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Needs and Supports in Transitional Housing for People Living with HIV/AIDS in Ontario, Canada

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ABSTRACT

There is a paucity of research on transitional housing for people living with HIV/AIDS (PHA) and even less so within the Canadian context. The present work addresses that gap and reports on the results from the *Transitional Housing Study*, a province wide community-based research collaboration involving PHA, service providers, and university researchers in Ontario Canada. This article answers the following research questions: What supports do residents in transitional housing for PHA access and what needs do these supports address? Developing from a thematic analysis of in-depth qualitative interviews with 25 residents in one of three transitional housing agencies in Ontario for PHA, the findings reveal that participants benefited from four key supports while in transitional housing: the provision of a *safe* environment, co-coordination and management of HIV (and other) drug therapies, assistance with appointments, and referrals to health and social services. Until more resources are available to increase availability of transitional housing for PHA, the nonprofit housing sector must fill the gap that exists by offering the types of supports identified in this study in order to address the needs of PHA. Future research may link these supports efficiently with concrete health improvements and permanent housing stability among PHA.

KEYWORDS

Community-based research; HIV/AIDS; qualitative research; supports and services; transitional housing

Transitional housing is an intermediary intervention on the continuum of housing responses to homelessness. The goal of transitional housing is to facilitate the transition from precarious housing situations to permanent independent living. It is designed specifically for those who initially seek out and enter into housing services but who are unable to manage the demands of maintaining stable housing. Unlike other housing interventions, transitional housing has as its goal skills building through support in employment, financial management, health, and activities of daily living in order to achieve self-sufficiency (Fischer, 2000). These support services are premised on the assumption that skills building in these core areas of living will increase the resident's capacity to manage the demands of long-term stable housing. There is a paucity of research on transitional housing for people living with HIV/AIDS (PHA). The work presented here attempts to address that gap and is based on findings from the *Transitional Housing Study* (THS), a research collaboration involving PHA, housing service providers, AIDS service organizations (ASO), and university researchers in Ontario, Canada. The THS sought to understand the role of transitional housing in the lives of precariously housed PHA, and the present article focuses on one aspect of the THS findings: the unique housing support accessed by PHA while in a transitional housing program and the immediate needs those support systems satisfied.

Current research reports a substantial number of PHA live in precarious housing conditions. For example, Aidala, Lee, Abramson, Messeri, and Siegler (2007) found that approximately 33% of a representative sample of PHA in New York City were unstably housed. Kidder et al. (2007) found that approximately 53% of PHA participants in the *Housing and Health Study* recruited from three major urban centers in the United States (Baltimore, Chicago, and Los Angeles) qualified as homeless while the remainder were at severe risk of homelessness. Clearly, there is a need for the full range of housing services to be responsive to the needs of PHA.

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Housing is a foundational requirement for the health and well-being of PHA. In a systematic review of 29 housing studies, Leaver, Bargh, Dunn, and Hwang (2007) found a positive correlation between housing stability and improved access to and utilization of health and social services, treatment adherence, and better overall health. These findings are consistent with a more recent review by Milloy, Marshall, Montaner, and Wood (2012) who found that inferior housing correlates with lower rates of appropriate health care, access and adherence to antiretroviral therapies, and HIV treatment outcomes. There appears to be some evidence that housing interventions for unstably housed PHA are associated with reduced readmissions to hospitals, low viral loads, and high CD4 counts (Buchanan, Kee, Sadowski, & Garcia, 2009; Hawk & Davis, 2012). Housing impacts health outcomes for PHA and, thus, plays a role in the trajectory of the AIDS epidemic.

