residents find other service user to be like them, was not supported. Indeed, (n = 2) participants shared the opposite sentiment, that counselling was for ‘other people’. These internalized barriers are not restricted to the homeless or previously homeless population. Fears of ‘counselling could harm me’ and ‘I am afraid to open up’ could be found in many populations, although the complex trauma histories of many PSH residents could exacerbate fears around opening up, being vulnerable, and being harmed by others (Horacio, Bento, & Marques, 2023). More work needs to be done inside PSH sites to counter these internal narratives that prevent residents from accessing support – see recommendations two, four, six, and nine.

Recommendations

1. Maintain accessibility for counselling in PSH sites by continuing the program as on-site, with flexible appointment times, one-on-one, and in comfortable rooms, to allow residents ease and self-discretion when choosing how and why to access counselling.
2. Consistent advertisement, dialogue, and rapport-building with PSH residents that emphasizes the benefits of counselling, what one may expect in counselling, and what kinds of considerations could be addressed in counselling. In particular, residents may benefit from reassurance that accessing counselling is not a waste of the counsellor’s time, that counselling session content is client-led, and that the process of exploring problems and emotions can be beneficial. Additionally, residents that have not accessed

counselling should know that they are always able to access counselling on a short-term or single session basis to address needs as they arise, and this will not obligate them to continue with counselling.

3. It may be beneficial to provide primers or training on the above point for non-clinical PSH staff, as they are crucial intermediaries between clients and clinical staff. This could also empower staff to better support residents with social-emotional concerns and provide more choice for residents in determining what kind of staff support (clinical or non-clinical) is the best fit for them.
4. Knowledge and recognition of the counsellor as a safe person was low for those who have not accessed counselling. Clinical staff should maintain consistent face time with residents (e.g. through tenant meetings, events, recreational programs, etc.) to allow residents to get to know the counsellor outside of a counselling setting, to build trust, and provide non-formal opportunities to answer questions about the counselling process.
5. It may be beneficial to encourage clinical staff to showcase relevant educational degrees, trainings, or certificates. While this may contribute to a gap of power and privilege between staff and residents, it may also facilitate an appreciation of the counsellor's competence and a recognition that activities perceived as 'a waste of time' (e.g. 'talking about feelings') are understood as beneficial by professionals.
6. Consider how to address privacy concerns from both residents that do and do not access counselling. This may entail refreshing current clients on confidentiality guidelines or altering the physical counselling space in the PSH sites to offer greater privacy and soundproofing, especially in Heath House and Willowbridge. Since not all privacy concerns in PSH sites are addressable (e.g. the common space is shared and entrance to

the counselling room is visible), protecting privacy where possible is especially important.

7. Having a larger clinical team in PSH sites could offer greater appointment time flexibility, offer residents choice in counsellor to match personality or gender preferences, and have a counsellor on-site more days of the week.
8. Clear and consistent advertising of other counselling services in the Kelowna area, such as Synergy through CMHA, Interior Health, and other ongoing Mental Health and Substance Use services. This will better equip residents who are not comfortable accessing counselling services on-site to make informed choices about community resources.
9. Per O'Carroll (2019), internalized barriers can be addressed through consistent low-barrier care, supportive and respectful relationships with staff, anti-stigma campaigns, and meeting basic needs first. Trust and willingness are developed slowly.

Conclusions and future directions

Homelessness is a pervasive issue and requires structural, social, and psychological intervention. It can be challenging to engage with and provide competent therapeutic intervention for the current and previously homeless population due to a complexity of needs and internalized barriers. In Kelowna, CMHA PSH environments provide low-barrier, free, and accessible counselling services. Still, service uptake can be a challenge.

We surveyed 24 participants in four PSH sites to get a better sense of residents' reasons for accessing and not accessing counselling services. After scalar and qualitative thematic analysis, results yielded four main themes: accessibility, clinical-intervention support, social-emotional support, and internalized barriers. Overall, we found that once clients access

counselling services in PSH sites, they find it helpful. The greatest gap in service provision is addressing challenges regarding initial service use. Several recommendations for the program explore how to maintain strengths and address weaknesses.

Appendix

Questionnaire Content

Title

Preamble, introduction, and informed consent

The purpose of this survey is to investigate how CMHA Supportive Housing residents feel about the counselling program offered, what they feel works, and what elements could be improved. Your participation is entirely voluntary. At any time, you may choose to not answer any question that has been asked. You may suspend your participation in the survey at any time for any reason whatsoever without a penalty of any sort. If you choose to withdraw during the session, all information obtained up until that point will be destroyed. Once data has been collected, your information will be anonymized, and it may be impossible to fully withdraw your data. Please do not hesitate to ask any questions or raise any concerns about the survey process, the use of your data, or confidentiality now or at a later date.

Questions during this survey will ask about your experience and perception of the counselling program offered in this housing site. Should you experience any emotional or psychological distress caused by any aspect of the process, the researcher will be available to guide you to support services. We are offering compensation in the form of one fruit cup and entry into a draw for a gift card for your time participating in this survey.

