

Coping amidst an Assemblage of Disadvantage: A Qualitative Metasynthesis of First-Person Accounts of Managing Severe Mental Illness while Homeless

Abstract

Introduction

An evidence gap concerning the impact of extreme socio-structural disadvantage, such as homelessness, on the nature and effectiveness of coping with severe mental illness (SMI) persists. While existing reviews of qualitative research into homelessness have focused on processes such as escaping homelessness and managing concurrent problem substance use, as well as on the experiences of specific vulnerable groups such as women and youth, no analogical review has been dedicated to the management of SMI during an episode of homelessness.

Aim/Question

A qualitative metasynthesis of first-person accounts was conducted to understand how individuals cope with SMI when experiencing homelessness.

Method

The systematic search strategy yielded 481 potentially eligible sources. Following a team-based full-text screening and a two-tiered quality appraisal procedure, 14 studies involving 377 participants with lived experience were synthesized following Noblit and Hare's metaethnographic method.

Results

Seven third-order concepts were derived capturing the complex nature and processual character of coping, as well as the contextual influences upon coping strategies. The resultant line-of-argument synthesis reveals the dialectical interaction between the two higher-order constructs- '*the continuum of coping*' and '*the assemblage of disadvantage*'.

Discussion

Despite the profoundly adverse impacts of biographical and socio-structural conditions, many individuals mobilised internal and external resources to enable various coping processes. Coping in the context of multiple disadvantage is not a monolith but rather a multidimensional, contingent and fluid phenomenon.

Implications for Practice

Nursing practice should espouse a humanizing, structurally competent, and strengths- and meaning-oriented approach in order to meet the complex and multifaceted needs of such multiply disadvantaged persons.

Keywords: serious mental illness; homeless; coping; disadvantage; qualitative synthesis

Accessible Summary

What is known on the subject:

- Understanding what strategies individuals use to cope with serious mental illness is vital for enhancing their quality of life, mental well-being, and effective use of services, and for supporting their mental health recovery;
- An episode of homelessness can be a profoundly disruptive event that often leads to chronic stress, social isolation, a negative belief about oneself, restricted access to care, among other adverse experiences;

What the paper adds to existing knowledge:

- In contrast to existing reviews of qualitative research focusing on escaping homelessness, managing problem substance use and growing resilience, the current review offers an in-depth, interpretive account of coping with serious mental illness during an episode of homelessness;
- This paper integrates evidence showing the diverse and intricate processes via which homelessness can impede an individual's ability to successfully cope with life stressors, including with serious mental illness;

- Despite experiencing severe social disadvantage, many individuals demonstrate positive adaptation and coping, and even personal growth;

What are the implications for practice:

- It is important to be aware of the many ways in which coping with serious mental illness can be influenced by adverse environmental factors such as poverty, homelessness, traumatic life experiences, and institutional discrimination;
- Nursing practice should recognize that coping efforts in individuals facing multiple forms of social disadvantage may be shaped by particular life events, institutional interactions as well as by the stresses and strains of living on the streets;
- Nursing practice should focus not only on reducing clients' mental illness symptoms and facilitating positive coping behaviours, but also on encouraging clients to leverage inner resources for personal growth and meaning-making.

Relevance to Mental Health Nursing

This review paper has direct relevance to nursing practitioners who seek to deliver holistic and person-centred care that meets the complex and multifaceted needs of persons with serious mental illness that are experiencing an episode of homelessness. This paper offers an insightful integration of qualitative research evidence on the various and profound ways in which homelessness (among other forms of structural disadvantage) impedes one's resources and opportunities for positive and successful coping with serious mental illness. This paper hopes to increase nursing practitioners' knowledge of how to best support those multiply marginalised individuals' symptom management, personal growth, and holistic well-being.

Introduction

Research into coping with illness symptoms and the impact of coping on daily functioning in individuals experiencing serious (or severe) mental illness (SMI) has resulted in the prolific generation of various typologies of coping ‘strategies’, ‘styles’, and ‘resources’ (Phillips et al., 2009; Roe et al., 2006; Skinner et al., 2003; Meyer, 2001). For instance, Phillips and colleagues’ (2009) systematic review revealed a multitude of coping strategies that individuals with psychosis flexibly mobilise, often simultaneously, to cope with their illness symptoms as well as with the general demands of daily life. Those strategies span general predispositions (coping styles) and situation-specific and often reactionary responses to illness-induced stress (coping responses and strategies). Other reviewers have typologised coping efforts according to their temporal ordering relative to the stressor (e.g. reactive, anticipatory and preventive coping; Roe et al., 2006), their dimension (e.g. emotion- and problem-focused coping; Schwarzer & Taubert, 2002), and the degree of change that occurs within the individual as a result of coping (e.g. assimilative and accommodative coping; Schwarzer & Taubert, 2002).

The abundance of psychological theorising underscores the significance of coping for understanding not only the complexity of the lived experience of service-users, but also for enhancing intervention effectiveness and the quality of care. For instance, Kravetz and Roe (2007) view coping as ‘*a potentially empowering activity that is a major part of the behavioral and experiential repertoire of individuals with SMI*’. (p. 337), while Yanos and Moos (2007) emphasize coping as one of the crucial determinants of good quality of life among people with schizophrenia. Others have highlighted research into service-users’ individual strengths and coping resources as integral to person-centred interventions that build upon service-users’ own assets and capabilities (Cleverley & Kidd, 2011; Kidd, 2003). Successful coping strategies have been shown to enhance the individual’s psychological resilience against adverse life events (e.g. Lindsay et al., 2000; Cronley & Evans, 2017, for a review). Furthermore, the empirical focus on coping behaviours has shown potential for identifying a range of health-promoting resources—both intrinsic (e.g. inner strengths, abilities and attitudes) and extrinsic (e.g. informal and formal support systems; Kidd, 2003, for a review; Cronley & Evans, 2017, for a review; Thompson et al., 2016).

Crucially, the nature and effectiveness of coping strategies tend to vary from individual to individual, with ineffective and potentially harmful coping strategies (sometimes termed '*maladaptive*')- such as substance use as self-medication for mental illness symptoms, behavioural disengagement, self-distraction, and others-receiving substantial empirical attention (e.g. Moore, Biegel, & McMahon, 2011). Many maladaptive coping strategies have been associated with a range of adverse outcomes such as symptom relapse, non-adherence to formal treatment, self-harm, low quality of life, and others (Aldao & Nolen-Hoeksema, 2012). Understanding the nature of coping mechanisms is therefore imperative for optimizing individuals' engagement in services, treatment effectiveness and general social functioning (Thompson et al., 2016).

Research into coping with SMI amidst profoundly *disempowering* conditions such as severe poverty and homelessness, however, has been markedly scarcer. Living with multiple, mutually reinforcing forms of socio-economic disadvantage is often synonymous with a '*unique and complex experience of marginalisation*' (Kramer-Roy, 2015, p. 1209). Persons with SMI who are homeless, in particular, often have multiple and complex needs, for instance, in terms of their increased susceptibility to self-harm, social isolation, interpersonal violence, illicit substance use, discrimination, physical health problems, offending, institutionalisation, and others (Scottish Executive Social Research, 2007; McCay et al., 2010). Importantly, such adverse life experiences have been shown to undermine those individuals' capacity to meet the demands of both illness-related and general life stressors (McDonagh, 2011; United States Interagency Council on Homelessness, 2015; Padgett et al., 2008).

Although there is a considerable amount of empirical literature on *general* coping strategies and mechanisms (e.g. Phillips et al., 2009), markedly less is known about *how* those coping processes manifest themselves in the context of severe poverty and/or homelessness (Klitzing, 2003; Gottlieb, 1997; Tischler et al., 2007; Washington & Moxley, 2008). The dominant theorising in the field, commonly rooted in a reductionist, psychologised view of coping, has been criticized for neglecting the socio-structural contexts, and the associated inequalities, that may undermine individuals' ability to mobilise resources for coping (Potter et al., 2018). As Potter and colleagues (2018) note, '*While coping may appear to happen on a personal level, as an ongoing process coping emerges through people's interactions with their*

social and cultural environments.' (p. 140). Ethnographic and other qualitative empirical investigations of how SMI is experienced and managed amidst homelessness offers the crucial opportunity to (re)contextualise the process of coping as '*woven into the tapestry of life*' (Gottlieb, 1997, p. 10) for individuals impacted by structural disadvantage and chronic life stressors (Klitzing, 2003; Ungar, 2012; Yanos & Moos, 2007; Ryan et al., 2014).

The unpredictability, chronicity, and graveness that commonly characterize the experience of homelessness are likely to pose profound challenges to the effective coping with, and recovery from, SMI (Padgett et al., 2012; 2016; Yanos, 2007; Klitzing, 2003; Gottlieb, 1997). Several lines of research have demonstrated the profoundly negative effects of extreme poverty and homelessness on vital enablers of positive coping, including mental health recovery (Kirkpatrick & Byrne, 2009), a positive self-concept (Padgett, 2007), social connectedness (Padgett et al., 2008), hope (Kirst et al., 2014), self-esteem, and self-efficacy (Watson & Cuervo, 2017).