However, such broad claims assume "housing" and "housing stability" are monolithic concepts. As Milloy and colleagues (2012) caution, there is no standard definition of "housing status" among the studies they reviewed. Leaver et al. (2007) note that in some studies, the word "homelessness" varied widely to include those who lived in or accessed housing services such as emergency shelters or single-room occupancy hotels to those who frequently accessed free meal plans. In other words, the methodological construction of housing in housing research often conflates a range of social housing services that are, or could be, quite distinct in scope and aim. Ignoring the specific focal objectives of particular types of housing interventions serves only to obscure the unique role each might play in alleviating precarious housing and the ways they may impact health among PHA. For example, the primary purpose of emergency and homeless shelters is to provide immediate respite from unsafe social arrangements (e.g., partner abuse) or adverse environmental conditions (e.g., weather). Subsidized housing provides rent-geared-to-income for those with low or moderate income, but presumes residents possess the capacity to manage the demands of living independently. Transitional housing is distinguishable from shelters and subsidized housing by its provision of skills-building supports and case-management to encourage self-sufficiency and independence. The current article attempts to document the role of these supports for PHA.

A small body of research in the United States has documented the process of delivering support in transitional housing. This research has captured, rather consistently across studies, the breadth of supports and, to some extent, resident satisfaction with those supports. Through archival research and qualitative telephone interviews, Baker, Niolon, and Oliphant (2009) identified the range of "self-sufficiency services" (e.g., job/education assistance, transportation assistance, money management) and "personal services" (e.g., case management, support groups, legal services, parenting class/workshops) accessed in transitional housing across 15 states and the District of Columbia. Their analysis of qualitative interview data revealed that 54% of executive directors of transitional housing reported residents were "very positive" or "mostly positive" about participating in transitional housing supports.

Outcome studies on transitional housing have reported the efficacy of transitional housing on key variables such as housing stability, quality of life, employment stability, mental health, and substance use (e.g., Tsai, Rosenheck, & McGuire, 2012). These studies have identified the immediate benefits of residency from transitional housing or the improvements over time. Rashid (2004) reported 100% of residents stably housed after discharge from transitional housing, although this rate marginally decreased at the six-month follow-up. Fischer (2000) reported that less than half of former residents of a transitional housing agency paid unsubsidized rent, but these numbers increased over time. Such findings are consistent with those of Jones (2011) who reported an increase in individuals who secured stable housing upon the three-year follow-up post-residency in transitional housing. The efficacy of transitional housing has been underscored by research from Melbin, Sullivan, and Cain (2003) who, upon asking participants in a transitional housing program "what they would have done had [transitional housing] not been available" (p. 456), report residents would have continued to live in dangerous or unsafe housing situations or would have ended up on the streets. Apparently, what little research exists on transitional housing suggests relatively favorable outcomes post-residency. It supports the general claim of the effectiveness of support in finances, employment, leadership, networking and referral, and mental health (Washington, 2002) that transitional housing provides.

The benefits notwithstanding, transitional housing reported in the literature varies widely by population. For example, research has focused on a range of populations accessing transitional housing. These include women (Fotheringham, Walsh, & Burrowes, 2014), homeless families, parents, and caregivers (Holtrop, McNeil, & McWey, 2015; Washington, 2002), youths transitioning out of foster care (Jones, 2011; Rashid, 2004), veterans (Tsai, Rosenheck, & McGuire, 2012), and survivors of partner abuse (Baker et al., 2009). Such research has indicated a diversity of needs that would necessitate altogether different supports with different skills-building foci. Transitional housing for single parent families offer parent training, with the goal of imparting parenting skills to new mothers (Fischer, 2000). In order for shelter and transitional housing to be responsive to the needs of transgender youth, services and programs must "affirm people's gender identity and sexual orientation, celebrate LGBTQ culture, employ LGBTQ staff, and provide ongoing training and support to staff" (Yu, 2010, p. 344). Still further, institutional mandates may dictate the range and breadth of service provision offered within transitional housing. For example, transitional housing that enforces abstinence as an entrance requirement (Tsai, Rosenheck, Kasprow, & McGuire, 2012) has tended to presume substance use as the cause of homelessness and sobriety as the solution (Dordick, 2002). Such institutional policies might direct services in ways that differ from those where harm reduction principles guide housing supports (Hawk & Davis, 2012). Collectively, then, the research on transitional housing suggests that one model of service provision does not fit all.

