360 Degree Scan of What is Known About Journey Mapping for People who are Homeless

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Journey Mapping and Homelessness

Journey mapping has emerged as a powerful and versatile tool for understanding complex experiences and driving systemic improvements across various sectors. Originally developed for business and marketing purposes, this method has been adapted and applied in diverse fields such as healthcare, social services, and advocacy. However, its application in the context of homelessness remains limited, with a notable lack of literature specific to mapping homelessness experiences.

The primary objective of this review is to identify literature that has successfully used client journey mapping and to highlight articles related to housing and homelessness so that interested organizations and governing bodies may adapt the principles of journey mapping to the context of homelessness. This study also aims to address the following research question: What is the most effective approach to conducting client journey mapping, being mindful of the trauma endured by individuals, to comprehensively understand the experiences leading to homelessness, and to enhance service delivery and proactive interventions?

Transitioning from homelessness to housing is a multifaceted process influenced by various risk and protective factors that impact an individual's ability to exit homelessness and achieve housing stability. Studies show that pathways into homelessness are not singular events but a succession or series of events, often beginning in childhood with poverty at its foundation (Boydell, 2000; Fotheringham, 2014; Kohut, 2022; Morrell-Bellai, 2000; Piat, 2015; Webb, 2017). Applying client journey mapping to the problem of homelessness may provide much-needed understanding of the unique and complex pathways individuals take into and out of homelessness, allowing for more tailored and effective interventions and support strategies.

This literature review examines five key studies that showcase the evolution and application of journey mapping in different contexts, from acting as an evidenced based advocacy campaign to improve accessibility for visually impaired individuals to understanding the complex care pathways of patients with opioid use disorder. The studies by Crosier & Handford (2012), Bearnot & Mitton (2020), Thompson et al. (2020), Flaherty et al. (2020), and Cormick et al. (2024), along with insights from Rawson et al. (2013) and the British Columbia Patient and Safety Council (2019), collectively demonstrate the adaptability and transformative potential of journey mapping. It is important to note that the lack of literature specifically addressing journey mapping in the context of homelessness, as highlighted by Crosier et al. (2012), still persists today. This gap underscores not only the need for innovative applications of journey mapping principles to better understand and address the complex issues surrounding homelessness, but also the need for better reporting protocols and standards for trauma informed care.

Upon examination, several key themes emerge: the adaptability and versatility of journey mapping, its focus on holistic, human-centered service design, its ability to understand user experiences, the power of visual representation, its potential for transformation, the value of collaboration, the importance of a person-centered view, the ability to reveal hidden aspects of experiences, stigma as experienced by marginalized people while navigating systems and its ability to impact multiple levels of change. Lastly, the interviews reveal that journey mapping as a participatory research approach that centers the participant is in itself, a trauma informed approach to system design, service delivery, and interventions to address homelessness.

Background

Customer journey mapping originated in the 1960s and 1970s as a market research tool designed to help businesses understand consumer behavior and motivations (Crosier & Handford, 2012). Initially applied in commercial settings to optimize retail environments and monitor customer responses, journey mapping records and analyzes the series of interactions and experiences customers have with a service, identifying both positive and negative experiences within the service process to enhance customer satisfaction (Crosier & Handford, 2012).

Client journey mapping soon expanded into various fields, particularly healthcare. Its application in this sector enhanced patient experiences by taking a patient-centric view to understand their perspectives throughout their interactions with health services (Ly et al., 2021). Ly et al. (2021) highlight journey mapping as an innovative method that reviews patient healthcare interactions over time, identifying pivotal moments to promote timely, patient-centered care. According to Cormick (2024) and Davies et al. (2022), journey mapping records all the stages of healthcare interactions, revealing gaps and strengths in care from the viewpoints of patients, families, and service providers.

The versatility of journey mapping is evident in its adaptation to different contexts. Connell et al. (2023) suggests that journey mapping, though new in social sciences, offers a holistic view of experiences through systems, helping to identify gaps and support program evaluation. Barton et al. (2019) describes a client journey map as capturing the steps of disease progression and interactions with healthcare professionals. Curry et al. (2021) emphasizes patient journey modeling as a novel tool for enhancing healthcare quality by focusing on the patient's movement through an organization from a patient-centric perspective.

McCarthy et al. (2016) used journey mapping as a human-centered design tool to reform and improve performance, maintain regulations, and improve patient experience. Journey mapping has also been used to gain insight into the transition from hospital to home, identifying critical touchpoints, pain points, enablers, and feelings experienced throughout the care process (Saragosa et al., 2023). McCarthy et al. (2016) report that patient experience is shaped through interactions and involvement with healthcare services, creating personal interpretations based on a series of encounters. While providers design these interactions, the actual experience is constructed by the patient, who judges the quality of the service based on their feelings and perceived benefits, that may differ from the operational aspects of the service.

The evolution of journey mapping from a market research tool to a comprehensive service design tool highlights its versatility and effectiveness in visualizing and analyzing user experiences across different sectors. It has been adapted to specific contexts, such as palliative care, where it identified opportunities for improving care delivery and addressing barriers for the dying (Ly et al., 2021). Journey mapping initiatives have also improved the home isolation experience of persons with mild COVID-19 (He et al., 2021). Frew et al., (2020) used journey mapping as a tool to assess burns in an emergency department. Cateriano-Arévalo et al., (2021) mapped journeys of individual women to document the way they used salt in an effort to change a population's salt intake habits.

Most recently, journey mapping has been adopted by the public sector to improve citizen engagement with public services and inform policy development (Stephens et al., 2024). This broader application underscores its value as a vital tool for enhancing service quality across various domains (Cateriano-Arévalo et al., 2021). By providing a structured framework for understanding client interactions, journey mapping continues to play a crucial role in enhancing

service delivery, improving user experiences, and driving positive outcomes in diverse fields. Journey mapping's evolution and diverse applications provides context for its use in understanding and addressing homelessness, as explored in the subsequent sections of this review.

Journey Mapping as a Tool for Advocacy

By observing patterns of patient function and healthcare encounters, participants pinpointed areas for enhancement and optimized care delivery across multiple settings (Ly et al., 2021). Journey mapping has been increasingly recognized as a valuable tool for understanding and improving service delivery in various fields, including social marketing, public health, and disability services (Cateriano-Arévalo et al., 2021). Crosier & Handford's (2012) historical account of the use of journey mapping found that although customer journey mapping had been used since the 60's and 70's as a common marketing technique, they discovered, that even though the social sciences had been using it since the 90's, not one published peer-reviewed article could be found in the PubMed database. The authors believed their study to be the first advocacy campaign to use customer journey mapping (CMJ) by a charity to educate businesses by appealing to the lucrative financial aspects of better serving a population with blindness while creating independence for people who are blind.

With over 10 million people living with disabilities in the UK, including approximately 2 million who are blind or partially sighted, this campaign is of significant value. In this study, despite existing legislation aimed at preventing discrimination and ensuring accessibility, many disabled people reported experiencing barriers in accessing various services. This article reports on an innovative advocacy campaign conducted by the Royal National Institute of Blind People (RNIB) to improve access to goods and services for blind and partially sighted people in the UK.

The campaign, part of RNIB's 2009-2014 strategy to create a more inclusive society, aimed to enable more blind and partially sighted individuals to shop independently and demonstrate the economic value of accessible services to providers. They employed customer journey mapping (CJM), a technique typically used in market research and service design, to explore the experiences of blind and partially sighted individuals accessing retail and transport services in three UK cities: Manchester, Lincoln, and Edinburgh. This marked a novel application of CJM as a tool for social change and advocacy (Crosier & Handford, 2012).

The methods for this study went beyond simply documenting what happens to customers as it also captured their emotional responses throughout their journey. 5-8 participants were recruited from each location who had various types of sight loss. The participants were asked to undertake physical journeys using public transportation to visit retail outlets. During one-on-one interviews at different stages of their journeys, participants were asked to verbally recount their journeys, including emotional responses, that were recorded both through audio and written notes. After being recorded, participants reviewed their journeys for accuracy creating case studies that were then synthesized as the foundation for a composite journey that reflected common concerns. The composite journey was validated through audio recorded group discussions. The audio recordings were then incorporated into a visual representation (a journey map), and presented at a forum with retail, travel and finance representatives to discuss potential solutions (Crosier & Handford, 2012). The output for this journey was an easy-to-read graph that pinpoints areas needing improvement. This visual representation allowed service providers and policy makers to quickly identify problem areas and opportunities for enhancing customer satisfaction. The technique was particularly useful for detecting "glitches" in service processes

and for understanding what worked well from the customer's perspective (Crosier & Handford, 2012).

The findings, presented as case studies, revealed several challenges faced by blind and partially sighted individuals in their daily lives. These included difficulties in navigating public spaces and retail environments independently, inconsistent quality of assistance and discrimination from staff in retail settings, and problems with public transport such as difficulty reading timetables and bus numbers. Once in the retail environment, participants also reported challenges in identifying products and reading labels and signs. Importantly, the study highlighted the significant impact of sight loss on independence and quality of life, with many participants expressing frustration at their inability to shop or travel independently (Crosier & Handford, 2012). These experiences underscored the need for improved accessibility in retail and transport services, educating staff on disability and customer service, and more consistent support for individuals with sight loss. The study demonstrates the effectiveness of customer journey mapping as a tool for advocacy, providing concrete, relatable evidence of the barriers faced by blind and partially sighted individuals in their daily lives. The use of CJM in this context represents a shift from its typical application in commercial settings to a tool for social change. By mapping the emotional journey of blind and partially sighted individuals as they interact with various services, the charity could provide concrete, relatable evidence of the barriers faced by this group (Crosier & Handford, 2012).