Rationale

While existing reviews of qualitative research into homelessness have focused on resolving and transitioning out of homelessness (Finfgeld-Connett, 2010; Iaquina, 2016); the management of concurrent problem substance use (Finfgeld-Connett et al., 2012); the experiences of women (Finfgeld-Connett, 2010; Phipps et al., 2019); and the phenomenon of resilience in homeless youth (Cronley & Evans, 2017), no analogical QES has been dedicated to the management of SMI. A systematic review of qualitative and other idiographic research with marginalised, 'hard to reach' and other groups experiencing intersectional disadvantaged (for instance, based on disability status, housing status, socio-economic status, and so on) holds promise for revealing the often hidden complexity of living with severe and multiple disadvantage (Phipps et al., 2019). Amidst persistent calls for enhanced interprofessional practice with people experiencing severe and multiple disadvantage, a QES of studies with homeless populations from within the fields of social work, public health, nursing, and psychiatry seems timely (Duncan & Corner, 2012).

Review Question, Aims and Objectives

Motivated by this recognition of the importance of the context-sensitive investigation of coping processes, especially in multiply disadvantaged populations, a qualitative evidence

synthesis (QES; Aguirre & Bolton, 2014; Walsh & Downe, 2005) was undertaken to generate an enhanced, integrative and systematic understanding of *how individuals cope with SMI when experiencing homelessness* (the review question). To our knowledge, this is the first published attempt to systematically synthesize original qualitative and mixed-method research into first-person accounts of coping with SMI during an episode of homelessness.

Methods

The current work adhered to the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) guidelines (Tong, Flemming, McInnes, Oliver, & Craig, 2012).

The synthesis methodology is *qualitative metasynthesis*- a systematic, inductive and interpretative approach to synthesising the findings from empirical qualitative studies (Zimmer, 2006; Walsh & Downe, 2005; Jensen & Allen, 1996). Although variations exist in the techniques used to conduct a metasynthesis, common analytic steps in this approach are '*...a comparison, translation, and analysis of original findings from which new interpretations are generated, encompassing and distilling the meanings in the constituent studies...*' (Zimmer, 2006, p. 312). The final phase of a meta-synthesis typically involves synthesizing the translations to elucidate more refined meanings, theories, and concepts (Walsh & Downe, 2005), and even to inform health and social policy (Zimmer, 2006). The final, 'synthetic' product represents a third-order interpretation-that is- '*... the synthesist's interpretation of the interpretations of primary data by the original authors of the constituent studies...*' (Zimmer, 2006, p. 313).

The current review employed the analytic steps essential to Noblit and Hare's (1988) metaethnography (see 'Data Analysis Strategy'). The data analysis in the current review was also informed by more recent guidance on conducting a metasynthesis (Atkins et al., 2008; Campbell et al., 2012; Lee et al., 2015).

The underpinning epistemology was *objective idealism*, which assumes that there is a world of collectively shared understandings (Barnett-Page & Thomas, 2009; Kearney, 1998). This philosophical positioning remains faithful to the core tenets of the interpretive paradigm,

while allowing for the meaningful integration of qualitative findings from diverse research contexts and empirical traditions (Zimmer, 2006).

Search Strategy

A pre-planned comprehensive search of five electronic databases (Scopus, PsycINFO, MEDLINE, CINAHL Plus and Social Services Abstracts) was conducted. The search utilized broad-based, free-text terms (e.g. *'experience'*; *'homeless/ness'*; *'mental'*; Shaw et al., 2004) and methodological filters (e.g. *'qualitative'*, *'mixed*'*, *'ethnograph*'*, *'interview*'*), in conjunction with qualitative research indices, where available (e.g. *'qualitative studies'*, *'qualitative research'*, *'qualitative methods'*, *'nursing methodology research'*; Shaw et al., 2004). The full electronic search procedure can be found in 'Supplementary Files'. In recognition of the inconsistencies of indexing of qualitative research in electronic databases (Booth, 2016; Barroso et al., 2003), to maximise the retrieval of potentially relevant articles, the electronic search was supplemented by bibliographic searches within the eligible studies, citation searches, and bibliographic searches within topical review papers (Finfgeld-Connett, 2010; Seitz & Strack, 2016; Edidin et al., 2012; Cronley & Evans, 2017; Iaquina, 2016; Finfgeld-Connett et al., 2012).

Inclusion Criteria

Eligible studies were published in or after 1994 (the year when the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders was introduced), in the English-language and represented original peer-reviewed empirical qualitative or mixed-method articles. In addition, all participants had to be 18 years of age or older, with a history of an SMI diagnosis (either self-reported or independently verified) and be defined as homeless at the time of data collection (unless the study features retrospective accounts of homelessness). Also, all included studies needed to fulfil a set of quality assessment criteria (See below). Non-empirical documents (e.g. conceptual papers, policy papers, review-type papers, commentaries) and unpublished studies were excluded. Finally, to ensure sufficient alignment with the review question (operationalized as the 'conceptual clarity' criterion; See 'Quality Appraisal'), eligible studies had to contain at least one theme addressing the experience of SMI, particularly the coping process. To optimize the inclusion of diverse representations of the phenomenon under inquiry (Jensen & Allen,

1996), *coping* was operationalized broadly as the conscious efforts to ameliorate and/or prevent the negative influences of SMI requiring the cognitive appraisal of a stimulus as problematic or threatening, the conscious assessment and mobilization of available resources for coping, and a commitment to coping action (Folkman & Lazarus (1988), as cited in Andersson & Willebrand (2003).

Abstract Screening and Full-Text Review

A team-based approach to the screening, full-text review and quality appraisal was implemented to enhance the rigour of the review process. The search and screening phases took place between December 2017 and February 2018. The literature review software, Covidence™ (<http://www.covidence.org>), was used to facilitate the title and abstract screening and full-text eligibility appraisal. The main electronic search was split between the first and the third authors. The full-text eligibility appraisal was carried out by all three authors. To progress through to the quality appraisal stage, each study had to be voted in independently by two of the authors. Covidence™ facilitated the inter-rater agreement and conflict resolution. Any voting conflicts were resolved at periodic team meetings.

1035 documents were imported for screening (1024 documents retrieved from electronic databases, and 11 from bibliographic searches; See ‘Figure 1’). After duplicates were removed, 481 studies remained for full-text eligibility assessment. 462 of those studies were excluded from the review due to not meeting the eligibility criteria (See ‘Figure 1’, for a breakdown of the reasons for exclusion). As a result, 19 studies that fully met the inclusion criteria were progressed through to the quality appraisal stage: Baldwin (1998); Bonugli et al. (2013); Gopikumar et al. (2015); Illman et al. (2013); Jensen (2017); Johnson et al. (2013); Kirkpatrick & Byrne (2009); Leipersberger (2007); Luhrmann (2008); Macnaughton et al. (2016); Muir-Cochrane et al. (2006); Patterson et al. (2012); Paul et al. (2018); Shibusawa & Padgett (2009); Stanhope & Henwood (2014); Stolte & Hodgetts (2015); Voronka et al. (2014); Wharne (2015); Zerger et al. (2014).

Quality Appraisal

A two-pronged approach to quality appraisal that operationalized ‘quality’ as the combination of adequate methodological rigour and adequate conceptual clarity was followed (Toye et al., 2013;

Malpass et al., 2009). The rationale behind quality appraisal being a determinant for inclusion is based on the assertion that studies of low quality are less likely to meaningfully contribute to the synthesis output and are likely to undermine the trustworthiness of the overall review process (Malpass et al., 2009; Campbell et al., 2012). Methodological rigour was assessed using an adapted version of the RATS (Relevance, Appropriateness, Transparency and Soundness) screening tool (Clark, 2003; 'Supplementary Files'). The RATS scale consists of 21 items, which can collectively yield a maximum score of 42. The threshold for adequate methodological rigour was set as 14 (Clark, 2003). Initially, a random selection of five of the included studies was allocated a methodological score by each author. Inter-rater agreement was assessed to be adequate (The pairwise correlations between the authors' RATS scores were 0.79; 0.99; and 0.77, respectively). Based on those estimates, it was decided that the remaining 14 studies would be split evenly and distributed among the three authors and would require only one score.

Adequate conceptual clarity of the studies that make up the metasynthesis is essential for enabling an enhanced integrative interpretation of the phenomenon of interest (Campbell et al., 2011; Toye et al., 2013; Toye et al., 2014). We operationalized conceptual clarity as the presence of a sufficient number of 'intelligible concepts' or 'metaphors' (Noblit & Hare, 1988) that could facilitate the understanding of the phenomenon under study as well as theoretical insight (Toye et al., 2013). All three authors independently assessed all 19 studies for conceptual clarity, assigning a score of two (high), one (acceptable) or zero (low) to each study. An adequacy threshold of a cumulative score of three was used.

As a result of the two-step quality appraisal process, two studies, Baldwin (1998) and Wharne (2015), were excluded due to low methodological rigour (i.e. <14 total RATS score). Another three studies, Kirkpatrick and Byrne (2009), Johnson et al. (2013), and Macnaughton et al. (2016), were excluded due to inadequate conceptual clarity. As a result, 14 studies were selected for inclusion in the metasynthesis (See 'Figure 1').

[Please insert 'Figure 1' here]

Data Analysis Strategy

The following four-step data analysis procedure was based on Noblit and Hare's (1988) guidance. In 'Step One', an exhaustive list of descriptive inductive codes was generated via line-

by-line coding of the Results/Findings sections of the included studies. The first-order (i.e. participant quotes) and second-order (the interpretations of the authors of the original studies) in each paper were extracted and coded together. Several of the paper used participant quotes sparingly-in those cases, the analysis relied primarily on the findings presented by the authors in the original studies. The coding was restricted to the results/finding section since the inclusion of the 'Discussion' sections would likely have introduced theoretical concepts and findings from other studies thus conflicting the idiographic, bottom-up logic of the metasynthesis.