To date, there is little research on transitional housing specifically for PHA and even less on transitional housing for PHA in Canada. In response, housing providers, ASO, and university researchers came together to develop the THS, the first province-wide, multisite qualitative study on transitional housing for PHA in Ontario, Canada. Following others (Chambers et al., 2014; Greene, Chambers, Masinde, & O'Brien-Teengs, 2013; Greene et al., 2010), the THS was guided by a social determinants of health framework. The term "social determinants of health" refers to "the economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole" and the ways in which they "determine whether individuals stay healthy or become ill" (Raphael, 2004, p. 1). This framework is critical of the prevalent public health preoccupation with individualistic approaches that locate public health interventions on individual risk factors and behavior change (Lupton, 1995; Petersen & Lupton, 1996). A social determinant of health approach instead acknowledges how context impacts individual health and well-being and, thus, insists on context-level interventions. The THS posited that housing is a social determinant of health and that the health and well-being of PHA are, in part, facilitated by secure and permanent housing. This article responds to calls to understand how the social determinants of health "get under the skin" (Raphael, 2006, p. 662). For housing researchers, this means the specific causal pathways from housing to (positive) health outcomes for PHA are still unclear (Milloy et al., 2012). Transitional housing is one such pathway and supports offered in and through transitional housing are the specific mechanisms that impact health. By identifying these supports, the current article contributes to a broader understanding of housing as a social determinant of health.

The THS adhered to the principles of community-based research. Community-based research is a collaborative partnership that involves equitable roles for social service organization representatives, researchers, and affected community members throughout the research process (Greene et al., 2009). Community-based research insists the research should reflect the needs and goals of those communities who are researched. To do so, the THS adhered to the "greater involvement of PHA" and "meaningful involvement of PHA" principles (Travers et al., 2008) in all stages of the study, including study conception, data collection, and dissemination. The study utilized trained peer research associates (PRA) who were PHA with a history of experience with housing instability (see also Greene et al., 2009). PRA played a pivotal role in the research through active involvement on the investigator team alongside representatives from each of the three transitional housing agencies for PHA in the province.

In the province of Ontario, transitional housing is offered in only three cities: Toronto, Ottawa, and London. Fife House Foundation (Toronto) served as the coordinating site for this study. Fife House Foundation provides secure, supportive, affordable housing to people living with HIV/AIDS in the Greater Toronto Area. Fife House offers 11 transitional housing units

to PHA for a nine-month maximum term of residency. Bruce House (Ottawa) can accommodate seven PHA residents for up to three years in its transitional housing program. John Gordon Home (London) provides transitional housing (eight units) for people with HIV/ AIDS and HCV (Hep C) for a maximum of 12 months. All transitional housing provides private living units with communal living and dining space, 24-hour intensive support services, and case management. The current article is less concerned with the overall effectiveness of transitional housing on imparting skills and, instead, prioritizes the following research questions: What supports do residents in transitional housing for PHA access and what health needs do these supports address?

Method

Participants

Participant selection was based simply on one's residency in a transitional housing program for PHA in Ontario and a willingness to participate in the study. Following a convenience sampling strategy, PRA approached all incoming residents of one of the three transitional housing sites during the time of data collection. None of those approached to participate in the study declined our invitation, which resulted in a sample of 25 participants. See Table 1 for the composition of the sample.

Collectively, the age range of the sample across the three research sites was 26–62 years with a male/ female ratio of 19/6. Unsurprisingly, Fife House Foundation, located in the most densely populated of the three research sites, garnered the most participants for the study. John Gordon Home, located in the smallest city of the three, generated the least number of participants. Given the sampling strategy, the results document the types of support accessed by residents in transitional housing for PHA. The results do not presume a representative sample, and the presentation of the results need not rely on generalizability to a broader research population.