Discussion

By presenting these experiences in a detailed and empathetic manner, the study was successful in creating meaningful changes in how services are designed and delivered to meet the needs of people with visual impairments. This innovative application of CJM demonstrates its

potential as a powerful tool for advocacy campaigns, particularly those focused on improving accessibility and inclusivity. While the latest research is presented in the articles that follow, this article is one of the oldest by date, but holds significant importance in relation to housing transitions and homelessness, which is a sector that also requires extensive advocacy. This article is introduced first not only due to its historical importance, reflected by its earlier publication date, but also because of its pioneering approach to using customer journey mapping as an advocacy tool, highlighting the flexibility and adaptive nature of journey mapping. The study's focus on advocacy aligns closely with efforts to support individuals experiencing or at risk of homelessness. It demonstrates how journey mapping, in 2012, was typically being used in commercial settings and health care settings, was easily adapted to drive social change and improve accessibility for marginalized groups that is still applicable in 2024.

This research is groundbreaking because it is the first instance of a charity using journey mapping as an advocacy tool that set the precedent for non-profits to use business techniques for social good. By combining researcher and customer perspectives as a layered journey map, a complex experience was easily broken down into a series of steps that advocates, organizations, and businesses could comprehend and organize around. Tracking the emotional aspects of this journey provided rich data that informed where the greatest changes needed to be made while keeping the process human centered.

The methodology that Crosier & Handford's (2012) used in this study was unique. Involving participants in the research process, synthesizing individual experiences into a "composite journey," and presenting findings to stakeholders offers a potential template for similar advocacy efforts in the homelessness sector. It demonstrates the importance of gathering and presenting compelling evidence of systemic barriers, to drive policy changes and improve

service. Also, the study's focus on accessibility for blind and partially sighted individuals provides valuable insight on inclusive service design. These principles of accessibility and inclusion are equally important when considering the needs of homeless individuals, who often face similar barriers in accessing services and navigating complex systems.

Crosier & Handford's (2012) innovative application of journey mapping provides valuable insights for organizations working with homeless populations, showing that effective communication of multiple experiences through a relatively simple journey map can influence service providers and policymakers to initiate great change for marginalized people. Also significant, was the focus on framing the advocacy and much needed changes as a financially sound reason to invest in creating opportunities to serve this population. Appealing to neoliberal capitalist principles, with market-driven solutions, can be a politically savvy approach to securing funding for the deep changes required to support people who are homeless. Following a similar pattern to reveal how much homelessness is costing the municipality, the province and the healthcare system, the use of journey mapping as a visual presentation may appeal to funding organizations, local businesses and government offices to help resolve the housing crisis in Ontario and beyond.

Health Care and Addiction

Bearnot & Mitton (2020) examined the complex issue of opioid use disorder (OUD) and related health complications, particularly endocarditis, that posed significant challenges for the healthcare system at Massachusetts General Hospital (MGH) in Boston USA, which had developed a comprehensive substance use initiative. They found that people who suffer from opioid use disorder often require complex, lengthy treatments across multiple care settings. Unfortunately, patients with OUD-associated endocarditis frequently faced barriers to effective

care. Journey mapping, originally developed for business and marketing, had more recently been adapted to healthcare settings at the time of Bearnot & Mitton's (2020) investigation and subsequent mapping initiative. Journey mapping allowed for the creation of easy-to-understand diagrams illustrating an individual's movement through Boston's complex health care system. The authors introduced journey mapping not only as a potential solution to address the complexities of care and better understand patient experiences, but as a way to address the limitations of their previous analysis, that couldn't accurately represent the unique and complicated episodes of care experienced by patients suffering from addictions to opiates and endocarditis.

The study involved semi-structured interviews with 10 patients who had culture-positive infective endocarditis and at least mild OUD. Participants were asked to recall their care experiences from their first hospitalization for OUD-associated endocarditis through the time of interview. The interviews covered details of hospitalizations, post-acute care, outpatient care, and drug use history. The median age was 37, with an even split between outpatients and inpatients. Most participants were non-Hispanic white, and over half were homeless at the time of the interview. All reported a history of intravenous opioid use, and most had received treatment with medication for OUD. Participants were recruited from both inpatient and outpatient settings, with a purposeful effort to include a diverse range of care experiences. The study used a grounded theory approach, with interviews continuing until thematic saturation was achieved (Bearnot & Mitton 2020).

Bearnot & Mitton (2020) analyzed the interview transcripts and survey data to extract details of patients' care experiences. They then developed a journey mapping structure to visually represent these experiences. This process involved creating and refining different mapping

modalities before settling on a final structure that could accurately represent each patient's journey. The researchers used a two-dimensional graph, with the vertical axis representing care intensity and the horizontal axis representing time. Different line styles and colors were used to indicate periods of substance use, engagement in addiction treatment, and instances where patients left care by choice.

The analysis revealed three main themes:

1. Two common patterns of care emerged. One pattern, characterized by early addiction treatment and intensive outpatient care, was associated with fewer re-hospitalizations. The other pattern, lacking addiction treatment and intensive outpatient care, often led to frequent re-hospitalizations.
2. Patients often made proactive decisions to leave or re-engage in care. Reasons for leaving included undertreatment of withdrawal symptoms, perceived discrimination, or trauma triggers. Re-engagement was often prompted by a return to substance use and a desire for recovery support.
3. Disengagement from intensive outpatient care and returning to substance use frequently preceded re-hospitalization. Housing instability and inadequate follow-up care were noted as contributing factors.

The study also found that participants had multiple hospital presentations during the study period, with some requiring surgical interventions. All received intravenous antibiotics and infectious disease consultations. Many transitioned to post-acute care settings after hospitalization, and all reported some form of outpatient care, often from non-MGH affiliated community resources. Importantly, all participants reported returning to substance use at some point after their initial hospitalization, highlighting the chronic and relapsing nature of OUD.

This finding underscores the complexity of caring for patients with OUD-associated endocarditis and the need for comprehensive, long-term treatment approaches. Also, a common theme in drug use studies, stigma emerged as a significant barrier to care, the maps revealing that negative attitudes towards individuals with OUD, both from healthcare providers and society at large, can lead to delays in treatment and poorer health outcomes. Patients may also internalize these negative perceptions, further complicating their care journey (Bearnot & Mitton 2020).

By employing journey mapping, the hospital was able to develop more patient-centered approaches to care for individuals with OUD-associated endocarditis. This included strategies to reduce stigma, improve care coordination, and address the unique needs of this vulnerable population throughout their treatment process. Bearnot & Mitton (2020) add that ultimately, the goal is to use these insights to design more effective, compassionate care pathways, leading to better health outcomes for patients with OUD-associated endocarditis and potentially inform improvements in care for other complex health conditions as well.

Discussion

This study was selected for its unique application of journey mapping in healthcare research, particularly focusing on patients with opioid use disorder (OUD)-associated endocarditis. This research stood out due to its intersection with issues of housing instability. This overlap makes the study especially relevant when considering the broader social determinants of health. Another key factor in choosing this article was its continued emphasis on stigma as a primary barrier to care. This theme aligns closely with the challenges faced by individuals experiencing homelessness, further highlighting the interconnected nature of these issues. The study's exploration of how stigma impacts healthcare experiences and outcomes for

this vulnerable population provides valuable insights when adapted to homelessness and housing transitions.

Importantly, the journey mapping approach used in this study revealed patterns and experiences that would not be apparent from interviews alone. This demonstrates the value of journey mapping as a research tool to reveal hidden intersections of drug use and health care, particularly when studying marginalized populations. By using journey mapping, the researchers were able to visually represent and analyze the intricate care pathways of individuals with OUD-associated endocarditis. By visually representing complex care trajectories, the researchers were able to uncover hidden trends and experiences that might have otherwise been overlooked. This approach offered unique insights into the impact of factors such as housing instability, stigma, and care discontinuity on patient outcomes. The study's findings underscore the potential of journey mapping as a powerful methodology for understanding and addressing the needs of marginalized populations in healthcare settings. This approach provides a deeper understanding of how factors such as housing instability, stigma, and discontinuity of care impact patient outcomes.

Women and Families

Thompson et al., (2020) studied 24 families who were experiencing homelessness in Northern Texas USA. The participants were recruited from shelters, rapid rehousing programs and a resource center for food and clothing. The majority (79%) of the families were women with two or more children. More than half (54%) were Black. In the context of housing and homelessness research, it is broadly recognized that women face specific barriers to finding housing and often remain in unsafe situations with violent partners due to lack of resources. Unhoused families with children face numerous health and social challenges while seeking

shelter. Traumatic stressors include food insecurity, social isolation, and disruption of educational continuity that contributes to poor academic performance and leaving school before graduation resulting in generational poverty.