The aim of 'Step One' was to identify and extract 'intelligible' metaphors, concepts, phrases and ideas that faithfully captured the original meanings of the primary data (Noblit & Hare, 1988; Toye et al., 2014). This was achieved by a process of open coding whereby the researcher creates categories of meaning corresponding to a unit of information in the primary studies (Creswell, 1998). Each unit of information represented a component of the phenomenon of interest (i.e. the experience of and coping with SMI). Codes could be in-vivo codes (i.e. the actual words used by the participants themselves, or by the authors of the primary studies) or descriptive codes that closely resembled the primary data. Examples codes include those related to a specific coping strategy (e.g. '*seeking refuges and sanctuaries to manage mental well-being*';(Stolte & Hodgetts, 2015)-coded as '*seeking refuges and sanctuaries*', and subsequently placed under the 'coping behaviours' category; See 'Table 1'); to an aspect of the context that is relevant to coping (e.g. '*negative social attitudes*'); or to a belief about oneself or about one's life that had relevance to whether and how one coped with SMI (e.g. '*hope for the future and appreciation for life*'; Bonugli et al., 2013). This step required constant reflectivity on part of the researcher as to the relevance of the data to the coping experience.

'Step Two' followed the principle of *reciprocal translation* (Noblit & Hare, 1988), whereby substantive analogies among the initial codes were drawn based on thematic relatedness. This step entailed progressively transforming codes into a higher degree of conceptual abstraction resulting in the development of a set of *third-order constructs* (a third-order interpretation of the participants' accounts) that helped capture the 'essence' or totality of the extracted data in an economic and insightful way (Toye et al., 2014). This process resembled Noblit and Hare's (1988) step of *metaphoric reduction*. A translation table (See 'Table 1', for the

translation table) was constructed demonstrating the derivation of third-order constructs from the original data.

‘Step Three’ involved assessing the adequacy of the initial list of third-order constructs. This was achieved by iteratively de-contextualizing and re-contextualizing the third-order constructs by developing and re-examining a concept-context matrix (see ‘Table 2’). This technique helped preserve ‘*essential contextual information*’ as the analysis progressed (Britten et al., 2002, p. 211; Lee et al., 2015).

The authors also remained vigilant of instances where the concepts were challenged or contradicted (*refutational synthesis*; Noblit & Hare, 1988). No apparent contradictions were identified among the concepts extracted from the individual studies. Instead, each study’s findings illuminate a different aspect of the third-order constructs. In other words, the concepts derived from the included studies had a reciprocal and a line-of-argument relationship among them (France et al., 2014).

In ‘Step Four’, the relationship among the concepts was expressed via a line-of-argument synthesis (Noblitt & Hare, 1988; Lee et al., 2015). The aim was to produce a final narrative or a synthesizing argument that accounts for, and integrates, all the data (Lee et al., 2015), and answers the review question. Also, following Noblit and Hare (1988), we focused on ‘*making a whole into something more than the parts alone imply*’ (p. 28). That is, the synthesizing argument was constructed to express an enhanced, novel and integrative understanding of the phenomenon under inquiry (Noblitt & Hare, 1988; France et al., 2014).

NVivo 11 was used to enhance the rigour of the coding process. The initial stages of the data analysis were carried out by the first author. The second and third authors audited the list of concepts and any necessary revisions were made following team discussions. Memoing of all analytic decisions and potential author biases (in the form of an audit trail), in addition to group reflexivity among the authors, was used to further enhance the rigour of the data analysis (Lee et al., 2015). Yet, the metasynthesis is an inherently interpretive process and the current authors have generated one of many possible interpretations of the current data set (Jensen, 1996).

Findings

Overview of the Design Characteristics of the Included Studies

Six of the included studies were conducted in the United States, five-in Canada, and the other three-in India, Australia, and New Zealand (See ‘Table 3’). The majority of the studies (eight) employed a traditional qualitative interview-based research design (Note: One study, Stanhope and Henwood (2014), conducted individual in-depth interviews in the context of a community-based participatory programme); three studies used an ethnographic design (including one ethnographic case study design; Stolte & Hodgetts, 2015); and three-a mixed-method design. The predominant data collection tool in the current sample of studies were in-depth individual semi-structured interviews. A minority of studies employed additional data gathering techniques such as participant observation, go-along interviews, photo-elicitation interviews, personal timelines and focus groups. Data analysis techniques of choice included content or thematic analysis (in five studies), grounded-theory based analysis (in four studies), phenomenological analysis (in one study), and non-specified analytic approaches (in four studies; Note: One study, Voronka et al. (2014), used peer-led data analysis).

The total number of participants with lived experience in the current sample of studies is 377 (52% female; Note: One study, Jensen (2017), did not report gender characteristics of the sample). The sample sizes range from one to 61. Participants’ housing status varied, including street homeless, and residing in shelters, supportive housing, or permanent and independent housing (for example, Housing First residents). Common mental health diagnoses among the participants included psychotic disorders (such as schizophrenia), major depressive disorder, post-traumatic stress disorder, and others. A summary table of the design components and methodological scores of the included studies can be found in ‘Table 3’.

Overview of the Findings of the Metasynthesis

The analysis resulted in the derivation of seven third-order constructs (See ‘Table 1’, for the translation table), which were grouped into two clusters of higher-order constructs: *continuum of coping* and *assemblage of disadvantage*. Those higher-order constructs were derived after examining the emergent third-order constructs for commonalities and differences among them. It first became apparent that the different manifestation of coping could be ‘arranged’ along a continuum-from the highly reactive coping as survival to the much more deliberative and reflective coping as meaning-making. The remaining third-order constructs represented the embeddedness of those coping processes in a range of influential contexts-from participants’ unique biographies to their shared experience of stigmatization.

1. Continuum of Coping

This cluster of analytic themes begins by examining how the demands for self-preservation deplete internal resources-such as time and focus-required to initiate efforts to cope with the symptoms of mental illness. Next, strategies targeted at ameliorating SMI are distilled, distinguishing between successful and unsuccessful (including maladaptive) coping, and between facilitators of and barriers to coping. Then, participants’ personal commitments, priorities and goals are synthesized, which all represent possible sources of motivation for more effective coping. The processes of reflection and meaning-making were also extracted from the data as distinct types of coping. The corresponding third-order constructs are, as follows:

- 1.1. Survival strategies and adaptations to life on the streets;
- 1.2. Coping with SMI and its impacts;
- 1.3. Personal reasons and motivations for coping;
- 1.4. Reflection and meaning-making;

2. Assemblage of Disadvantage

This cluster of analytic themes captures the multiplicity of what are primarily external influences upon the nature, content and effectiveness of coping with SMI. Specifically, the impact of personal biography, including adverse life events; the impact of structural barriers rooted in

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systems of care; and the impact of attitudinal structures such as stigma, are discussed. The corresponding third-order constructs are, as follows:

2.1. Context of early life: Emotional and psychological consequences of traumatic and other adverse life experiences;

2.2. Structural barriers to receiving effective health care and social supports;

2.3. Pervasive complex social stigma and its impact

[Insert 'Table 1' here]

[Insert 'Table 2' here']

[Insert 'Table 3' here]

Survival Strategies and Adaptations, and their Impact on Coping with SMI

The majority of included studies (eight) offered accounts of the stresses and strains of poverty and homelessness, as well as of the adaptations that individuals had developed to self-preserve. Those adaptations referred to various day-to-day tactics and internalised predispositions that ensure (physical) survival and the effective management of general life stressors. Specifically, the chronic stress, precarity, extreme poverty, the exposure to violence and other adverse environmental stressors led some participants to engage in cautionary social distancing, constant vigilance, risk-taking, among other self-preserving strategies (See 'Table 1').

Often, however, the necessary preoccupation with survival and self-preservation *impinged upon* the individuals' efforts required to effectively access and mobilise the resources needed to cope with the symptoms of SMI. For instance, one of Illman et al.'s (2013) participants poignantly stated (p. 218): *'I am not trying to recover now because there's, there's, there's no need, it's survival nowadays is, no conditions, the way the conditions are these days. It's just, it's survival you know.'* Similarly, many of Stanhope and Henwood's (2014) participants discussed the immense difficulties of attending to their health needs amidst severe economic deprivation and housing instability.

For some participants, a profound consequence of homelessness and poverty was social disaffiliation, which had far-reaching effects on those participants' sense of self-worth, on the quality of their social supports, and on their recovery. To demonstrate, Shibusawa and Padgett

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(2009) report that: *'Many of the participants struggled with feelings of being out of sync with their "normal" peers. Some attributed this to the severe deprivation of homelessness and accompanying survival mechanisms.'* (p. 192). According to Shibusawa and Padgett's analysis, the stigma and alienation that some participants experienced entrenched their (internalized) feelings of 'abnormality', which, in turn, hindered their efforts to reintegrate into society as productive members.

Tensions and contradictions often emerged between the behaviours and predispositions that were adaptive for living on the streets and those that were adaptive for successfully navigating the health and social services sector and receiving appropriate help. For some of the participants, the aptitudes that have adaptive advantages on the streets (e.g. being tough, displaying strength) were antithetic to those that helped someone benefit from services (e.g. seeking help, developing trust; Luhrmann, 2008; Stanhope & Henwood, 2014; Bonugli et al., 2013). Patterson and colleagues (2012) use the metaphor of 'hardening' to denote some of their participants' social distancing and lack of trust for others due to long-term social exclusion and disadvantage. This is also echoed by one of Luhrmann's (2008) participants: *'You have to keep your guard up at all times...'* (p. 17). In contrast, fully benefitting from peer support entailed sharing personal experiences in an open and authentic manner, as well as forming meaningful bonds with the group members (Stanhope & Henwood, 2014).