Materials

In-depth interviews with participants were intentionally broad and wide-ranging. Participants of the THS were interviewed upon their entry into and upon exit from housing residency between 2012 and 2013. Entry interviews focused on the social and health conditions that compelled the resident to seek housing. For the purpose of this article, the findings were derived from the data generated through the exit interviews, which focused on the resident's experiences within transitional housing. These interviews were guided by the following interview questions:

1. I would like to understand your experiences in this transitional housing program. What has your residency been like?
2. Can you tell me about the supports and services you were able to access or get linked to during your stay at this transitional housing program?
3. What were the specific supports and services offered at the transitional housing program?
4. How accessible were these supports and services, both within the transitional housing program and outside the program?
5. How did your needs change while residing in transitional housing?
6. How has your life changed since you accessed transitional housing?

PRA used prompts and administered interview questions as needed to elicit elaboration and depth in responses. Interviews were delivered in a flexible manner in order for participants to share their experiences and to express themselves on their own terms. Exit interviews took approximately one to two hours to complete.

Table 1. Participant details.

Housing Agency	Fife House Foundation	Bruce House	John Gordon Home	Total
Number of participants	14	8	3	25
Age	Average: 42 Range: 26–62	Average: 49 Range: 35–62	Average: 47 Range: 43–55	Average: 46 Range: 26–62
Gender	Male: 11 Female: 3	Male: 6 Female: 2	Male: 2 Female: 1	Male: 19 Female: 6

Procedure

Ethical approval was granted by the University of Toronto (Toronto, Ontario) and Wilfrid Laurier University (Waterloo, Ontario). Cognizant that housing sites would be identified in the study, transcribers ensured all information from the data that could potentially reveal specific participants and the housing site in which they resided were removed from all transcripts. This included any names of health/social service providers and the agencies with which they were associated. As investigators of the study and as coauthors of the current article, representatives of the housing services gave final approval for the presentation of the data to ensure confidentiality.

PRA conducted all interviews, assisted in the coordination of the study, and liaised with study participants. All interviews took place at the agency providing transitional housing where participants were granted residency. The time between entry and exit interviews ranged from approximately two to ten months and depended on each participant's residency term, which was based on need and the length of allowable stay within each program. All participants received an honorarium for their time. PRA obtained written informed consent before commencing with the interviews.

Interview data were transcribed orthographically. The analysis would best be described as a thematic analysis (Braun & Clarke, 2006). This process involved careful reading of each transcript, cataloguing relevant data in relation to the research question, and organizing and synthesizing data into themes. Although well aware of extended discussions on the dilemmas that arise from realist approaches to qualitative data analyses, analysts treated participant talk as transparently reflecting the interviewee's subjective experiences in transitional housing. Treating the data in this way allowed for pragmatic suggestions for service provision and future research.

Findings

Prior to their residency in transitional housing, all participants lived in what could be characterized as precarious or unstable housing conditions. Among some of the participants, states of homelessness or housing instability emerged from diverse situations such as poverty, substance use, partner abuse, and forced migration. All participants were HIV positive and were referred to transitional housing from other ASO. Many participants took up residency in transitional housing having already secured a breadth of services including food banks, government financial support, health care specialists, and de-addiction programs. Participant residency was fairly unstructured and flexible. Accessing support from within transitional housing was not mandated, and participants felt it was largely voluntary to access whatever assistance they required.

The key findings reported here are the specific supports residents accessed through transitional housing for PHA and the needs these supports satisfied. Throughout the interviews, participants reported a shift in life orientation expressed as a progression toward independence, direction, control, and stability as a result of living in transitional housing.

> So like my life was kind of like all over the map, it's now sort of condensed where, it's controllable now and it's able to… it's no longer insane like you know and all over the place and no direction, there is now starting to get more focus, more… ability to make decisions like you know to figure out where I wanna go, what I wanna do, how I wanna get around it, the services available to me, the people available to me like you know it takes time like you know, it takes a lot of question asking and what not.

> For years now, it's been thinking day by day by day. Now it allowed me to… oh I can think about tomorrow. I can think about next week. I can think of my life. I can think of my health.

This shift in life trajectory was achieved, in part, through the benefits of supports accessed in and through transitional housing. The remainder of this section reports on the institutional supports that encouraged this shift: providing a *safe* environment, co-coordinating and managing HIV (and other) drug therapies, assisting with appointments, referring to health and social services.