Children who have experienced homelessness are at a heightened risk of developing mental health issues, including anxiety, depression, and behavioral disorders. In the long term, children who experience homelessness are also more susceptible to chronic physical health conditions, such as asthma. Mothers who are the main caregivers and who are experiencing homelessness face unique challenges, including exposure to violence, abuse, many suffering from mental health issues like post-traumatic stress disorder and depression. Women and children also tend to be what is commonly known as, hidden homeless, which refers to doubling up with friends, couch surfing, staying in motels and living in vehicles (Thompson et al., 2020). Among these common themes, women were also afraid of shelters due to stigma associated with homelessness. Journey mapping revealed that mothers experiencing homelessness who live in shelters experience loss of privacy and dignity, stress, and find they need to protect their children in shelter environments. This implies that there are many more women experiencing homelessness than statistics show and many more who are staying in unsafe housing because they have children (Thompson et al., 2020).

Thompson et al., (2020) journey mapping research discovered a trifecta of barriers for participants seeking housing. Participants were unable to secure housing without jobs. They were unable to secure jobs without daycare. Also, for those who did secure daycare, transportation was a main barrier adding hours on a bus between daycares and jobs and for many, without a job, transportation of any kind was financially out of reach. Families experiencing homelessness face numerous challenges related to employment, childcare, and access to resources. Thompson et al.,

(2020) journey mapping research created opportunities for families to reflect and recommend specific strategies and interventions to aid in transitioning back into stable permanent housing such as:

1. Integrated workforce programs that simplify childcare eligibility and access.
2. Enhanced transportation options, including additional school buses
3. Increased financial and resource support for childcare services

This study found that families struggle with complex eligibility procedures for subsidized care and finding trustworthy providers. Journey mapping with families also revealed not having childcare interfered with consistent school attendance. Participants reported that finding childcare was a particularly difficult barrier during extended school breaks. Also, frequent relocations associated with homelessness often necessitate difficult decisions about children's school enrollment, leading to multiple school changes or prolonged periods without schooling (Thomspon et al., 2020). They also found that shelter policies can exacerbate these challenges, with restrictions on family size resulting in separation or delayed access to services. Participants suggested creating a centralized, online resource list with improved search capabilities based on family-specific criteria. They also emphasized the need for more child-friendly activities within shelters to help children cope with their feelings about their circumstances (Thompson et al. 2020). Studies show that instability experienced by homeless families can negatively impact children's development, academic performance, and health. To address these issues, policymakers should consider:

1. Redesigning shelter infrastructure to accommodate larger families and create child-friendly spaces
2. Developing flexible, gender-neutral family spaces to prevent family separation

3. Establishing a comprehensive, easily accessible service information system to help families navigate available resources

These recommendations could alleviate many of the burdens faced by homeless families and improve outcomes for both parents and children (Thompson et al., 2020).

Discussion

While the Thompson et al. (2020) article did not include any visual representations of journey mapping, the process was explained as drawing a "typical" journey map (borrowed from previous customer journey mapping reports) on a white board so that participants could easily erase elements or add elements that they thought they missed as the interview progressed. However, the article did include example questions from the semi-structured interview guide that are copied below:

Example questions from the semi-structured interview guide. (Thompson et al., 2020)

We'd like to build a map or drawing of where you are today from where you started. Let's start by talking about where you are today. [Repeated until complete].

Where are you currently living, I don't want the address but just a description, are you staying with a friend or at a shelter or something like that?

Who are you living with?

How long have you been at this location?

How did you get to this location?

Was it easy to get to? Was it hard to get to?

How did you find out about this resource? (if applicable).

Are your children at this location? If not, where are they? If so, what was it like getting them to this location?

How do you feel at this location?

How safe do you feel at this location?

What were some challenges you faced at this location?

Probe: violence, space for children, safety, transportation, employment.

What would make it easier to get to this location?

Throughout this journey, how did you find resources?

How would you prefer to find resources?

What would make that easier?

Can you please talk about how having children impacted your search for housing?

While Crosier & Handford (2012) noted a lack of peer-reviewed articles on journey mapping in social sciences, Thompson et al.'s work represents a significant step towards filling this gap, specifically in relation to homelessness. Thompson et al. (2020) journey maps revealed critical insights into the challenges faced by homeless families, including the loss of privacy and dignity in shelters. Thompson et al.'s (2020) study has significant transformative potential, particularly in informing policy and service delivery for homeless families. Their findings on the trifecta of barriers and the complex interplay between employment, childcare, and transportation provide concrete areas for intervention, demonstrating how journey mapping can drive meaningful improvements in service delivery and system design.

Thompson et al.'s (2020) methodology, which involved semi-structured interviews and interactive mapping sessions with participants, exemplifies the collaborative and participatory approach that is central to effective journey mapping. This aligns with the approach highlighted in studies like Cormick et al. (2024) and the British Columbia Patient Safety & Quality Council (2019), emphasizing the importance of involving service users in the mapping

process. Thompson et al.'s (2020) journey mapping revealed several hidden aspects of the homeless experience, such as the fear of shelters due to stigma and the complex decision-making processes families undergo regarding school enrollment. These insights demonstrate journey mapping's ability to uncover aspects of experiences that might not be captured through traditional research methods.

Thompson et al.'s (2020) study exemplifies the potential of journey mapping to understand and address homelessness. It demonstrates how the method can be adapted to capture complex social experiences, provide deep insights into user experiences, and inform service improvements; The study's findings on the interconnected challenges faced by homeless families highlight the need for comprehensive, coordinated interventions, providing a valuable model for future research in this area. This application of journey mapping represents and significant step towards addressing the gap in research, demonstrating how journey mapping can be effectively used to understand and address the complex issues surrounding homelessness.

Life Mapping Homelessness

Flaherty & Garratt (2023) combined visual journey mapping techniques with a historical life course approach, underpinned by an adaptation of a social work technique, named family finding, to reveal how social networks informed participants housing transitions. The author called this combined biographical narrative and accompanying graphical facilitation, life mapping. The importance of this article to this study is that it is one of the few journey mapping initiatives that is both peer reviewed and specifically housing focused. This study also considered the ethical implications of working with people who have or are experiencing homelessness which is related to the main research question for this review.

Flaherty & Garratt (2023) recruited 39 current or formerly unhoused adults through a variety of methods including shelter staff, posters and snowball sampling. They used large flipchart paper and coloured pens to allow participants to hand draw their life maps. Participants were encouraged to draw their housing history as they narrated. After asking the participant to draw the first house they remembered living in, they were asked to recount each housing situation throughout their lives from childhood to present day. The interview was conversational, probing for details on housing transitions, specific homeless periods and reasons for the transitions. The participants could present their history in any way they wished. For those who were unable to draw the process was adapted to a standard qualitative interview. In at least one interview the researcher starts to draw for the participant and the participant took over showing agency. Throughout the mapping session, the researcher referred to the map to clarify timelines and transitions which allowed the participants time to reflect as they moved back and forth. Flaherty & Garratt (2023) recognized that this gave the participant not only insight but allowed for distance from more emotional events and transitions. Participants were given the opportunity to take pictures of their maps and were debriefed. This combination of life history interviewing and journey mapping allowed the researchers to gain valuable insights into participants housing histories, transitions and perceptions of homelessness through the lifecycle. Several important findings were highlighted:

Moving Beyond Rehearsed Narratives: The study revealed that many people who have been homeless have become accustomed to telling their stories in a particular way, as "poor stories" especially when interacting with various social services. By using journey mapping, researchers were able to get underneath these rehearsed accounts and gained deeper insights. In keeping with the human-centered theme of journey mapping, this study allowed participants to

share their life histories more comprehensively, revealing the multifaceted intersections of people who face homelessness. The visual aspect of this approach encouraged participants to share "housing and homeless biographies" they might not have mentioned in a typical qualitative interview, providing a more holistic view of their housing transitions (Flaherty & Garratt 2023).

Life Mapping as a Reflective Process: The researchers found that the act of visually mapping one's life history served as a powerful tool for self-reflection. As participants engaged in this process, they re-evaluated their experiences and retold their stories from different perspectives. This reflective journey uncovered causal relationships and risk factors that may not have been apparent through traditional interview methods. The visual nature of the mapping process prompted participants to recall experiences they hadn't previously identified as homelessness, for example, some participants did not consider themselves homeless until they were sleeping rough, yet they had been couch surfing and visiting shelters for some time. The process allowed both the participants and researchers to gain new understandings about housing transitions and self-perceptions related to homelessness (Flaherty & Garratt 2023).

Role of Social Networks: The life mapping technique outlined in this study was particularly effective in illuminating the significance of social networks in the context of homelessness. These networks, both formal and informal, played significant roles in shaping individual experiences of homelessness. The article's focus on social networks reveals important information about connection to family resources that help keep people housed or conversely, contribute to hidden homelessness. Flaherty's research also highlights how lack of such networks often marks the beginning of rough sleeping, stigma and self-identification with the term homeless (Flaherty & Garratt 2023).