Coping with SMI and its Impacts

All 14 studies contained accounts of distinct strategies and other behaviours specifically enacted to manage, mitigate, and/or cope with, the symptoms of SMI. Across those studies, coping manifested itself across various domains-the psychological (or cognitive), the affective, the relational (or interpersonal), and the instrumental (or behavioural) domains. To demonstrate, while some participants emphasized the maintenance of optimism, pride and dignity, and normalized their experience of SMI (e.g. Paul et al., 2018; Gopikumar et al., 2015; Leipersberger, 2007; Bonugli et al., 2013), and identifying productive emotional releases (Jensen, 2017), others tended to report a range of behavioural strategies-such as engaging in peer support (Stanhope & Henwood, 2014), seeking formal help with medication management and seeking refuge (Muir-Cochrane et al., 2016; Stolte & Hodgetts, 2013), and staying active and engaging in various occupational activities (Illman et al., 2013; Stolte & Hodgetts, 2013).

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Among the key enablers of effective coping were also achieving emotional stability by (re)gaining control over one's health (e.g. Muir-Cochrane et al., 2006), developing an insight into one's health and life challenges (Paul et al., 2018), rekindling hope (Paul et al., 2018), and maintaining autonomy in daily life (Stolte & Hodgetts, 2013).

Furthermore, the *relational nature* of some of the reported coping behaviours emerged as another prominent aspect of coping with SMI. For instance, some participants tended to cope by searching for an 'anchor' in a significant other in response to feeling powerless (Paul et al., 2018). Similarly, staying connected to one's cultural and communal ties was another helpful response to the burden of SMI (Paul et al., 2018). Other participants found humor (an essentially social activity) to be a useful strategy for tackling the stigma associated with both mental illness and living in a homeless shelter (Jensen, 2017). The interpersonal aspects of coping with SMI are vividly demonstrated by Stanhope and Henwood's (2014) account of the value of peer support to their participants. The participation in peer support groups offered those participants a welcomed sense of connectedness—a common antidote to the experience of homelessness. Peer support also aided disclosure and provided assurance, in addition to increasing the participants' knowledge, confidence and sense of empowerment (Stanhope & Henwood, 2014).

Participants' accounts revealed that the enactment and maintenance of the aforementioned effective coping strategies tended to be hindered by a range of internal (e.g. referring to internalized maladaptive predispositions and/or coping responses) and external (e.g. socio-structural) barriers. For some participants, for instance, medication adherence was associated with practical, physiological and psychological barriers. Unsurprisingly, being homeless complicated medication-taking (Muir-Cochrane et al., 2006). Many participants reported substituting psychiatric medications with illicit substances, which served to blunt unwanted thoughts and emotions (*'Cause I didn't care, 'cause I was still using.'*; Leipersberger, 2007, p. 11; Muir-Cochrane et al., 2006; Shibusawa & Padgett, 2009). Other persistent barriers to effective coping include pessimism and hopelessness (Patterson et al., 2012; Zerger et al., 2014; Leipersberger, 2007), minimizing and hiding symptoms from others (Henwood & Stanhope, 2014), the fear of disclosure (Paul et al., 2018), and the lack of knowledge about available resources (Leipersberger, 2007).

Personal Reasons and Motivations for Coping

The participants in almost half (six) of the included studies offered accounts of some of their personal reasons and motivations for coping. The desire to (re)connect with one's 'true' self (Paul et al., 2018; Zerger et al., 2014), to return to normality and to achieve happiness (Leipersberger, 2007), as well as the belief in oneself and the possibility of a positive change (Paul et al., 2018; '*I have a lot more to grow on...*' (Bonugli et al., 2013, p. 833) were discussed by some participants as important drivers of positive coping. For other participants, fostering positive relationships with others-with their community, family and/or children-was a powerful catalyst of coping. For them, the process of social reintegration promised the restoration of their dignity, respect and trust (Zerger et al., 2014; Paul et al., 2018; Gopikumar et al., 2015). In addition, several participants poignantly shared their accumulated wisdom, awareness of their 'time left', the intrinsic volition for a meaningful and satisfying life-beginning to 'live', not just 'exist', and the potential opportunities to spread this wisdom and give back to others, as being important reasons to (continue to) 'do well' (e.g. Shibusawa & Padgett, 2009; Bonugli et al., 2013).

Reflection and Meaning-Making

A small proportion of studies (four or 29%) featured accounts of various reflective and/or meaning-making activities enacted by participants. Meaning-making can be defined as '*a global orientation*' related to the '*pervasive, enduring – though dynamic*' feeling that the individual has that the world is comprehensible, that the future challenges are manageable, and that efforts to overcome those challenges are meaningful and worthwhile (Lundman et al., 2010, p. 252, citing Antonovsky, 1988). Notably, those accounts demonstrate that such meaning-making processes are possible despite the existence of immediate stressors and the profound concerns that the individuals may have about their survival and well-being.

To demonstrate, some participants valued opportunities to pause, reflect and evaluate their past, present and desired future, which brought a sense of purpose, coherence and self-efficacy (Shibusawa & Padgett, 2009). Furthermore, some of Bonugli et al.'s (2013) participants engaged in introspective activities that lead them to rethink their past traumatic experience and nurture a sense of gratitude, reliefs and hopefulness, e.g. '*That leads me to believe that there's a purpose for me ... In this life, you know? And God has allowed me to go through all this stuff...*' (p. 833).

Practising faith and spirituality are other manifestations of such higher-order meaning-seeking activities that emerged from the data (Paul et al., 2018).

Yet, those quests for meaning were not bereft of anxieties and uncertainty. The sense of loss and regret, and the awareness of the finiteness of life caused some participants to experience significant existential concerns, as evidenced in Shibusawa and Padgett (2009).

Context of Early Life: Emotional and Psychological Consequences of Traumatic and other Adverse Life Experiences

This third-order construct captures significant aspects of participants' narratives in four (29%) of the studies. Collectively, adverse life experiences tended to carry profoundly negative social, emotional, psychological and existential consequences for those individuals. To demonstrate, some of Bonugli et al.'s (2013) participants reported a sense of social disconnectedness, hopelessness, powerlessness and unresolved anger, blame and guilt, as a result separation from the family and periods of victimization. Similarly, Patterson and colleagues' (2012) biographical narratives revealed '*[...] trajectories of accumulating risk and marginalization that contributed to their current experience of social devaluation, despair, and constrained choices.*' (p. 141).

The long and deleterious 'reach' of adverse life events is especially evident in some participants' accounts of their *current* despair, emotional pain, emotional disconnectedness, low self-esteem and apathy (Bonugli et al., 2013; Patterson et al., 2012; Gopikumar et al., 2015). Importantly, past traumatic and other negative life events seemed to hinder those individuals' current efforts, strategies and resources available to cope with SMI. For instance, the emotional 'blunting' and the internalized lack of trust in others seemed to prevent some participants' from effectively managing their illness symptoms, in the context of homelessness (e.g. Bonugli et al., 2015). Moreover, the existential loneliness, loss of touch with oneself and the sense of 'uprootedness' appeared to hinder opportunities to create coherence out of life (Bonugli et al., 2013; Patterson et al., 2012).

Structural Barriers to Receiving Effective Health and Social Supports

Numerous structural and systemic barriers located within the healthcare and other public systems negatively affected individuals' coping with SMI-both directly and indirectly- as

evidenced in six (43%) of the included studies (e.g. Voronka et al., 2014; Leipersberger, 2007; Stanhope & Henwood, 2014; Muir-Cochrane et al., 2006). Among the reported barriers to receiving effective mental health support were the restricted access to care due to financial and other structural barriers (Voronka et al., 2014; Muir-Cochrane et al., 2006), the distrust in health professionals (Stanhope & Henwood, 2014), and the humiliation and disrespect experienced as a result of health system encounters (Bonugli et al., 2013). Interactions with service staff were among the main sources of discontent; often, there was a lack of understanding from staff, as well as overt prejudice and discrimination (Voronka et al., 2014; Leipersberger, 2007). Past negative experience and/or anticipated negative encounters (due, for example, to social stigma and/or self-stigma/internalised stigma) were shown by some of the studies to perpetuate the clients' loss of self-worth, their neglected mental health needs and the clients' social disenfranchisement (e.g. Voronka et al., 2014). Furthermore, several participants pointed out that the dominant philosophy of care and institutional practices were unhelpful in their developing self-management skills and a degree of autonomy (Voronka et al., 2014). Some participants emphasized the importance of recovery- and social justice- oriented care, and the caring and responsive stance of services providers (Voronka et al., 2014).

Pervasive Complex Stigma and its Impact

The participants in most (ten out of 14) studies reported experiences of stigmatising attitudes by the general public, by their caregivers, and/or their social networks (Gopikumar et al., 2015; Bonugli et al., 2013; Patterson et al., 2012). Negative social attitudes tended to create alienation and marginalisation: *'This general feeling of being different, of being an outsider, was a common thread in participants' narratives.'* (Voronka et al., 2014, p. 265). The resultant social distancing impeded mental health recovery (Zerger et al., 2014). Some individuals internalised those negative social beliefs, which motivated continued social distancing and also led to a damaged sense of self, which, in turn, adverse impacted on coping with SMI (Zerger et al., 2014): *'The powerful negative experience of stigma both caused and exacerbated feelings of not being normal...'* (Shibusawa & Padgett, 2009, p. 192).