Safe Environment

The single most important support cited by participants was the provision of a *safe* environment within which participants could stabilize their health and get their life back on track. According to one participant, "There was a lot of support and a lot of assistance in like you know who to go to, what direction to go in my life so like you know." According to another,

> I'm in a safe environment, you know. The staff is very cooperative and they understand the illness. And people around me they understand. I mean it's kind of a family thing sometimes I feel. Because I don't have my own family, so but I'm not alone, that's for sure.

By "safe," participants typically referred to housing that was not only informed of the health needs that arise as a result of often extended living in precarious housing situations, but was also accommodating of the demands associated with recovery from numerous or severe health problems.

> I knew that there was a lot of care that needed to be involved in my situation. Like you know I wasn't capable of doing it myself and I had to have assistance and I was glad to find somewhere that I can receive the assistance and be able to take my time to recover and you know, get my health back on track. You know, be able to assist myself with my needs like you know which was really, really high at the time. You know still are quite a bit right now but not as much as what they were then. Like now I can deal with my situation whereas before I couldn't. You know it's very difficult. I…I need somewhere where I could tend to my medical needs and my disease and everything else and get so much stress out of my life like I'm just, you know, be able to relax, sit back and you know and get back on track.

In sum, participants felt safe housing provided a context that allowed them to pursue their health goals. The provision of a safe environment was made possible by staff that were well aware of the diverse needs and experiences associated with living with HIV. Providing such a context allowed participants to improve their health, which formed the base upon which participants could then begin to consider a future direction.

Coordination and Management of Drug Therapies

As a result of transitional housing support, participants claimed improved routinized intake of HIV and other drug therapies: "[M]y medication is working out quite well"; "[M]y medications are in order"; "I think it's almost under control now, it's better." These improvements were contrasted by the difficulties in prioritizing medications that participants experienced outside of transitional housing: "I forget my meds, whatever, [transitional housing supports] remind me. But, when I'm home, no one's going to be in my living room waiting for me to take my meds." One participant made explicit the need for "somebody giving me my tablets every morning and at bed time."

Participants linked improvements with treatment routinization with "med-reminders" provided by transitional housing staff. The term "med-reminders" is used loosely to describe the dispensing of medical therapies to residents at prescribed times during the day. According to participants, "[The transitional house] dispense[s] my medicine"; "[T]he house kinda helps ya, reminds ya, you know"; "[Transitional housing] kept me on my meds properly"; "[S]o somebody giving me my tablets every morning and, at bed time … like night time." At one transitional housing agency, a public health nurse dispenses the medications to residents: "[The] public health nurse comes every day in the morning at say eight thirty to observe me, make sure I'm taking my medication." Of course, medications to manage HIV have been relatively simplified since the advent of antiretroviral therapies. Nevertheless, participants required assistance when several medications needed to be coordinated throughout the day.

Coordination of medications involved the organization and management of multiple drug therapies. According to one participant, "I got my medication organized yesterday, so that took a week here but before, it was a mess." The difficulties with managing and adhering to drug therapies were exacerbated, in part, by strict requirements for particular therapies. Several participants expressed exasperation in maintaining an unmanageable medication regiment without practical assistance. In the following excerpt, a participant and a PRA commiserate over the shared difficulties of managing multiple drug therapies.

> Participant: You know I just got tired of taking [medications], and that's not an uncommon thing. I think with people, especially living alone, who don't have like support of like an intimate relationship, family, because people on medication regimens, especially ones like that I, you know the HIV, that's what I'm saying is one pill a day. It's the freaking heart medicine and the timing of all that. It's like nine pills in the morning. You know like then another three at 5:00 and another. There is a ton of stuff to remember.
>
> Interviewer: It's hard to always be ready when your alarm goes off, right?
>
> Participant: Empty stomach, full stomach, before bed and then some days you just like I don't care anymore.
>
> Interviewer: It's like how am I supposed to take this pill and be able to eat and sleep?
>
> Participant: Oh yea, yea.