Agency and Self-Perception: This study offers significant ethical advantages when conducting research on sensitive topics with vulnerable groups, particularly in the context of homelessness. Flaherty & Garratt's (2023) research provided a non-exploitative way to explore participant's biographies, allowing researchers to delve into potentially traumatic stories while maintaining ethical sensitivity. Flaherty & Garratt's (2023) reports that shifting the focus to the act of drawing, made it easier for participants to discuss sensitive information, reducing the pressure typically associated with traditional interviews. This method also empowered participants by giving them control over their narrative by allowing them to move back and forth through their timeline at will, highlighting agency and potentially countering stereotypical views by offering a more dignified research experience. The visual nature of life mapping enabled participants to present multiple facets of their identities, moving beyond the stigmatized label of "homeless" to include other roles and experiences. Flaherty & Garratt (2023) also reported that participants displayed a sense of ownership and pride in their life maps, suggesting that the process itself can be validating. These themes collectively demonstrate the depth and richness that life mapping brings to understanding homelessness. Along with the narratives of work, addiction, health and trauma, that became apparent in Flaherty & Garratt's (2023) study, an exhaustive long-term study highlighting each of these intersections could be mapped to give an incredibly nuanced and multi-faceted composite of an individual's journey of housing transitions throughout the life cycle.

Discussion

As previously discussed, the literature search revealed few articles that addressed journey mapping through a homeless to housed lens, making Flaherty & Garratt's (2023) life mapping study another valuable contribution to this review. Flaherty & Garratt (2023) combines the well-

researched life history approach with journey mapping to understand homelessness and housing transitions. This review shows that Flaherty & Garratt's (2023) use of the life mapping technique closely resembles traditional journey mapping, except for the length of time that the mapping covers. Flaherty & Garratt's (2023) aim to visualize and understand the dynamic social experiences and transitions individuals facing homelessness undergo, provided an intersectional and storied view of their journeys.

Flaherty & Garratt (2023), also expands on traditional journey mapping by asking participants to draw their life story starting with their first childhood residence, including social and familial networks. The researchers' distinction between "place" and "home" added nuance, recognizing home as a more complex concept than just a physical structure, revealing hidden aspects of participant's experiences. What made this approach particularly successful was the use of simple, open-ended questions like "what happened next?" while having participants draw their responses. This allowed participants to dig deeper into memories, breaking through conditioned answers typically given to social services. This aspect not only addresses the adaptability and versatility of journey mapping, showcasing how journey mapping can be modified to suit specific research contexts but highlights journey mapping's ability to transform the interview process itself, giving researchers a different way to conduct qualitative interviews.

Flaherty & Garratt (2023) life mapping was also transformative because by encouraging participants to move beyond practiced narratives of their housing situations, the participants were able to access different memories, moving back and forth through their journey in one sitting, adding memories and reframing events. This process deepened connections to life events, places, and spaces that contributed to their housing transitions. Flaherty & Garratt (2023) reported participants thought that the process felt like a form of therapy, enabling them to see patterns and

exercise agency over their stories. While the researchers found the idea of "therapy" to be an ethical conundrum in this circumstance, it still maintains that the potential for transformation, by demonstrating how journey mapping not only gathers data but also positively impact participants. By encompassing the entire life history of individuals, Flaherty & Garratt (2023) offered a gentler yet comprehensive way to explore difficult life events while yielding rich nuanced data about the complex pathways into and out of homelessness. By disrupting expected narratives, tracking housing transitions through a life cycle, and revealing a more comprehensive and holistic representation of individual's lives, life mapping struck a balance between gathering in-depth information and respecting participant's dignity and agency. This review puts forward that journey mapping itself is inherently trauma-informed and that its principals of being person centered. collaborative, and empowering, offers an ethically sound method for researching sensitive topics, particularly with vulnerable populations.

Reform vs Transformation

The literature reveals that journey mapping has positively influenced every industry that has implemented it. From mapping journeys that used the technique to interact at specific touchpoints to better suit the client while positively affecting the bottom line, to improving working conditions for care providers by creating better communication channels between departments and other agencies, to tracking the emotions of patients and their families enabling better care, journey mapping has proven to be an effective tool for enabling great change. While these changes are often spoken of in terms of reform, Rawson et al., (2013) takes client experience much further using it as a tool for transformation. In agreement with Flaherty & Garratt (2023), Rawson et al., (2013) encourages organizations to go beyond touchpoints and pain points, to look at the full end to end journey. They discovered that the customer experience,

is best envisioned as a "cumulative experience across multiple touchpoints and multiple channels through time." In their study, most service encounters were positive when seen as singular events, but customers were reporting a negative experience overall. Rawson et al., (2013) writes,

> "At the heart of the challenge is the siloed nature of service delivery and the insular cultures that flourish inside the functional groups that design and deliver service" (p. 92).

An organization embarking on redesigning service and processes through journey mapping will require transformation from the typical top-down, siloed management approach to bottom up, client-centered interaction with a cross-functional approach to service delivery. To start, Rawson (2013) suggests, identifying immediate process and policy changes in typical top-down management styles that will set the foundation for becoming a journey-centric organization. From this point forward, bottom-up research must commence, through both client and employee surveys and operational data to understand touchpoints, from both perspectives.

After identifying key customer journeys with employees, it's crucial to examine each journey in detail to understand the causes of current performance. This deep dive involves additional research, including customer and employee focus groups and call monitoring. Combined with initial bottom-up analysis, this allows the company to map the most significant permutations of each journey from the customer's perspective, revealing the sequence of steps they're likely to take. The mapping exercise exposes departures from the ideal customer experience and often reveals policy choices or company processes that unintentionally generate adverse results. Involving frontline employees in identifying and solving problems, and empowering them to innovate, is crucial. Engaging customers in the design process ensures that solutions meet their needs, potentially leading to more efficient and satisfying processes.

Creating centralized change leadership teams and assigning executives to oversee implementation across different regions or functions helps maintain momentum and focus. For example, an energy company broadened its scope to include five critical journeys, with executive team members conducting weekly reviews with stakeholders from each function.

Discussion

In the context of housing and homelessness, managing client journeys requires understanding the broader reasons behind each client's access to or barriers to different touchpoints through the social service system. For instance, as revealed in Thompson et al. (2020), a trifecta of barriers became apparent that made exiting homelessness with children incredibly difficult and even impossible at times. Also, a client might require help with issues like securing uninterrupted counselling or addiction services after homelessness, understanding landlord/tenant responsibilities and rental agreements, or resolving persistent maintenance problems with difficult landlords.

Addressing these interactions holistically involves not only handling the immediate concern but also identifying and addressing underlying causes, creating feedback loops to enhance overall service delivery and support. Working with people who have experienced the trauma of homelessness often repeated throughout the lifecycle, improving their care and transitions into permanent housing will require transformation of the whole system starting with organizational shifts while mapping the full end to end journey of past and present client journeys. Rawson et al., (2013) says, "Optimizing a single customer journey is tactical; shifting organizational processes, culture, and mind-sets to a journey orientation is strategic and transformational."

Multilevel Impact of Journey Mapping

In response to an ongoing public health emergency, The British Columbia Patient and Safety Council (2019), referred to as the BC Council (2019) for the remainder of this section, engaged in journey mapping "to develop a shared understanding of how primary care system is experienced by health care providers and patients/peers" (p.5) who are accessing treatment for substance use. The BC Council (2019) distinguishes between journey mapping and process mapping suggesting journey mapping is more expansive because it includes internal processing of individual experiences such as "mindsets, beliefs and emotions" adding the human or client-centric element at each stage, rather than only creating a map of systems steps.

The BC Council (2019) completed two different mapping projects, one for the general population engaging with primary care and the second specifically for Indigenous people also engaging with primary care that resulted in a total of 6 maps: four for general primary care and two for Indigenous perspectives on primary care engagement. On each of the two occasions, three groups came together over several hours to create their maps. Peers, health care providers (including social workers, pharmacies and harm reduction workers) and municipal/provincial level organizations. Peers and providers were separated into two groups with organizational leaders assigned to each group to ask questions and clarify emerging themes. Sticky notes were used to write the initial thoughts, ideas, feelings and experiences of those accessing services or the experience of service providers accessing the public health system regarding treatment options for people who use opioids. Upon completion, the two groups came together to share their maps resulting in deeper understanding of each other's positions and a possible way forward to make accessing treatment for opioid use easier for both groups. The mapping revealed eight main themes and what the BC Council (2019) refers to as change ideas:

1. Care Models: The mapping found that current treatment often fails to meet peer's cultural, financial, spiritual, physiological, or social needs. Change ideas included introducing wrap around care, integrating social workers and cultural counselors, peer to peer support, child care and legal help into care models.

2. Navigational Challenges: Both peers and providers find the treatment system difficult to navigate, leading to frustration and avoidance. Proposed changes included adding peer navigators and support groups, coordinating care, and updating disability support criteria.

3. Trust Issues: Trust is critical but often lacking between providers, peers, and families. Recommendations included framing substance use as a medical condition, increasing appointment times, and creating programs that empower peers as mentors.

4. Access Barriers: Treatment is not always available when peers are ready. Solutions involved supporting rural healthcare initiatives, offering rapid access clinics, and developing home detox programs.

5. Stigma and Mindsets: Substance use disorder is not widely viewed as a chronic disease. Suggestions included telehealth access to specialists, involving peers in education and research, and training providers in cultural safety and trauma-informed care.

6. Inconsistent Care: Variation in treatment protocols undermines confidence in care. Ideas included creating a peer advocacy body, regulating treatment centers, and standardizing care quality measurement.

7. Chronic Pain Management: Pain is often inadequately addressed during substance use treatment. Proposals included expanding access to complementary therapies and addressing pain issues before an individual leaves care (against medical advice) to treat the pain themselves through substance use.