Furthermore, stigmatization and discrimination tended to occur across various axes of social division-including mental illness, disability, homelessness, gender, race and age (Bonugli et al., 2013; Shibusawa & Padgett, 2009; Gopikumar et al., 2015; Zerger et al., 2014).

Line-of-Argument Synthesis

A ‘Continuum’ of Coping

Collectively, constructs 1.1-1.4. comprise a ‘*continuum of coping*’, whereby individuals employ, often simultaneously, adaptive predispositions to maximize self-preservation, and problem- and emotion-focused coping behaviours to optimize illness symptom management, in addition to the processes of reflection and meaning-making to *transcend* the immediate stressors and to achieve a global sense of coherence. This continuum of coping processes is therefore enacted to meet those individuals’ multiple and complex needs- ranging from their immediate survival to the higher-order need for meaning and purpose in life. Crucially, the synchronization of those processes has to be achieved while navigating structural barriers-socio-material, attitudinal and ideological.

The Assemblage of Disadvantage

Constructs 2.1-2.3. capture the plethora of structural and biographical influences on participants’ coping. Those influences affected coping with SMI both directly-via ‘instilling’ concrete, often maladaptive, coping strategies, or indirectly-via limiting the resources and opportunities, tangible and intangible, for successful coping. On the whole, the nature and process of coping was shaped by biographical events, institutional interactions, the socio-cultural milieu, as well as by the daily hardship imposed by poverty and homelessness. The ‘*assemblage*’ (borrowing the term from Voronka et al., 2014) of disadvantage constrains the ‘continuum of coping’ in a multitude of ways.

Altogether, the ‘continuum of coping’ and the ‘assemblage of disadvantage’ concepts expand the understanding of the multiplicity and the contextual embeddedness of coping with SMI amidst severe and multiple disadvantage, and demarcate the critical components of the coping process. In particular, the current metasynthesis offers valuable insight into the relationship between influential contextual conditions (e.g. housing insecurity, poverty, responsiveness of services), internal (e.g. self-esteem) and external (e.g. social support) resources for coping, accountings of the motivation for more effective coping (e.g. a desired self; reconnecting with others), and a range of coping outcomes (e.g. negative/maladaptive

coping, successful coping, non-coping). The metasynthesis also identifies a number of contingencies, including the exposure to violence, the depletion of social support, the volatility of life on the streets, and institutionalization, that can profoundly undermine the management of, and the recovery from, mental illness. Such conceptualisation of coping as a multi-determined phenomena offers several potential avenues for interventions by support services aimed at maximizing coping capacities and empowering clients to achieve personally defined, desired outcomes. Ultimately, gaining an in-depth insight into the challenges to sustaining mental well-being, into the sources of vulnerability, into the structural determinants of coping, and into the dynamics of personal growth and recovery, is essential for helping initiate and sustain the mechanisms of change, both individual and societal, that enable better well-being.

Discussion

This metasynthesis sought to generate an enhanced, integrative understanding of how individuals cope with SMI while experiencing homelessness. Despite the relatively small number of reviewed studies (14), the current line-of-argument synthesis offers useful insights into the dialectical interaction between *the continuum of coping* and *the assemblage of disadvantage*, as evidenced through the first-person narratives of individuals with lived experience *and* through the primary studies' authors' interpretations.

Consistent with prior reviews on SMI (e.g. Phillips et al., 2009), the current metasynthesis found evidence of a wide range of coping behaviours. The additional insights offered by the current metasynthesis, however, pertain to the *origins* and *situational variation* of those coping behaviours in people facing an episode of homelessness. Specifically, it was found that the social ecology of 'street life' and that of public institutions tended to engender specific sets of coping responses-both effective and ineffective (including maladaptive ones). For instance, for some participants, the need for self-preservation in what can be a hostile, threatening and uncertain street and/or shelter environment can give rise to avoidance- (e.g. hypervigilance, social distancing, avoiding confrontation) and impression management-oriented (e.g. hiding vulnerabilities, displaying strength) coping strategies. Notably, for some of the participants in two of the studies, those survival behaviours were costly insofar as they diminished internal resources available for successful illness symptom management (Stanhope & Henwood, 2014; Illman et al., 2013). Certain institutional interactions (both experienced and anticipated) also seemed to shape coping behaviours. Several aspects of the attitudinal environment in both the shelter system and the health care system were deemed by some participants as unhelpful, including the lack of compassion and respect and the demeaning attitudes of staff (e.g. Voronka et al., 2014; Leipersberger, 2007; Patterson et al., 2012). Crucially, those adverse structural factors were often associated with stigmatization, which, in turn, tended to undermine the individuals' resources for coping, namely social connectedness, the continuity of care and the sense of self-worth. Among such adverse factors were the increased social marginalization, the

deepening of one's feelings of being abnormal, the 'assaults' on one's dignity, and the diminished prospects of help-seeking (e.g. Zerger et al., 2014; Luhrmann, 2008).

For many people who face concurrent homelessness and SMI symptoms, coping efforts must be enacted in the context of pervasive structural barriers, including complex stigma. Those structural barriers occurred both at the organizational or macro-level (e.g. bureaucratic barriers; Voronka et al., 2014) and the interactional or micro-level (e.g. difficulties in relating to and trusting professionals; Leipersberger, 2007). Importantly, those factors had negative implications for both formal coping (e.g. help-seeking; patient-provider interaction; Muir-Cochrane et al., 2006) and informal coping (e.g. lowered self-esteem; Bonugli et al., 2013). The accounts of many of the participants were imbued with experiences and perceptions of discrimination, marginalization and alienation caused by social attitudes (e.g. Bonugli et al., 2013). The detrimental effects of stigma were reported in terms of increased social distancing limiting the access to formal help; in terms of internalized stigma resulting in a damaged sense of self; and in term of an entrenched feeling of abnormality and deviance, among others (Voronka et al., 2014; Gopikumar et al., 2015). The existence of *intersectional stigma* was accounted for in several of the studies, which show the compounding effects of stigma based on mental illness, female gender, marital status, poverty and homelessness, and ethnicity (Zerger et al., 2014; Bonugli et al., 2013). The accumulating evidence of the effects of intersectional stigma on well-being warrants focused efforts by service-providers and policy-makers to ensure equity of care and outcomes for this underserved population.

In their seminal transactional model of coping, Lazarus and Folkman (1984) purport that coping is situation-bound and cannot be considered in generalized terms. What they fail to consider, however, is that current coping behavior may be (at least partially) borne out by an *'ongoing lifecourse process of adapting and accommodating to [...] destabilizing or threatening experiences.'* (Gottlieb, 1997, p. 4). The evidence of the 'rootedness' of present-time coping behaviours within some individuals' life experiences (life history) found in four of the included studies highlights the importance of a biographic approach for enhancing the *person-centred care* for those experiencing multiple disadvantage (McKeown et al., 2006; Padgett et al., 2008; Phillips et al., 2009). Notably, only two (14%) of the synthesized studies (Patterson et al., 2012; Shibusawa & Padgett, 2009) employed a life history approach as their main data collection tool.

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Overall, despite the relatively small number of topically relevant studies identified, the metasynthesis explicated the *multidimensionality* of coping with SMI amidst severe deprivation. Coping can manifest itself in seeking stability *and* in making change (Paul et al., 2018; Shibusawa & Padgett, 2009); in the hectic rhythm of routine activity *and* during the quiet moments of reflection (Stolte & Hodgetts, 2013; Shibusawa & Padgett, 2009); in the (in)voluntary social isolation to preserve the self, *and* in (re)establishing meaningful connections with others (Bonugli et al., 2013).

Finally, despite evidence of the theoretical and analytical utility of salutogenic concepts such as *inner strength* (Lundman et al., 2011), the inclusion of salutogenic concepts in the reviewed studies was markedly scarce. To demonstrate, *mental health recovery* is the main focus of only one study (Gopikumar et al., 2015), and is mentioned by only six (43%) of all included studies. Similarly, the term (*psychological*) *resilience* is invoked by only five (36%) of the studies, while (*inner or psychological*) *strength* is featured in four (29%) of the studies. This trend in the current sample of studies reflects the topical literature's preoccupation with vulnerability to the neglect of individuals' strengths and empowerment (Thompson et al., 2016; Thomas et al., 2012; Bender et al., 2007).

Strengths, Limitations and Reflexivity

First, the current metasynthesis was limited in its scope by including studies with adult samples only and with persons with a history of SMI (excluding, for instance, persons experiencing subclinical psychological distress, personality disorders, problem substance use only, and others). Second, to ensure the manageability of the analysis and the adequate methodological rigour of included studies, no gray literature was included. Third, the presence of our focal construct, coping with SMI, had to be subjectively extrapolated from the original accounts, which often proved challenging because of the inherently fluid nature of coping, especially in persons experiencing chronic stress, whereby coping with SMI can become indistinguishable from coping with general life stressors. This concern is echoed by Gottlieb (1997, p. 10), who notes that, in the context of chronic stress, '[...] *it is not meaningful to point to one set of behaviors and cognitions and say that they constitute coping, whereas all the rest is ordinary living.*' Fourth, despite the comprehensive search strategy, a relatively small body of work was

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located that met the current inclusion criteria, which seems to reflect the general paucity of research into coping with SMI in this population. However, this raises moderate concerns about the adequacy of the original data (Glenton et al., 2018). For the complete self-assessment of the confidence in the findings of the current metasynthesis, see 'Table 4'.

Future investigations should address the paucity of qualitative and mixed-method research exploring the lived experience of mental illness, including coping, in individuals with a history of SMI who are experiencing homelessness, especially in the U.K (lacking in representation in the current sample of reviewed studies).