Support for administering medications simplified a participant's life by reducing the complexity of drug therapies.

> Participant: The part I think that's, what's really good about [transitional housing] is that's one of the things they do. Your prescriptions come to this place.
>
> Interviewer: Yea
>
> Participant: And you have to go to the office to get them and they expect you to. Which at first I thought wow that's bullshit and then you know, the more I think about it it's like "that's great." I never have to touch the thing man, it goes from the doctor to the pharmacy to the front office and if I miss something they call me [laughs].

In sum, transitional housing support alleviated the difficulties participants experienced in coordinating multiple drug therapies while med-reminders encouraged daily routinization of medications. These supports were, in part, educative and illustrated to participants how drug therapies can be maintained.

Assistance with Appointments

Being HIV positive and on social assistance sometimes necessitates an array of appointments at various agencies. Supports from transitional housing ensured that participants were able to maintain their commitments to—what was for residents—a myriad of health and social service appointments. Participants found keeping track of the sheer number of appointments with health or social services overwhelming: "To access these services, at these different agencies, means being able to keep to an appointment, which was a very, very difficult task for me."

Transitional housing provided participants with reminders for these (often daily) appointments. As a result, participants expressed improvement in maintaining appointments. As one participant reports,

> So I was able to keep going, keep being on track with all these exciting activities going on in these different agencies, because staff from [transitional housing] would normally give me a reminder call, knock on my door, they tell me "hey, you know, this appointment at…" which is really, really helpful.

According to another,

> Participant: I've been having appointments all week last week, so that's been keeping me busy, and I've been feeling good about myself cause I've been getting things done, I've been going to the dentist and doing things, you know?
>
> Interviewer: Okay, and so these appointments, do you get help in terms of being reminded through [the transitional housing staff]—someone reminds you about your appointments, keeps tabs on you and says "your appointment is…." [Through the transitional housing program], they help you to remember what appointments you have?
>
> Participant: Yeah, yeah, exactly.

In addition to appointment reminders, appointment organization and proper scheduling was key to ensuring participants maintained scheduled social service and health care appointments.

> One of the most important services that I've been getting from [transitional housing], it's the reminder calls…. All of my morning appointments, I kept missing all of them, until I sat down one day and figured out that this is a problem. I can't really do with morning appointments so, it was when I came out, and let [staff] know, that morning appointments won't work for me here and not in any other institution, so they actually helped me make like general calls to places that I mostly need to go to frequently, saying um looking for an alternative of other times for my appointments, and which one of the most important ones was getting my doctor to give me a continuous afternoon or uh evening appointments, instead of early hours appointments.

In sum, participants benefited from assistance with remembering and managing social and health care appointments. This support improved utilization of existing social and health services.

Resource and Service Referral

Many residents entered into transitional housing having already accessed HIV and non-HIV-related health care and social services. Nevertheless, transitional housing staff made residents aware of a range of services—otherwise unknown to residents—within and outside the housing agency. Staff functioned as a resource for practical information. One participant states, "[T]hey know what's going on with people living with HIV and AIDS." Another stated,

> Well I didn't know much about HIV at the time, when I first got to the house.… But at the end, I would have studied some books with [staff member], and talk with staff about things.… I was able to get more informed about what it was all about and everything else.

Service referral was particularly helpful for refugee claimants and new Canadians who were unaware of the available services both within and outside the transitional housing.

> Without the [transitional housing], it probably wouldn't have been possible to get those information, because as a newcomer, you know, very new person in the country, having these, you know, health complications, issues and all that, sometimes, or many times, you know we don't feel like talking to somebody, or in the mood to, you know, really say what you feel or what you're going through at that time and all that but the staff are always there, like they let you know a bunch of things, within those bunch of things there is definitely one or two or more that would best fit the situation one is going through at that time. You say, "OK, this one is useful for me now, it's more practical, I'll take this service."

Through service referrals from housing staff, participants were able to connect to services, including mental health services, acupuncture, optometrists, dentists, recreational services, physiotherapy, and case management. Thus, transitional housing functioned as a resource for information and also imparted practical knowledge on finding alternative housing once a participant's term approached its end.