8. Community Support: Strong community connections are vital for recovery. Suggestions included developing online peer support, creating mobile care units, and promoting partnerships between support organizations and clinics.

A key consideration for the BC Council (2019) was that journey maps be used to inform service providers and policy makers of point in time style snapshots of a service rather than to be used as a static report on what services should look like in the future. They report that each map is unique with different language and terminology used across different individuals and groups so each mapping session should inform the next exploration. The BC Council (2019) concludes that experiences and perspectives of participants during any mapping session are meant to be conversation starters, foundational to subsequent mapping sessions. These conversations may be used for the purpose of critically thinking about assumptions that may expose stigma, aid in strategic planning and help to design ongoing services.

Discussion

BC Council's (2019) journey mapping highlights the multi-level impact that journey mapping can have within complex systems like healthcare. Adapting this concept to homelessness, reveals the potential to create significant impact at individual, organizational, and systemic levels by providing valuable insights into the complex experiences of people facing homelessness to inform more effective interventions and policies. BC Council's (2019) approach to journey mapping had a significant impact on both service users and providers. By separating peers and providers into distinct groups for initial mapping, and then bringing them together to share their perspectives, the process fostered deeper understanding between these groups. This approach allowed individuals to see beyond their own experiences and gain insights into the

challenges and perspectives of others. For patients and peers, the mapping process provided a platform to voice their experiences, needs, and frustrations with the healthcare system.

At the individual level, journey mapping will give voice to those experiencing homelessness, aiding them to share their unique pathways, challenges, and interactions with various services while helping service providers gain a deeper understanding of lived experiences with the goal of improving their approach to service delivery. By mapping the emotional journey of homelessness alongside the physical one, as emphasized in the BC Council's approach, we could uncover the psychological impact of homelessness and the various touchpoints that either support or hinder an individual's journey towards stable housing.

At the organizational level, BC Council's (2019) journey mapping exercise revealed several key themes that have significant implications for healthcare delivery organizations that can be easily adapted to the issue of homelessness. The identification of intersectional issues such as inadequate care models, navigational challenges, trust issues, and access barriers provides clear direction for organizational improvements. For instance, the suggestion to introduce wrap-around care models, integrate social workers and cultural counselors, and provide peer-to-peer support indicates a need for healthcare organizations to adopt more holistic and integrated approaches to care. The emphasis on trust-building between providers, peers, and families highlights the need for organizational cultures that prioritize relationship-building and patient-centered care. These insights can drive organizational change, leading to the redesign of services, processes, and upstream interventions to help people quickly find housing again.

Thompson et al.'s (2020) journey mapping highlight critical gaps in how shelter services are delivered, revealing a way forward through well known issues such as, fragmented services, complex navigation processes, and lack of coordination between different service providers (like

housing agencies, healthcare providers, job training programs, and social services). Organizations, collaborating with other agencies and government bodies, could use these insights to redesign their services, creating more integrated and user-friendly systems. For example, Thompson et al. (2020) found that families experiencing homelessness had difficulty finding resources; especially those that would enable them to have their children in daycare, so they requested the creation of a centralized information system. Changing systems to suit who they were created to serve will lead to more effective prevention strategies, improved coordination between different sectors and inform policies that address the root causes of homelessness.

Systemically, the BC Council's (2019) journey mapping project was able to influence broader healthcare policy and practice. By identifying overarching themes such as the need for stronger community connections, better chronic pain management, and addressing stigma around substance use disorders, the project provides valuable input for system-wide reforms. The recommendation to view substance use disorder as a disease, for example, could reduce stigma influencing how the entire healthcare system approaches and treats addiction. Adapting this concept to housing, journey mapping might reframe narratives of undeserving poor and instead, confirm a lack of support during critical transition periods (such as when leaving institutional care or immediately after losing housing), prompting organizations to develop targeted programs for these vulnerable times. By understanding the full journey of individuals experiencing homelessness and presenting it in a visual way that clearly shows the structural risk factors of being unhoused through to successful rehousing and community reintegration, journey mapping is a dynamic and robust tool to help identify key intervention points and systemic barriers, informing broader policy changes and system-wide transformation.

Multi-level Impact continued and Cultural Safety

Along with British Columbia's Health Equity organization, this literature review revealed that Australian researchers are at the forefront of journey mapping for the purpose of meeting the needs of marginalized people in healthcare. They have integrated the central themes of person-centered care, collaboration with multiple levels of organization, and cultural safety. Cormick et al. (2024) created a multipurpose tool in collaboration with the Lowitja Institute, which funded the tool's development and has integrated it into their healthcare system for Indigenous Australians. Cormick et al. (2024) have also been working with and tracking the use of their tools in (name countries) and are currently eager to work with people interested in using journey mapping in their research and organizations.

This research collaboration aimed to improve cultural safety in healthcare for Australian First Nations people. The researchers recognized that existing healthcare systems often fail to meet the diverse needs of First Nations patients due to institutional racism and discriminatory practices. To address this, they sought to review and enhance previously developed journey mapping tools, to continue to help understand patient priorities and healthcare delivery challenges. This work contributes to ongoing efforts to address systemic discrimination in healthcare and improve care for First Nations people in Australia.

The project involved four cycles of participatory action research, including a literature review and survey to assess the existing Managing Two Worlds Together (MTWT) tools. The survey gathered information from First Nations patients, families, researchers, and healthcare professionals to develop new Health Journey Mapping (HJM) tools. The name of the tools were previously named, Patient Journey Mapping (PJM) but families and patients wanted to use the word health to encompass the full experience as a patient within the healthcare system. They

found that while the MTWT tools were widely used, many users faced initial difficulties and suggested improvements. Based on end-user feedback, three new HJM tools were developed for different purposes: clinical care, detailed care planning, and strategic mapping. These were accompanied by comprehensive resources, guides, and examples, linked to quality improvement and accreditation standards to encourage adoption in healthcare settings (Cormick et al., 2024).

This study emphasizing the importance of co-designing tools with First Nations stakeholders and highlighting the potential of journey mapping to enhance cultural safety in healthcare delivery. It also underscores the need for continuous learning and reflection among healthcare professionals to create truly culturally safe environments. The development and implementation of Health Journey Mapping (HJM) tools exemplify the multi-level impact that journey mapping can have on healthcare systems and touch on the various organizational changes required to effectively implement such projects. This case also highlights the crucial role of inter-organizational collaboration, as demonstrated by the involvement of the Lowitja Institute, in ensuring health equity for Indigenous people. The researchers concluded that the new HJM tools effectively map diverse patient journeys and promote strengths-based, holistic, and culturally safe approaches to healthcare. The research employed a cyclical participatory action research (PAR) and co-design approach with four main phases:

Literature search: This phase involved a comprehensive review of citations of the Managing Two Worlds Together (MTWT) patient journey mapping tool. The team used Google Scholar to capture a wide range of sources, including grey literature. They analyzed the citations to identify who had used the tool, for what purpose, and to what extent. The team found 73 published works that cited MTWT publications, including included peer-reviewed articles, PhD theses, reports, conference papers, and textbook chapters from various countries. Notably, six

sources reported actual use of the MTWT tool for mapping patient journeys, primarily in Australia with growing use in Canada.

MTWT survey: The researchers conducted an online survey to evaluate how the MTWT tool had been used since its inception, inviting 77 potential participants who had used or adapted the MTWT tool to map a journey. The survey covered ten areas, including demographics, tool application, ease of use, and suggestions for improvement. Participants included First Nations patients and families, as well as First Nations and non-First Nations healthcare professionals, researchers, and educators. The research team used cyclical participatory action research (PAR) and co-design approach to continuously review and update the resources based on feedback from end users. The survey revealed that the majority of MTWT tool users were non-First Nations researchers, with a few educators and healthcare professionals. The tool enabled users to identify gaps in patient journeys, provide evidence for care, and consider multiple perspectives. However, many users reported initial difficulty engaging with the tool and suggested improvements such as simpler language and visual resources.

End user industry review and co-design: This phase aimed to develop new journey mapping tools and education materials based on feedback from the previous phases. The team created an initial prototype and shared it with end users, including First Nations patients and families, and First Nations and non-First Nations healthcare professionals, researchers, and educators. They employed an iterative decolonising co-design approach, where end users' expertise identified needs and informed the development of new mapping tools and resources. The principles of cultural safety, reciprocity, compassion, collaboration, empowerment, and trust underpinned the co-design approach. Feedback from participants was reviewed weekly in collaborative meetings involving both First Nations and non-First Nations research team

members. Emerging ideas and suggestions were inductively analyzed thematically, then discussed in the next round with end users to gain consensus. This process was repeated for several months, with different participants engaging with the project and providing feedback on different iterations of the prototype and resources.

Field testing and piloting: In this final phase, the team tested the applicability and usability of the new Health Journey Mapping (HJM) resources by engaging healthcare professionals and managers within existing research sites to actively use the HJM tools for mapping. Concurrent field testing allowed participants who couldn't actively use the tools in their practices but who were familiar with their work context, during the study period, to provide feedback on near-final versions. Based on feedback, the team developed three distinct HJM tools: clinical (for busy clinicians), detailed (for comprehensive care planning), and strategic (for bringing together multiple perspectives). They linked these tools to continuous quality improvement and healthcare standards. The team also created supplementary resources, including educational PowerPoints, videos, and worked examples to support tool use. All of these resources including the tools can be downloaded without cost by joining the **Lowitja Institute** as a community member.