Among the strengths of the current review are the comprehensive search strategy, the use of a two-stage quality appraisal strategy that minimized the risk of low-quality studies compromising the credibility of the findings, and the use of software (e.g. Covidence™; NVivo 11), where appropriate, enhancing the rigour and transparency of study screening, data extraction and synthesis procedures. Furthermore, the focal construct, coping with SMI, was purposefully defined broadly when approaching the literature in order to (a) minimise potential biases stemming from favouring any strong theoretical model of coping; and (b) allow 'coping' to emerge organically from the context of each individual study. Last but not least, through the reciprocal translation and the line-of-argument synthesis, the current metasynthesis achieved a relatively high degree of conceptual abstraction and synergy among the concepts of the original studies-thus increasing the potential of the findings to advance theory and inform practice.

Researcher reflexivity is essential for ensuring that the findings of the metasynthesis authentically represent the primary data (Lee et al., 2015). Reflexivity was practiced throughout the current metasynthesis by, for instance, holding regular team meetings to appraise key methodological decisions, and to illuminate any background knowledge and beliefs that might be biasing the review process. Nonetheless, the conduct of a qualitative metasynthesis is an inherently interpretive act; therefore, acute awareness of the potential influence of the reviewers' identities and cultural and disciplinary biases on the findings is warranted. The review team of the current metasynthesis is highly diverse-culturally, geographically, professionally and academically. It is comprised of a Bulgarian male (public health and health policy), an Asian female (social work) and an American female (social work) PhD students, the latter two of whom have had professional social work practice experience with persons experiencing

homelessness and/or mental illness. It is hoped that the diverse composition and expertise of the reviewer team contributed to a nuanced, inclusive and empathetic analytic perspective. Finally, the first author, who led the data analysis stage of the review, had an affinity towards the critical realist philosophy, particularly towards theoretical perspectives of the influence of the structure-agency nexus on mental health phenomena. This philosophical inclination might have inadvertently biased the line-of-argument synthesis.

Implications for Mental Health Nursing

The current metasynthesis elucidates the complexity and interconnectedness of the needs of multiply disadvantaged persons with SMI. Their support needs are likely to be unique, evolving and situated within complex social contexts (Fisher, 2015). The current findings emphasize the need for psychiatric and mental health nursing practice to espouse a (a) *humanizing*, (b) *structurally competent*, and (c) *strengths- and meaning- oriented* approach in order to meet the complex and multifaceted needs of persons with SMI that are experiencing homelessness. To begin with, the current findings exemplify the heterogeneity and uniqueness of the concurrent experience of homelessness and SMI. Moreover, the synthesis explicated various manifestations of human agency, including self-definition, goal-seeking, dignity, expansion of the self and the negotiation of structural barriers, among others. Those findings strengthen the call for humanizing practice in mental health nursing, which should adopt '*an understanding of others' worlds grounded in experiences of real people living through complex situations – the holistic context for understanding quality of life*' (Todres et al., 2007, p. 59; Todres et al., 2009).

Moreover, mental health and psychiatric nursing practice should extend beyond the narrow focus on 'coping efforts' and 'coping skills' as merely intrapsychic phenomena by developing adequate *structural competency* (Metzl & Hansen, 2014). Structural competency broadly refers to being cognizant of the structural and contextual 'forces' that shape clients' interactions with services, and clients' health-related behaviours and experiences more generally (Metzl & Hansen, 2014). Proponents of the strengthening of the structural competency of service-providers insist that '[...] *inequalities in health be conceptualized in relation to the institutions and social conditions that determine health related resources.*' (Metzl & Hansen, 2014, p. 127). As applied to the coping in the context of multiple disadvantage, such an orientation of care provision entails moving beyond the notion of coping with SMI as merely determined by

'internal psychological processes' (Holman et al., 2018, p. 393), and towards coping as at least partially shaped by enduring structural, cultural and contextual conditions. Appropriate nursing care should, therefore, include advocacy for eliminating structural barriers to accessing services and to maintaining positive mental well-being, as one its core missions.

Last but not least, nursing professionals should attempt to *'encompass [human] complexity in human lives, needs, desires and existential meaning'* (Kogstad et al., 2011, p. 480), by nurturing the individual's growth potential, in line with the personal recovery philosophy (Slade, 2010; Farkas et al., 2005). Beyond meeting the basic (survival) needs of people who are homeless and have SMI, and enhancing their coping skills, practitioners should attend to those individual's (intrinsic) striving towards meaning, coherence and self-transcendence (Runquist & Reed, 2009). To enhance one's well-being and possibly thrive despite those early life experiences, and their impacts, practitioners should aid service-users in marshalling resources for both coping and self-transcendence (Reed, 1991; Nygren 2005). Rooted in existentialism, self-transcendence entails marshalling of one's ability to concentrate beyond the immediate barriers and limitations (e.g. imposed by SMI symptoms, poverty and/or homelessness) and towards the *'...expansion of one's boundaries inwardly in various introspective activities, outwardly through concerns about others and temporally, whereby the perceptions of one's past and future enhance the present.'* (Nygren, 2005, p. 355, citing Reed, 1991), which, paradoxically can be triggered by vulnerability and adversity (Runquist & Reed, 2007; Roe & Chopra, 2003). An increased research focus on multiply marginalised individuals' own constructions of well-being, personally defined goals and sources of self-determination has the potential to inform holistic and recovery-oriented interventions (Thomas et al., 2012; Roe & Chopra, 2003).

Conclusion

Despite the profoundly adverse impacts of biographical and socio-structural conditions, many individuals with a history of an SMI who are facing an episode of homelessness mobilise internal and external resources to enable various coping and salutogenic processes. Coping in the context of multiple disadvantage is not a monolith but rather a multidimensional, contingent and fluid phenomenon. Qualitative evidence syntheses of the experience of coping with SMI can help

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unravel the multiple dimensions and the contextual embeddedness of this dynamic process carrying useful implications for both nursing research and practice.

Conflict of Interest

The authors declare no conflict of interest.

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Table 1: Translation table

Example first- and second-order data (i.e. participant quotes and authors' interpretations in the original studies):	Third-order data (i.e. the metasynthesis authors' interpretations): Descriptive categories (in bold italic) and 'child' codes (in non-italic):
A CONTINUUM OF COPING (a higher-order construct):	
<p>'...hypervigilance was displayed in maintaining heightened awareness...' (Bonugli et al., 2013); 'I am not trying to recover now because...there's no need, it's survival nowadays...It's just, it's survival...' (Illman et al., 2013); 'I don't let people get close to me.' (Bonugli et al., 2013); 'Female interviewees were more apt to talk about social distancing as a survival technique.' (Zerger et al., 2014); 'Many of the participants struggled with feelings of being out of sync with their "normal" peers. Some attributed this to the severe deprivation of homelessness and accompanying survival mechanisms.' (Shibusawa & Padgett, 2009); 'health-enhancing tactics' (Stolte & Hodgetts, 2015); 'Creating a landscape for temporary respite and care' (Stolte & Hodgetts, 2015); 'For many, the reality of life on the streets made it virtually impossible to both prioritize their health over the other challenges they faced and negotiate the logistics of managing their health without stable housing.' (Stanhope & Henwood, 2014)</p>	<p><i>Survival strategies and adaptations to life on the streets:</i></p> <p>Survival strategies; constant vigilance; health-enhancing tactics; cautionary social distancing; avoiding conflict and danger; hiding vulnerabilities; risky activities and risk-taking as a necessity; seeking respite in daily life; street smart; the struggle for survival made one feel 'out of sync' with normality; survival displaces foci on recovery and other needs; priority of basic needs; daily survival needs displace recovery; displaying strength</p>
<p>Coping behaviours (Paul et al., 2018); 'seeking refuges and sanctuaries to manage mental well-being' (Stolte & Hodgetts, 2015); 'He claims that these activities and interactions are important to his health and ability to 'stay sane' (Stolte & Hodgetts, 2015); 'repositioning stigma through humour</p>	<p><i>Coping with SMI and its impacts:</i></p> <p>Self-management as doing things and staying active; maintaining a sense of autonomy and control; coping as a lifelong process; coping with stigma through dignity and humour; occupational repertoires; maintaining pride; normalising SMI; psychological masking; seeking instrumental support;</p>