Discussion

In Canada, a proliferation of qualitative housing studies has sought to understand the diverse experiences of PHA (e.g., Chambers et al., 2014) more generally and the experiences of more specific populations, such as older adults (e.g., Furlotte, Schwartz, Koornstra, & Naster, 2012), African and Caribbean mothers (e.g., Greene et al., 2013), and parents (e.g., Greene et al., 2010). Collectively, these studies identified the ways race, gender, age, stigma/disclosure, and economic insecurity intersect to inform both the experiences of PHA in securing housing and the needs such housing must address. There has been some research, mainly in the United States, on the role of transitional housing and the role it plays in addressing the needs of diverse populations. The present article contributes to this body of research and sheds light on the specific role transitional housing plays in the lives of precariously housed PHA in Ontario, Canada.

Given that previous research has identified a relationship between housing and improved health among PHA (e.g., Hawk & Davis, 2012) and that those who do access HIV-designated housing are then exposed to the stigma and discrimination associated with living in these "marked houses" (Greene et al., 2013), PHA require housing services that are responsive to the specific needs associated with living with HIV/AIDS. The present work identified the unique supports PHA in a transitional housing program required above and beyond those that might be required from non-PHA residents in a transitional housing program. Of course, many PHA in transitional housing may require broad-based skills-building support for employment, networking, and finances (Washington, 2002). They may also require support to address social and health needs not necessarily specific (though potentially related) to their HIV status, such as those related to partner abuse or recent immigration. However, participants reported the necessity of four kinds of support accessed in and through transitional housing to manage their health and well-being: The provision of a *safe* environment, coordination and management of HIV (and other) drug therapies, assistance with appointments, and referrals to health and social services. These findings are discussed in relation to the previous housing research.

Transitional housing provided a safe and informed environment that was conducive to improving participant health and HIV status. In previous research, safety figured prominently in the housing needs of PHA in Ontario. However, safety encompassed a range of meanings across these studies. Chambers et al. (2014) reported that participants defined safe housing as housing that was physically well maintained and free from criminal activity and stigma. Similarly, Greene et al. (2010) reported HIV positive parents in need of housing voiced concerns for housing contexts free from high crime, substance use, and social discrimination related to race or HIV status. Similar concerns were raised specifically among older adult PHA about discrimination and the lack of appropriate health care because of gay sexuality (Furlotte et al., 2012). For our participants, safety meant that participants could pursue their health care within a context that was conducive to addressing their HIV-related needs.

Support in coordinating and managing drug therapies imparted skills to participants to routinize multiple drug therapies and treatment regimes. Participants discussed the difficulties many PHA experience when managing multiple drug therapies for

the full range of their health care needs. PHA were often overwhelmed by the sheer logistical difficulties of remembering—let alone coordinating—their medications. Our findings provide an explanatory account for the statistical associations between precarious housing status and poor adherence to drug therapies (Leaver et al., 2007; Milloy et al., 2012). As many have found, community-housing settings where information and support for HIV treatment are unreliable cultivate anxiety and distress among PHA (Bernays & Rhodes, 2009). Support within transitional housing potentially relieved (or pre-empted) these anxieties and encouraged the adoption of medication routinization.

Our study identifies the ways in which transitional housing leads to greater access to and effective utilization of primary health care services. Our results shed light on the statistical links between housing and routine use of primary health services (Milloy et al., 2012). Just as transitional housing is seen to impart the skills needed to access and maintain permanent independent housing, it also imparts the skills needed to access and maintain adequate health care. Support from transitional housing helped mitigate the difficulties associated with maintaining health care and social service appointments required by PHA. Similarly, transitional housing support made residents aware of existing services previously not known. While health and social services may already be widely available to PHA, such availability is not of any use or benefit if unstably housed PHA are not aware of such care or are not situated in a social context that can assist in managing the demands associated with that care. In other words, transitional housing played a key role in removing barriers to these services.