Discussion

Cormick et al.'s (2024) journey mapping project exemplifies the adaptive nature of journey mapping while revealing its power as a trauma informed research approach and an agent of transformation. Their study was human centered, collaborative, and far reaching in its scope, bringing together researchers, organizations, and institutions that changed service design, and policy to achieve cultural safety within the healthcare system for Indigenous people. The involvement of the Lowitja Institute in this project exemplifies the importance of inter-

organizational collaboration in addressing health equity for Indigenous people. As Australia's national institute for Aboriginal and Torres Strait Islander health research, the Lowitja Institute brings expertise and community connections to the project. The Institute's participation ensures that Indigenous perspectives are centered through out the research process, aligning with the person-centered theme of journey mapping. The project also assures that there is a direct link between the research and advocacy for policy changes to Indigenous health equity. Also, the collaboration with Lowitja, benefitted the project because of the institute's extensive networks in Indigenous communities and health organizations. By funding the review of the original MTWT tools and supporting the development of the new HJM tools, the Lowitja Institute played a pivotal role in bringing together academic research, healthcare practice, and community needs. This collaboration demonstrates how inter-organizational partnerships can enhance the relevance, impact, and cultural safety of health research and interventions.

This article shows how the multi-level impact of journey mapping, as illustrated by the HJM project, underscores its potential as a transformative tool in healthcare. However, it also shows that realizing this potential requires significant organizational changes at various levels, from individual practice to system-wide policies. The involvement of organizations like the Lowitja Institute is crucial in ensuring that these efforts effectively address health equity for marginalized populations. As municipalities and healthcare systems consider adapting journey mapping to address complex issues like homelessness, they should be prepared for the multi-level changes required and the importance of building strong inter-organizational collaborations. By embracing these challenges and opportunities, journey mapping can become a powerful catalyst for creating more equitable, responsive, and effective health and social services.

Journey Mapping as a Trauma Informed Interview Technique

While none of the articles specifically used the term, "trauma informed care," Cormick et al. (2024) did refer to trauma informed practice as a way to ensure ethical treatment and discernment around the systemic issues that Indigenous people face. BC Council (2019), Flaherty and Garratt (2023) and Cormick et al. (2024) all show deep consideration for participant comfort and wellbeing during the research process. These studies use journey mapping to exemplify trauma informed care principals. Journey mapping, with its person centered, adaptive, collaborative approach, that includes the people being studied throughout the research process, offers dignity, agency, empowerment, and cultural safety which is inherently trauma informed.

Three researchers and one provincial organization was contacted for an in-depth, qualitative interview on journey mapping. Two researchers and one provincial organization responded and agreed to be interviewed for 30-45 minutes on their journey mapping initiatives. One researcher was unable to interview due to time constraints on their schedule. The three participants agreed to be recorded for transcription and analysis.

Each of the participants were asked how they came to journey mapping, their specific journey mapping research, how they implemented trauma informed care and what they would do differently in their next journey mapping endeavour. Barriers and enablers to doing journey mapping from a research perspective was also asked. Lastly, I asked specifically what they thought an organization should start with to engage in their own journey mapping initiative. The interviewees will be identified only by participant number (1-3) and letter (a, b, c) for this review to preserve anonymity as per REB. The interview protocol was approved by Trent University's Ethics Review Board.

The three participants were chosen because of their adaptation of journey mapping to issues of homelessness, and/or intersections with other vulnerable groups including women and children, people who use opiates, women with disabilities and violence against women. The three interviewees were geographically chosen from Australia, United States and Canada highlighting journey mapping as a tool that can be used across cultures and environments and also to highlight the collaborative nature of journey mapping not just between researchers and participants, but also between research organizations as each of the interviewees were incredibly gracious and happy to share their findings and insights from using journey mapping as a qualitative research tool. All three of the participants were passionate about their research and passionate about journey mapping as a tool for change. Each one was also very caring and concerned about the welfare of their participants, focusing on making sure that participants were coming away with something for their time, be it a different sense of themselves, an honourarium, a good "yarn" (chat) and/or heartfelt acknowledgement.

Participant 1A

When asked about using a trauma informed approach to journey mapping, participant 1A, reflected that traditionally, research has not considered the needs of participants, especially when working with marginalized people so a lot of care needs to be shown about the human being who is giving a part of themselves--their story--to a researcher. Participant 1A made this very clear by saying, "Point number one, I think, for this approach is making sure that people know that it's not extractive, that you're not seeking to just take their information and run away with it. And that it's not going to be used against them. So being very explicit about that, I think is really important up front."

Participant 1A reiterates with concern: "Yeah, and when you're working with marginalized communities, so many of them experience research in a very extractive way, where they might've been asked for information before, or it's a very one-way exchange. Like, I will tell you my story. I will give you data. And then somebody goes off and does something with it. And sometimes, somebody goes off and does something with it to their detriment. Not necessarily in research per se, but in service, for instance, information that you share can actually be used against you." They continue, "The purpose of journey mapping is important if anybody's going to engage with it. We want to understand these stories so that we can improve. We can do X, Y, and Z to improve things. [We can say] we know that it may not directly benefit you right here and now; This is hopefully going to benefit, hopefully you in the future, perhaps, or other people in your situation, or your life circumstances, or your identity group.

When speaking about power and agency, participant 1A says, "So that purpose, I think, is really important to get people on board. And I guess for us, the big focus was the power, the power differential, bringing in quite explicit emphasis that they are the expert of their own life, that I'm here to learn. I'm not here to take information and then go do something, because I know everything, which is sometimes how research and universities are conceived, these ivory towers that are useless. We're not, I promise. So, I suppose making sure that the power in the moment is shifted, so that they have control over what they share with you, and where the story is going to go."

Another concern Participant 1A spoke about was "story fatigue" which was what Flaherty & Garratt (2023) described as rehearsed stories or poor stories. Part of being trauma informed, in this case, is recognizing that marginalized people are expected to disclose very personal information, on a very regular basis, to whatever authority asks to get their needs met. Nichols

(2014) refers to this as "institutional work." Every time a marginalized person speaks to someone with authority, they are engaging in the work of survival and the management of who they are expected to be, in a system that doesn't see or respect them as human beings but as objectified consumers of services.

Participant 1A says, (about journey mapping), "It's a very accessible format. It's a very kind of…lived experience, story-based format. And I thought that would work really well because everybody with disability has different type of disability, different intensity of disability, and they have different requirements. There is a lot of storytelling fatigue for people with disability. So, this gives them a lot of control over how they tell their story." Participant 1A continues, "So it was about weaving in accessibility and inclusion. It was about weaving in kind of a trauma informed approach that was focused on making sure the participant had a lot of power and a lot of autonomy. And we built in lots of breaks, lots of relationship building. And that really opened my eyes to the power of journey mapping because it really does give participants so much power in their own story. Sometimes when we tell our stories, we worry about what other people want to hear, or we kind of limit and constrain ourselves, whereas this creates a nice format. It's like, I want to hear your whole story and tell me about this and tell me about that. And it's a very empowering sort of experience, which I really love. And I'm looking to do a lot more of it."

Participant 1A continues with themes of inclusion, accessibility, autonomy, empowerment, compassion and understanding from the researcher, also, identification with the participant and making the experience conversational rather than structured and clinical, by saying, "It's very exciting. The great thing about it [journey mapping] is that it also, I think I touched on it briefly earlier, is that it's not just empowering for the individual, but it's actually

very accessible for systems and services to engage with. And the mapping that we do includes a visual representation of the journey, and that suddenly becomes a very engaging, concrete thing to kind of understand this kind of visual representation. And everybody will focus on slightly different parts of the journey according to who they are and what they do. But at least there's this really concrete thing to engage with that is common for both the service provider and the person. Like it's a very grounding thing that they can all work and understand together too. Like it brings in the human element so beautifully. We can all relate as human to human. Sometimes the way our systems and services are set up, we don't do that. We silo, we separate out the human and the needing to do stuff. This really brings that together quite nicely, yeah."

The above transcription speaks to being human-centered, building trust, reciprocity and reparation of harms done by research and researchers in the past. In this context, the researcher also, without explicitly stating it, alludes to colonization as having played a large part in marginalizing the people that we now study and that part of the reparation of harms done by researchers and research in the past must consider power imbalances. The term extractive was very poignant in this context which echoes the displacement of people from their lands to extract resources, with no thought or care about the inhabitants. Journey mapping, as a trauma informed research tool, is now helping to reconcile some of those harms and from participant 1A's conversation, is acting as a promise to change the systems and services for the people who have been harmed.

At this point, participant 1A was asked specifically about their methods and how the journey mapping was carried out. They responded, "So the approach we did, and it changed slightly for each participant, but we chose to do it over two interviews, interviews, you know, chats. Yarning [chatting] is a very open kind of format of like, I'm not asking you very specific

questions, we're just going to chat. And whatever needs to come up will come up. So we did that over two interviews. And the first one focused very much on building trust and the relationship. We started by asking questions about the person, what was important to them in their life right now? Who are you? What is important to you? Where are you at right now? What are your needs? [In this way} we got to know the whole person. And that helped inform subsequent questions."