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<p>(Jensen, 2017); searching for an ‘anchor’ in a significant other in response to feelings of powerlessness (Paul et al., 2018); ‘There was also a degree of empowerment that resulted from the group...’ (Stanhope & Henwood, 2014); meaningful daily activities (incl. work and leisure activities; Paul et al., 2018; Illman et al., 2013); ‘Being indoors is a lot, I mean you get to have more time with yourself.’ (Stanhope & Henwood, 2014); ‘...drugs offered escape and relief.’ (Muir-Cochrane et al., 2006); side effects of medications (Muir-Cochrane et al., 2006); fear of medication (Leipersberger, 2007); ‘Being homeless made the most seemingly simple aspect of medication management a significant problem’ (Muir-Cochrane et al., 2006); internal barriers (Stanhope & Henwood, 2014); postponement; minimization of symptoms; hiding symptoms (Stanhope & Henwood, 2014); ‘...the profound sense of being alone reinforced their helplessness about finding a way out of their predicaments.’ (Zerger et al., 2014); perceiving a negative future as inevitable (Patterson et al., 2012); problem substance use as a barrier to successful coping with SMI and to reintegrating into society and to feeling ‘normal’ (Shibusawa & Padgett, 2009)</p>	<p>finding emotional releases; seeking refuges and sanctuaries; gaining an insight into difficulties and achieving (self)acceptance; maintaining ties with own (ethnic) community to help validate feelings related of illness and homelessness; finding an anchor; the value of informal supports; restoring one’s dignity; connecting with peers/mentors; seeking respite.</p> <p>Barriers to coping; maladaptive coping; SU as a coping mechanism for blunting unwanted thoughts and emotions; SU interfering with the positive effects of psychiatric medications; Treatment adherence difficulties; self-harm; depletion of informal networks; internal barriers; lack of knowledge of available help and resources; negative self-image; pride; reluctance to disclose symptoms of mental illness; pessimism; social distancing; negative experiences with social services and care providers; distrust towards others, including medical professionals; feeling degraded and humiliated</p>
<p>‘...definitely one of the big turning points because it simply allowed me to um, reevaluate things, you know, and just, and get my life together from there...Direction, just where was I heading... what was my purpose, you know...’ (Shibusawa & Padgett, 2009); time for self-reflection (Shibusawa & Padgett, 2009); goal-setting (Paul et al., 2018); ‘Participants’ reminiscences were often infused with a sense of agency about making changes in their lives...’ (Shibusawa & Padgett, 2009); ‘Participants were keenly aware of the toll in death and illness that their homeless peers had suffered and suspected</p>	<p><i>Reflection and meaning-making:</i></p> <p>The value of ‘time out’ and ‘doing nothing time’; having space and time to evaluate; the lack of time for pausing and reflection; developing creativity and a new perspective on life; existential concerns; conceiving the desired life and the desired self; sense-making; expression of hope for the future and appreciation for life; importance of goal-setting; belief in one’s potential for personal growth; nourishing one’s gratitude and hope; accumulation of wisdom; the value of reflecting upon the past, adversity and one’s younger self; grappling with regret and a sense of loss; restoring</p>

<p>their own life spans were going to be truncated.’ (Shibusawa & Padgett, 2009); ‘The women were able to make meaning of trauma by attributing the importance of the event in shaping who they were resulting in a sense of peace.’ (Bonugli et al., 2013); ‘That leads me to believe that there’s a purpose for me ... In this life, you know? And God has allowed me to go through all this stuff...’ (Bonugli et al., 2013); ‘A total of 15 participants described drawing strength from ‘having faith’ in a higher power and were ‘thankful’ to this higher power for ‘taking care’ of them.’ (Paul et al., 2018)</p>	<p>oneself in the world; spirituality and religiosity;</p>
<p>Regaining the lost trust and respect in children and family; (Paul et al., 2018); fostering positive social relationships (Gopikumar et al., 2015); maturation and wisdom; a sense of responsibility (Gopikumar et al., 2015); ‘awareness of the future and ‘time left’ (Shibusawa & Padgett, 2009); ‘...congruence between the real and ideal self, and the drive to assume a more powerful identity and/or pursue self-actualisation’ (Gopikumar et al., 2015); ‘the striving for self-realisation, purpose and meaning of life’ (Gopikumar et al., 2015); hope for the future; appreciation for life; self-responsibility; giving back to others; changing lives and reconnecting with others (including children); maturation; desire for a new life; the conviction that ‘I have a lot more to grow on...’-; belief in one’s higher purpose in life; opportunities to share knowledge and wisdom to help others; intrinsic volition as a desire for change; beginning to ‘live’, not just ‘exist’ (Bonugli et al., 2013); Being ‘normal’; being ‘human’; being ‘happy’; belief that change is possible (Leipesberger, 2007); Hope and belief in one’s own abilities; self-confidence; having goals (Paul et al., 2018)</p>	<p><i>Personal reasons and motivations for coping:</i></p> <p>Connecting to self and to others; return to normality; achieving happiness; desire for change; belief in one’s personal growth as a lifelong process; wisdom and maturation; self-realisation; achieving a positive self-identify; belief in the possibility of a better life; spiritual connectedness; self-confidence; a desire for autonomy</p>

THE ASSEMBLAGE OF DISADVANTAGE (a higher-order construct):	
<p>‘... many participants described trajectories of accumulating risk and marginalization that contributed to their current experience of social devaluation, despair, and constrained choices.’ (Patterson et al., 2012); ‘Removal from the home environment, even though abusive, resulted in lost hope and feelings of alienation as reflected in the words of a participant...’ (Bonugli et al., 2013); long-standing patterns of social withdrawal, loneliness, and lack of meaningful relationships (Bonugli et al., 2013); a breakdown of trust and security (Gopikumar et al., 2015); traumatic life events leading to SMI (Patterson et al., 2012); social and emotional ‘uprootedness’ (Bonugli et al., 2013); feelings of anger, shame, blame and guilt (Bonugli et al., 2013); apathy (Bonugli et al., 2013); emotional blunting and loss of touch with oneself (Bonugli et al., 2013); ‘hardening’ and diminished hope (Patterson et al., 2012)</p>	<p><i>Context of early life. Emotional and psychological consequences of traumatic and other adverse life experiences:</i></p> <p>Multiple traumatic life experiences; marginalisation; victimisation; social disconnectedness; powerlessness and helplessness; chronic deprivation; lack of control and stability; emotional and psychological consequences of traumatic life experiences;</p>
<p>‘Participants cited as useful relationships with service providers who “threw out the textbook” and offered care based on mutual communication, as well as those that provided advocacy when negotiating with other professionals...’ (Voronka et al., 2014); unresponsive organizational policies; lack of compassion by staff (Leipersberger, 2007); high staff turnover hindering the continuity of care (Leipersberger, 2007); a sense of distrust towards health professionals (Stanhope & Henwood, 2014); financial resources frequently impeded access to medications (Muir-Cochrane et al., 2006); ‘Participants reported that in such instances, it was difficult to convince some health professionals of the veracity of their story and so they were often denied a repeat prescription...’ (Muir-Cochrane et al., 2006); ‘...many participants’</p>	<p><i>Structural barriers to receiving effective health care and social supports:</i></p> <p>Biomedical model seen as unhelpful; compulsory treatment, rigidity and conditionality seen as unhelpful; difficulties accessing services; financial struggles; the fragmentation of services; bureaucratic barriers; unresponsive policies; lack of understanding from staff; importance of a sensitive and caring stance of the social workers; importance of a recovery- and social justice-oriented care; lack of privacy and security in the shelter system; the hospital environment as demoralising and demeaning; intersectional disadvantage-based on both mental health status, socio-economic status and housing arrangements</p>

<p>reflections point to structural factors operating beyond their control...’ (Patterson et al., 2012); ‘Within the shelters, the women often felt disrespected by shelter staff. (Bonugli et al., 2013)</p>	
<p>‘These negative social attitudes further increase the alienation and marginalization of this population.’ (Bonugli et al., 2013); ‘The women in this study endure the three-fold stigma associated with mental illness, homelessness, and victimization.’ (Bonugli et al., 2013); ‘Aware of their status as a “homeless person,” many participants reflected on how they were unfairly treated by public systems of care and by members of mainstream society...’ (Patterson et al., 2012); ‘A female living with a disability is often treated with scant respect and dignity.’ (Gopikumar et al., 2015); ‘Even when social distancing was not a direct result of stigma, and even when it was deemed necessary for recovery to progress, it had myriad negative effects which entrenched participants further into poverty and homelessness.’ (Zerger et al., 2014); ‘The powerful negative experience of stigma both caused and exacerbated feelings of not being ‘normal,’ and awareness of one’s age sometimes heightened these feelings.’ (Shibusawa & Padgett, 2009); ‘When women refused services, they often did so publicly and on the grounds that they were not “crazy” (Luhmann, 2008)</p>	<p><i>Pervasive complex social stigma and its impact:</i></p> <p>Alienation and marginalisation caused by social attitudes; social and structural stigma towards the homeless; Intersectional stigma based on gender, mental illness and socio-economic status; mental health stigma in the family; negative staff attitudes; the detrimental effects of stigma-motivated social distancing; fear of being labelled as a barrier to formal help-seeking; race-based discrimination; identity struggles caused by stigma; self-stigma; feeling shame; homelessness as a cultural deviation; anticipated stigma</p>

Table 2: Concept-context matrix: Prevalence of third-order concepts among the original studies

Study/Third-order construct	Survival strategies and adaptations to life on the streets	Coping with SMI and its impacts	Reflection and meaning-making	Personal reasons and motivations for coping	Context of early life	Structural barriers to receiving effective health care and public supports	Pervasive complex social stigma and its impact
Bonugli et al. (2013)	Yes	Yes	Yes	Yes	Yes	-	Yes
Gopikumar et al. (2015)	-	Yes	Yes	Yes	Yes	-	Yes
Illman et al. (2013)	Yes	Yes	-	-	-	-	-
Jensen (2017)	-	Yes	-	-	-	-	Yes
Leipersberger (2007)	-	Yes	-	Yes	-	Yes	Yes
Luhrmann (2008)	Yes	Yes	-	-	-	Yes	Yes
Muir-Cochrane et al. (2006)	-	Yes	-	-	-	Yes	-
Patterson et al. (2012)	-	Yes	-	-	Yes	Yes	Yes
Paul et al. (2018)	Yes	Yes	Yes	Yes	-	-	-
Shibusawa & Padgett (2009)	Yes	Yes	Yes	Yes	Yes	-	Yes
Stanhope & Henwood (2014)	Yes	Yes	-	-	-	Yes	Yes
Stolte & Hodgetts (2013)	Yes	Yes	-	-	-	-	-

Voronka et al. (2014)	-	Yes	-	-	-	Yes	Yes
Zerger et al. (2014)	Yes	Yes	-	Yes	-	-	Yes