Do you agree with everything above?

Questions

Background

1. Gender (select all that apply)
 - a. Male
 - b. Female
 - c. Gender diverse
2. Age range

- a. Less than 25
 - b. 25 to 35
 - c. 36 to 45
 - d. 46 to 55
 - e. 55+
3. How long have you lived in any CMHA Supportive Housing building?
- a. Less than 3 months
 - b. 3 to 6 months
 - c. 6 to 12 months
 - d. 12 to 24 months
 - e. More than 2 years
4. How many times have you accessed counselling within your building?
- a. I have never accessed counselling
 - b. I have accessed counselling between one and five times
 - c. I have accessed counselling more than five times, but only once in a while
 - d. I have accessing counselling more than five times, and I access it regularly (for example, every week or every month)

If you have accessed housing counselling:

1. Perception of the counsellor
- a. The counsellor treated me (well / poorly / neutral).
 - b. I find the counsellor to be (rude, condescending, only in it for the pay cheque / respectful, warm, willing to go the extra mile / neutral).

- c. I find the counsellor to be competent, qualified, and knowledgeable (yes / no / neutral).
- d. The gender/ sex of the counsellor is an important factor in determining if I participate in counselling (agree / disagree / neutral).
- e. I think that the counselling room is clean, warm, and comfortable (yes / no / neutral).
- f. Generally, how does the counsellor treat you? Are you satisfied with the counsellor that is offered to you?

2. Ease of access to counseling

- a. The days of the week that the counsellor is available work for me (yes / no / neutral).
- b. The counsellor is available enough days of the week (yes / no / neutral).
- c. It is (easy / hard / neutral) to make an appointment for counselling.
- d. Would you still access counselling if it was not available on-site? (yes / no / neutral).
- e. If I wanted off-site counselling, I know where to go to get it (yes / no / neutral).
- f. How easy or hard is it for you to access counselling? What other supports are you connected to?

3. Structural logistics of access

- a. The housing staff judge me for accessing counselling (agree / disagree / neutral).

- b. I only use counselling to address specific issues as they arise (agree / disagree / neutral).
 - c. I don't like meeting one-on-one with the counsellor (agree / disagree / neutral).
 - d. What do you think about accessing counselling one-on-one in the supportive housing site? What makes it challenging? What is easy?
4. Outcomes of access (in general)
- a. I go to counselling to address substance use, mental health, or emotional concerns (agree / disagree / neutral).
 - b. Counselling helps to support me in ways I'm not supported elsewhere (agree / disagree / neutral).
 - c. The counsellor helps me with things beyond mental health counselling, like attending appointments and talking to my greater support team, etc. (agree / disagree / neutral).
 - d. Does counselling help, harm, or change you? Is it a good fit for you? What does the counsellor help you with?

If you have not accessed housing counselling:

- 1. Perception of the counsellor
 - a. I think the counsellor would treat me (well / poorly / neutral) if I went into counselling.
 - b. I find the counsellor to be (rude, condescending, only in it for the pay cheque / respectful, warm, willing to go the extra mile / neutral).

- c. I find the counsellor to be competent, qualified, and knowledgeable (yes / no / neutral).
- d. The gender/ sex of the counsellor is an important factor in determining if I participate in counselling (agree / disagree / neutral).
- e. I think that the counselling room is clean, warm, and comfortable (yes / no / neutral).
- f. Generally, how does the counsellor treat you? Are you satisfied with the counsellor that is offered to you?

2. Ease of access to counseling

- a. The days of the week that the counsellor is available work for me (yes / no / neutral).
- b. The counsellor is available enough days of the week (yes / no / neutral).
- c. It is (easy / hard / neutral) to make an appointment for counselling.
- d. Would you access counselling off-site? (yes / no / neutral).
- e. If I wanted off-site counselling, I would know where to go to get it (yes / no / neutral).
- f. How easy or hard would it be for you to access counselling if you wanted to?

3. Structural logistics of access

- a. The housing staff will judge me if I access counselling (agree / disagree / neutral).
- b. I would be open to counselling, but only when specific issues arise (agree / disagree / neutral).

- c. I would be open to counselling, but I do not like meeting one-on-one (agree / disagree / neutral).
 - d. What do you think about accessing counselling one-on-one in the supportive housing site? What makes it challenging? What is easy?
4. Personal advantages of access
- a. I believe that I have substance use, mental health, or emotional concerns that could be addressed in counselling (agree / disagree / neutral).
 - b. I feel that I'm already well-supported and do not need to go to counselling (agree / disagree / neutral).
 - c. I believe the counsellor can help me with things beyond mental health counselling, like attending appointments and talking to my greater support team, etc. (agree / disagree / neutral).
 - d. Do you think that counselling could help, harm, or change you? Would it be a good fit for you? What could a counsellor help you with?

Postamble

Thank you for your participation in this survey! Should you have any questions in the future regarding this project, please contact the counsellor at your housing site.

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