"From there, we had a big piece of butcher's paper, old school. And I asked if they wanted to do the drawing or if they wanted me to do the drawing. And then basically, as we talked, I started drawing on the butcher's paper, writing notes, drawing arrows, drawing stick figures, that kind of thing. Eventually this map over the course of the conversation would emerge. And then we would arrange to meet again in another week or two. Then I would come back to the second meeting with a copy of that map, probably a little bit tidied up, often because my notes were a little bit scribbly, so that it was legible and checked the map with them. So, there was that kind of checking process of, did I get this right? Did I hear you right? Did I miss anything? Is there anything you would like to add? Anything you would like to take out? I used a different color pen for the second one so I could keep track of one and two, was we just talked about the experiences and the feelings that sat around that journey. So, like when you had this interaction over here, how did that feel? How did that impact your health seeking behaviors in the future? You said this person over here was really supportive. Tell me about that. And so, we kind of deep dived a little bit into some of that so that we got richer data."

"Because we'd already talked and we'd shared the journey, and like you, I have lived experience, so I was able to share my stories too. I think that also helps. And so, we were able to kind of talk about what that feels like and what that looks like. And then at the end, what we

really wanted to do was focus on a very strengths-based, what next? If you were the boss of that service, what would you do to change? If you could talk to other people in your situation or with your background, what would you tell them? What would you like to see change? Who do we need to talk to next? So, it was a very strengths-based focus, particularly at the end, we tried to make sure that it was strengths-based throughout. So, we weren't just focusing on the bad stuff, basically, we were focusing on the good stuff too. There was a lot of affirming and encouragement built in through that."

When asked about specific barriers and enablers to doing the study and commonalities between stories, participant 1A responded: "I did the journey mapping with eight people in total. So not a huge cohort, but I think it's because it's very time intensive. And actually, even though everybody's story is so different, that's often enough to get a really strong sense of some really common themes. So yeah, in terms of the kind of the common stuff, those, yes, definitely [arose]. Everybody's journey was very different. And at first, we tried to make one big composite map, and we realized that that wasn't going to work. We needed a couple of different versions. We looked at everybody's individual map and figured out which ones looked a bit similar and which ones looked a bit different. And we ended up, basically at the moment, [realizing] we are talking about two journeys: One is the experience of chronic violence, so those in very abusive relationships or multiple abusive relationships, versus those who experienced an acute episode of violence; those who experienced sexual violence or a kind of a sudden big escalation in a relationship and then exited the relationship. So, the kind of acute versus chronic almost to use the same language. And we're currently creating those composite maps at the moment."

When asked about the barriers that participant 1A faced when using journey mapping as a research tool, they said, "The biggest barrier really, was around recruitment because we're

dealing with very vulnerable groups who are rightfully suspicious of researchers. You know, a lot of people with disability have had too many people in white coats and clipboards in their life coming, [saying] tell me something, you know? So, there is an engagement. And then of course you've got this layer of trauma on top of that. And then possibly other intersections as well. [For example], some of the women I interviewed were from culturally and linguistically diverse backgrounds, were Indigenous, had lots of other stuff going on in their lives. So, there is a lot of intersecting layers of vulnerability and marginalization going on for these women. So, for them to participate, there's a lot of barriers for them to overcome and lots of barriers for me to overcome in finding them and convincing them, if that makes sense.

Participant A1 continued, "Like a big one, so a big enabler was actually making sure that I had ethical approval to go to the women where they were. Universities tend to not like you going to people's houses, for example. It's a safety issue, which is very real, especially as a solo female researcher. But, you know, I think making the very strong and important argument that this is an accessibility issue for a lot of these people. You know, sometimes their disability prevents them from getting out and about, or it makes it incredibly onerous. They don't have the time, they don't have the energy and the spoons for that sometimes, you know? So that's a barrier that I can remove and go to them in a place that they feel comfortable with, a place that they feel safe. So that was a real enabler. [Also], I was able to offer a small payment. It wasn't a lot, but a small payment just in thanks. And that, I think, it's not about the money, it's about the acknowledgement that comes with it, that their time is important, you know? Like, yeah, it kind of helps level out some of that kind of extractive feel."

"I think another enabler was the format that we chose about doing it across two interviews. I think that was actually really big. We did at one point think about doing three and

then realized that was probably a bit too onerous. But we knew that we couldn't just stick to one because it felt so, you know…[extractive]. That really was an enabler, in terms of me understanding their stories and having the time to go away and reflect and listen back to the recordings, take more notes, rewriting the maps so that A, they were more legible, but B, it also helped concrete their journey in my mind too. You know, the act of writing does actually embed stuff in your brain a bit more. So that was a real enabler too, because then I was much more deeply invested, if that makes sense."

When asked what participant 1A would do differently they answered: "I think probably two things that I would do if I was to do the same thing again, so to speak. The first one would be to be a more rigorous note taker. And so, the process of adapting the tools was quite an organic one. We had a few chats, and we took a few notes, and we tried this and we tried that. And it just kind of grew and happened over time, bit by bit. And keeping track of all of that, I realize now at the end of it all, I'm like, oh, why did we make that decision? And when did that change? And keeping track of that, I should have kept better track of that. So that was a researcher fail. I should have done a much better job at that. So that would be one thing I would change for sure. I'm really hoping to write up a paper about the tool adaptation. Finding the time to do that is another question, but I'm really hoping that we can do that. Because I think that will be hopefully useful for others. It's not like here's how to do it, but just here's what we did and here's some things that might be useful. Some lessons that we learned."

"And the second thing would be around the recruitment and trying a few different avenues. At the time, I felt a little constrained about who I should approach and how forward I should be in that. And I think in hindsight, I probably should have been a little bit more multi-pronged in my efforts. It worked out well in the end; We were aiming for 10 and we got eight. So

that's not too bad. I'm pretty happy with that. But yeah, a lot of those were people who [we already] knew, people who participated, you know? So, it's a half of them. Like a snowball effect. It wasn't a purposeful snowball recruitment, but that's just how it happened. So, I probably needed to be a bit more plugged in to services that already had relationships like that. And some of those relationships started to build to a point where they could have been fruitful right at the end of the project."

When asked where should a municipality or other organization start their journey mapping initiative, Participant 1A continues to speak of relationship building and the importance of tapping into services who have already developed trusting relationships with service users who would be a good fit for journey mapping, saying, "So I would, relating to the last point I made about those relationships that might've helped with the recruitment, I would start with those relationships first and foremost. So, the services in the city that are providing housing and homelessness services, who providing supports, crisis shelters, anything that might vaguely fit in that sphere, as well as probably healthcare, kind of those big overlapping universal services where people often go to as well. I would start talking to people about, hey, this is something that we're wanting to do. Just having those conversations really early would be probably a really good point to start."

"The other point to start would be building a protocol essentially of how you want this to go. So, what you want your end point to be, kind of like your purpose, your big, this is where we want to end up. This is the purpose of doing this journey mapping. These are the things, this is how it's going to inform policy and practice. And then reverse engineering and building the steps to get there. And so the journey mapping is one way, one part of that essentially. And I think linking those journey maps to a very real-world outcome, I think will be really important too.

Because once you've always got that end point in sight, you can, the rest of it all makes sense. Yeah, rather than getting caught up in the nitty gritty, always have that ready to refer back to."

The final conversation organically came out of talking about how to begin a journey mapping initiative, centered around how journey mapping can change the system and how it can be used as an evidence informed tool for advocacy. They not only speak about the tool of journey mapping but what, as researchers our responsibility is to be bridges between research and systemic change so that people who are marginalized can be heard. They also remind us that journey mapping is a form of story telling and that story telling reveals hidden aspect of people's experiences, keeping them at the center of the work that should drive change. Participant 1A says, "Yeah, that's right. And that's a really important point that so many people are so disempowered, not kind of disempowered as in, oh, poor me, but they're actively, their power is removed from them. So that they cannot, not will not, cannot advocate for themselves. They will not be heard. And this is a mechanism, if as a researcher, I can bring my skills and be a part of helping bridge that gap, then I'm all for it. And like I was saying, like stories at the end of the day are an incredibly human, deep way of understanding. And this brings stories, but it also brings that systems perspective that services and systems can engage with and go, oh, this happens here, and this is why this happened. And, you know, they can see those gaps, chasms along the way and start to really understand the full picture. Like you said, you know, like often in silos, they're just doing this little bit, but a person's story isn't in this little bit. It's across here (widening arms in an expansive gesture). You can't just focus on this bit. You have to understand the whole picture."

Participant 2B

This interview began with asking Participant 2B how they found journey mapping. They were working with a local organization on family homelessness, particularly, children's homelessness, hoping to highlight the stories of mothers who had lived experience and the barriers they faced. They were seeking possible points of intervention where the system could be adjusted to be more supportive of families facing homelessness as they recognized that the barriers are different for families with children than for single people. Participant 2B says, [We were] kind of going back and forth with this community organization and their children's homelessness coalition. We found journey mapping because we realized it's not a one size fits all journey for these families. We really wanted to understand how they're going through different cycles, maybe doubling up with people, entering shelters, staying in a car and really trying to understand those different points, what are some of the barriers and supports that exist. So we felt like it was the most flexible methodology while also giving a chance to give that lived experience voice to a family."