The strength of our research is in our contribution to the literature on housing as a social determinant of health. Our research documents the specific housing mechanisms that impact health. Where previous studies in Ontario (and elsewhere) have sought to document the experiences of precariously housed PHA, our findings demonstrate the ways in which health can be facilitated through housing support services. Unlike Hawk and Davis (2012), the design and scale of the THS precludes a reliable analysis of clinical outcomes that might result from residency in transitional housing. This proviso notwithstanding, some of our participants did report health benefits while in transitional housing. One participant stated:

> Before I left [the transitional housing] I got on medication. After 4 weeks, a month probably, my viral load was undetectable, you know within 4 weeks, and my CD4 count increased immensely and I never had any health issues while I was here. Not even headache[s] or anything and I guess I was happy staying here and I take my medication on time and I see my doctor at the right time and I do whatever I've got to do to make me happy. I guess happiness lies with good health.

These general improvements to health are at least partly the consequence of the support offered in and through transitional housing for PHA. Thus, broad-based support in conjunction with those individuals reported here improves health. In turn such health improvements increase the likelihood of sustainable, independent, and permanent housing for unstably housed PHA.

Given our findings, transitional housing—irrespective of its targeted population—should provide the kinds of support identified in this article. Since transitional housing specifically for PHA is limited in Ontario and elsewhere, unstably housed PHA are likely to access other affordable or transitional housing options not specific to PHA. This situation requires housing agencies to provide training to both management and frontline workers not only on the social and health dimensions of living with HIV/AIDS, but also on the support specifically accessed and required by PHA. In short, unless and until more resources are available to increase transitional housing or more supportive housing for PHA more generally, the nonprofit housing sector must fill the gap that exists to address the needs of PHA.

Conclusion

To conclude, this study identified the range of supports accessed by PHA in transitional housing. The contention of this article is that these supports constitute the concrete processes through which PHA residents might achieve health in a transitional housing program. However, the study has a number of limitations. First, this study can only allude to long-term benefits of transitional housing for PHA on housing stability. Althouth participants in the study claimed a change of life trajectory, only some advanced to independent housing after their tenure in transitional housing. Some reported relapses into uncontrolled substance use that mired attempts to access and maintain stable housing. Some transitioned to permanent

supportive housing services for PHA. Others reported having found stable so-called market rent, non-HIV designated housing. These reports cannot be treated definitively as the general effectiveness of transitional housing. Outcome measures such as the capacity to secure permanent housing and employment would best be gleaned from a longitudinal cohort study, which would follow residents across a time-span beyond their residency in transitional housing. Furthermore, such outcomes, as Fischer (2000) suggests, must be considered in light of regional indices such as housing availability and employment rates.

Second, clinical data (e.g., CD4 count) of participants were not collected because the THS was primarily interested in PHA experiences in transitional housing. The reliance on participant self-reports (of health) prevents a distinction between the experiences of those participants in our study who may be HIV positive and those who are living with AIDS. While our conflation of the needs of people who are HIV with those who have AIDS does not necessarily undermine the results from our study, such an elision renders problematic the use of our results as justification for the implementation of housing supports in some locations in the United States because funding and resources are reserved for PHA who are diagnosed specifically with AIDS.[1]

These limitations give some direction for future research on transitional housing for PHA. First, future research might build on the present study through an examination on the long-term effects of transitional housing. While our qualitative study has identified the housing processes (i.e., supports) through which health and housing stability might be achieved, quantitative research might definitively conclude the outcome of these processes on health and long-term housing stability among PHA. Second, future research might better distinguish between people living with HIV and those living with AIDS. There may be differences in housing needs between people living with HIV and those living with AIDS. Understanding this distinction in future housing research would better inform how funds should be allocated in relation to those needs.

There has been a developing body of research on the role of transitional housing for marginalized populations. The current work furthers efforts to advocate for accessible transitional housing for PHA. Through the identification of concrete transitional housing supports the research presented here provides some direction for service providers, policymakers, and housing advocates to ensure that transitional housing can meet the needs of PHA.

[1] We would like to thank an anonymous reviewer for bringing this to our attention.

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