Table 3: Design characteristics and methodological assessment scores of the included studies (N = 14)

Author(s), (Year), (Setting)	Research Question(s)	Sample Characteristics: <ul style="list-style-type: none"> • Sample size=N; • Age range and mean; • Gender ratio: % female; • Ethnicity breakdown; • Mental health status; • Housing circumstances 	Study Design: <ul style="list-style-type: none"> • Design type; • Sampling method; • Data collection method(s); • Analytic method 	RATS Score
Bonugli et al. (2013), (USA)	To understand the experiences of homeless women of SMI and victimisation; To describe the resources used to avoid victimisation	<ul style="list-style-type: none"> • N = 15; • 22-62 y.o.a; • 100% female; • 7 White, 6 African-American, 2 Hispanic; • A mix of schizoaffective disorder, MDD, bipolar disorder and SZ; • Residing in a homeless shelter. 	<ul style="list-style-type: none"> • Qualitative description; • Purposive sampling; • Semi-structured interviews; • Content analysis 	26/42
Gopikumar et al. (2015), (India)	To understand the causes for becoming and remaining homeless; To reveal approaches to support personal recovery in institutional settings	<ul style="list-style-type: none"> • N = 27 service users; N = 8 mental health professionals; • N/A; • 100% female (service-users); • 100% Indian; • N/A; • A mix of housing experiences and 	<ul style="list-style-type: none"> • Mixed methods design; • Purposive sampling (maximum variation); • Focus groups, individual interviews, patient records; 	25/42

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		current circumstances	<ul style="list-style-type: none"> • Phenomenological analysis 	
Illman et al. (2013), (Canada)	To understand occupational engagement in homeless persons living with mental illnesses	<ul style="list-style-type: none"> • N = 60; • Median: 44.5 y.o.a; • Range: 20–64 y.o.a; • 33% female; • 24 White, 10 Asian, 15 Black, 11 Other; • N/A; • A mix of Housing First participants and TAU participants 	<ul style="list-style-type: none"> • Mixed-method design; • Stratified random sampling from a larger sample; • In-depth interviews; • questionnaire; • Constant comparative analysis 	36/42
Jensen (2017), (USA)	‘How does one nonprofit organization create a culture of dignity for their homeless and mentally-ill guests?’	<ul style="list-style-type: none"> • N = 6 workers; N = 4 volunteers; N = 5 guests; • N/A; • N/A; • N/A; • Residents of a hospitality house 	<ul style="list-style-type: none"> • Ethnographic design; • Theoretical sampling; • Participant observation; field notes; semi-structured interviews; • Constructivist grounded theory 	17/42
Leipersberger (2007), (USA)	To explore mental health consumers’ perspectives of the mental health system	<ul style="list-style-type: none"> • N = 25; • Range: 22-54 y.o.a.; • 60% female; • 13 White, 12 African-American; • N/A • Residing in homeless shelters or supportive housing projects 	<ul style="list-style-type: none"> • Qualitative design; grounded theory; • Purposive sampling; • Semi-structured interviews; field notes; • Constant comparative analysis 	28/42
Lurhmann (2008), (USA)	To understand why persons experiencing both homelessness and mental illness often	<ul style="list-style-type: none"> • N = 61; • N/A; • 100% female; • N/A; • SZ, bipolar disorder, 	<ul style="list-style-type: none"> • Ethnography; • N/A; • Semi-structured interviews; • N/A 	19/42

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	refuse help, especially formal help	<ul style="list-style-type: none"> and others; Residing in homeless shelters; supportive accommodation; and street homeless 		
Muir-Cochrane et al. (2006), (Australia)	To understand the experiences of homeless young people with a history of mental health problems of managing medications.	<ul style="list-style-type: none"> N = 10; Range: 16-24 y.o.a.; 50% female; N/A; N/A; Residing in temporary housing 	<ul style="list-style-type: none"> Qualitative design; N/A In-depth interviews; Thematic analysis; interpretative phenomenology 	25/42
Patterson et al. (2012), (Canada)	To explore experiences of inequity in homeless persons with mental disorders	<ul style="list-style-type: none"> N = 31; Range: 26-66 y.o.a; Mean: 45 y.o.a; 35% female; 18 White, 2 Black, 8 Aboriginal, 3 Mixed; Psychotic disorder, MDD, PTSD and others; 25 absolutely homeless, 6 precariously housed 	<ul style="list-style-type: none"> Qualitative design; Purposive sampling; Semi-structured narrative interviews; personal timelines; Thematic analysis 	28/42
Paul et al. (2018), (Canada)	To study ‘...the personal perceived strengths, attitudes and coping behaviors of homeless adults of diverse ethnoracial backgrounds experiencing homelessness and mental illness in Toronto, Canada’	<ul style="list-style-type: none"> N = 36; Mean= 37 y.o.a. (SD=11.3); 22% female; 8 Black African, 8 Black Canadian, 6 Black Caribbean of mixed ethnicity, 4 Middle Eastern, 3 South Asian; 1 Latin American; Depression, psychosis, PTSD; Housing First and Treatment as Usual homeless persons 	<ul style="list-style-type: none"> Qualitative design; Purposive and stratified sampling; Semi-structured interviews; Thematic analysis 	29/42
Shibusawa &	To study the lived	<ul style="list-style-type: none"> N = 25; 	<ul style="list-style-type: none"> Qualitative 	30/42

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<p>Padgett (2009), (USA)</p>	<p>experiences and key life events of being homeless and having a serious mental illness and/or substance use problems</p>	<ul style="list-style-type: none"> • Mean: 53 y.o.a (SD=5.81); • 40% female; • 13 White, 9 African-American, 2 Latino/a, 1 Other; • Schizophrenia, bipolar, major depression, psychosis; • 15 supported housing; 2 shelters; 2 independent housing; 3 single-room occupancy apartments; 2 long-term transitional housing 	<p>design;</p> <ul style="list-style-type: none"> • Purposive sampling (maximum variation); • Semi-structured interviews; • Thematic analysis; case study analysis 	
<p>Stanhope & Henwood (2014), (USA)</p>	<p>To understand consumer perspectives on the major barriers and facilitators to addressing their health and social needs presented by concurrent homelessness and SMI</p>	<ul style="list-style-type: none"> • N = 15; • N/A; • 100% male; • N/A • N/A; • Housing First participants 	<p><input type="checkbox"/> Qualitative, community-based participatory design;</p> <ul style="list-style-type: none"> • N/A <input type="checkbox"/> individual semi-structured interviews; <input type="checkbox"/> Thematic analysis 	<p>26/42</p>
<p>Stolte & Hodgetts (2015), (New Zealand)</p>	<p>To explore the ways in which a homeless man maintains his health.</p>	<ul style="list-style-type: none"> • N = 1; • 47 y.o.a; • 100% male; • N/A; • Depression; • Street homeless 	<ul style="list-style-type: none"> • Ethnographic case study; • N/A • A biographical interview, photo-elicitation project, photograph-based interview, health interview and various go-along conversations and direct observations; 	<p>14/42</p>

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			<ul style="list-style-type: none"> • N/A 	
Voronka et al. (2014), (Canada)	To understand participants' experiences of health and social services provision.	<ul style="list-style-type: none"> • N = 30; • N/A • 33% female; • 16 White, 8 non-White, 6 Aboriginal; • N/A; • At Home/Chez Soi and Treatment as Usual homeless participants 	<ul style="list-style-type: none"> • Qualitative design; • Stratified and purposeful sampling • Narrative interviews; • Peer-led data analysis 	19/42
Zerger et al. (2014), (Canada)	To explore '...how individuals who bear these multiple identities of oppression navigate stigma and discrimination, and what affects their capacity to do so'	<ul style="list-style-type: none"> • N = 36; • N/A; • 25% female; • 24 Canada-born; 12 foreign-born; • Psychotic disorder and others; • Absolutely homeless or precariously housed 	<ul style="list-style-type: none"> • Mixed-method study; • Purposive and stratified sampling; • In-depth interviews; • Grounded-theory informed analysis 	33/42

Table 4: Assessment of the confidence in the findings from the current metasynthesis using the GRADE-CERQual method (Lewin et al., 2015)

GRADE CERQual Component: Self-Assessment	Outcome of the Self-Assessment
<p>Methodological limitations:</p> <p>A systematic quality appraisal was conducted and studies of low methodological rigour was excluded. Yet, the majority of included studies were of medium rigour. Some common methodological caveats of the original studies are worth noting: thin description of themes; minimal or no engagement with theory; lack of information on rigour assurance and respondent validation; inadequate detail of the data analysis process.</p>	Moderate concerns
<p>Relevance:</p> <p>Based on the inclusion criteria, only studies whose entire samples</p>	Minor concerns

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<p>were persons with a history of an SMI and who were homeless at the time of the study (unless they narrated about their experience of being homeless) were considered. The assessment of conceptual clarity ensured that only studies that were highly relevant to the review question were included.</p>	
<p>Coherence: The line-of-argument synthesis derived demonstrates the high degree of coherence among the third-order constructs. Few significant ‘untranslated’ concepts remained. The results represent a mix of descriptive and interpretive findings.</p>	<p>Minor concerns</p>
<p>Adequacy of data: Despite the comprehensive search strategy, only 14 studies met the inclusion criteria after quality assessment. Two of the third-order concepts were supported by only four (29%) of the original studies.</p>	<p>Moderate concerns</p>
<p>Overall assessment: Moderate confidence: It is likely that the findings from the metasynthesis are a reasonable representation of the phenomenon of coping with SMI in the context of homelessness.</p>	