Participant 2B was then asked if they could recall a journey mapping session and highlight a challenge. They replied, "So I think for us, the strategy that we use, knowing that it wasn't a one-size-fits-all approach, we created a pretty flexible interview guide that asked, when was your last stable residence? And then to help, we brought small whiteboards with us, where we could indicate, okay, this was your last stable housing. Now tell me, where did you move to next? And we tried to draw out their journey at the beginning, so then we could ask about each location and getting to each location along the way. So I think for us, having that whiteboard and something that we could agree upon together and draw out with the participant was really useful.

And also, as you're going, all of a sudden, they'd be like, oh, yeah, I forgot about XYZ. And then we'd easily be able to erase and add it to the journey."

They continued, "I think what was somewhat challenging is, for folks who were more chronically unhoused, it was just a longer process to go through. And that just made it a little, like no interview was the same. There were some [people] that lost their housing, and they came immediately to emergency shelter, so it was a very different conversation. It [journey mapping] just allowed for a lot of flexibility. Then we tried to probe with similar questions about what made it hard at this location? What were things that you liked at this location? What was it like for your children? And also asking, did they become separated from their children along the way? So that's the approach that we have used. And I think we learned along the way as well in implementing it." As reported in this review, Participant 2B's experience with journey mapping was felt as flexible enough to changed things as the session progressed which speaks to its ability to be trauma informed, but also highlights that there are no standard protocols or guidelines for journey mapping developed at this point.

Participant 2B was asked if they used any specific trauma informed protocols to which they answered, "No not explicitly. I don't think we explicitly baked that into our methodology. We would ask about, safety and violence and some of those things along the way to recognize that these can be sometimes vulnerable situations. And I think also building rapport at the beginning of the interview and that trust, so that way we could have these more open and honest conversations were kind of the main strategies we use, but we didn't explicitly have a particular protocol around trauma-informed interviewing."

Next, Participant 2B was asked about challenges encountered while executing their journey mapping sessions. When describing how challenging it was to find places to do the

interviewing, they revealed that privacy was an issue as they had to go out to the families to interview them. They disclosed, "It was me along with some staff members. Myself and some students and a staff team member. So, we would go out in pairs to do the interviews at different locations. So, it was it was a team effort. I think probably some of the biggest challenges we encountered were just navigating some of the structures, like locations where we were conducting interviews that weren't always private, like we were in a gym for some of them. I met a lot of people at McDonald's or other fast-food locations. So, I think that was probably the most challenging aspect, finding that kind of quiet space without distraction. And we're talking about predominantly women with small children. So then also, having to get the children settled and find things to distract the children with while their parent is talking. So, yeah, I think those were probably our predominant challenges and we tried to deal with it by having at least two of us there at all times." A best practice for journey mapping, may be to make sure that there are places that are suitable for different groups to do their mapping. For example, Participant 1A went to the homes of people suffering from disability. For women with children, a full day with extra people to organize around kids, perhaps bringing everyone together for breaks and lunch, would help to get the best results. People living in shelters may appreciate doing their mapping away from the shelter either as individuals or as a group with a catered nutritious lunch would enhance their experience while offering a relaxed atmosphere.

The next question was, "Was there anything that you wish you had changed? They answered, "Oh, that's a good question. I think maybe in the publication, we ended up focusing more on the barriers piece, because I think we were trying to speak to what in the system needs to be changed or adjusted. What I wish we could have spent a little more time on in the publication was some of the facilitators. And I think for some of the families we talked to, having

children made it more challenging to find housing. I think it gave them a sense of resilience and drive for seeking support because they were doing it not just for themselves, but for their children as well. So, I think that type of resilience piece wasn't really discussed in the publication, but definitely came through in some of our conversations.

They were then asked how the research group measured the impact of the journey mapping on interventions? Yeah, so I think initially, because this was done pre-pandemic, there was a family homelessness committee within our continuum of care in the region. And using some of the results that we had to help to bring together different stakeholders on that committee who weren't traditionally there, like our childcare services, transportation services, the city. Again, just trying to find ways to work collaboratively to help support families. And then, with the pandemic, we saw this major shift where our continuum of care was like, look, we solved family homelessness, but that was just because no one was getting evicted anymore and people had to stay where they were at. The organization I worked with, they are very evidence informed and in their theory of change within the work that they do are prioritizing things like early childhood education, childcare, and helping their clients find jobs that pay a living wage. So even though it may not be a direct link, they're using not only the evidence from that study, but others as well to address some of those key barriers." This shows the collaborative nature of journey mapping as different organizations and levels of government gathered to support the project. Also poignant, is how seemingly external factors like the pandemic changed the narrative around housing, in this case, "solving" it because evictions were no longer an acceptable option for dealing with tenancy issues. This echo's what BC Counsil (2019) reported that journey maps are snap shots of time and place, and the results of each map should be conversation starters rather

than seen as solutions to constantly evolving situations like addiction and housing transitions showing that as the narrative changes, the journey changes.

When asked about their collaboration with the other organizations and agencies, they said, "I think what really helped was that the community organization that funded us had a lot of credibility and was already a champion in this space. I think that helped open a lot of doors for us. That that would have been a little bit more challenging otherwise. That being said, in any city, there's turf wars and things like that. So, I can't speak to if being paired up with that organization could also be a hindrance. You never know, right? But I do think that really helped open the doors and make those good linkages to be able to help with recruitment and then also in disseminating the findings." Cormick et al, (2014) study also benefitted from it's support and collaboration with the Lowitja Institute highlighting that seeking beneficial connections with community partners is paramount to a successful journey mapping initiative.

When asked what the researcher would have liked to do differently, they replied, "It's a big question. Yeah, I think one of the things we struggled with at the beginning was our inclusion criteria was a little vague. We ended up getting some folks who may not have appropriately met the target population we were trying to reach. Particularly men who were unhoused but were separated from their children. So, they weren't necessarily going through the same challenges as a parent or caregiver with children in tow. I think that was, and that's not related to methodology per se, but in some ways we didn't realize all of that until we started doing the journey mapping and we're like, oh, you haven't been with your kid in two years. So, that just was a challenge for us. And then finding, we at the beginning, tried to have some, markers and things for when we were drawing out the journey that would like indicate, oh, a good thing happened or a bad thing; we tried to have a legend, but that just became a little too cumbersome. So we ended up just

doing a lot of writing around the journey, rather than using kind of a standardized legend, which I think I've seen other places do. I just don't think, given the locations where we were doing the interviews and the distractions, it was an option for us, but I wish we could have done it better." Both participant 2B and 1A speak of a lack of structured methodology or guidelines around organizing the data so that needs to be considered when preparing to engage in journey mapping.

Participant 3C

The interview with participant 3C highlights the experiences of an organization involved in journey mapping within the context of quality. They share insights on conducting journey mapping sessions that focused on opiate treatment within the healthcare system. This organization has had a longstanding relationship with journey mapping but only recently conducted their own studies using the method. Participant 3C is committed to helping others complete mapping journeys, noting that there were few resources available to walk them through their first initiatives. Also discussed, is the evolution of their methodology from in-person to virtual sessions, highlighting the challenges and benefits of each method.

Next the participant was asked, “How did journey mapping come to the attention of your organization and what was your initial reaction?” They answered, "So we've been quite familiar with journey mapping for a number of years. My organization has a pretty broad mandate, and we do a lot of different stuff related to quality improvement. And one of the core parts of quality improvement is engagement with patients and families and communities. So, the different tools for doing that, whether it's a conversation like this, that we're having, you know, a focus group or participational long project or journey mapping has kind of been conceptually known and shared and taught through our organization for, over a decade probably. We did support others to do journey mapping, based on some of those core principles. But we ourselves, to my knowledge,

did those first ones that you saw. They were the first that we ourselves led. The nature of our organization is generally supporting others to do the work. We're more consultants rather than coming in and doing it for people. It's more of a community development approach we take with people working in the system. But these were some examples where we did it ourselves."

"And actually, I was really surprised because I had known conceptually about journey mapping, but this was the first time that I was designing and leading it and doing the whole shebang, obviously not alone. But I was really surprised that there weren't more toolkits, resources, case studies, things out there published. So, it's a, it really is a gap. And that's why we felt very strongly to share our journey maps and also share a little bit about what we did in it. You know, not that it's a full toolkit, but just that definitely is a gap. We get questions and it's on a maybe eventual to do list. We definitely get questions from people so there's an appetite for it."

We did the journey mapping related to primary care, but more specifically to opiate treatments, with not a complete focus, but more of a focus on rural, semi-urban and remote areas versus some of our urban cores. So, it was a little bit more focused. I participated in the journey mapping, but not as a participant; I was the lead designer and one of the facilitators during the session. And then with a small team, the ones who did the analysis and the dissemination [of results] afterwards. What we heard loud and clear was [that people needed] more choices and that the people really being the ones who are establishing their goals for care differ because some people's goals for care are to get totally off of any sort of, the street supply, off of a medicalized supply, everything. And for others, it's different. Their version of success was I'm on opiate agonist therapy and I'm going to stay on it and my life is stable and this is my success, [which is] fair enough."

Because the organization has completed more than one mapping journey and with different focuses, the conversation shifted to whether any of the same participants were retained through the different journeys or if the organization solicited a new group each time. They report, "From the first mapping to the second? No, we didn't. However, a few of the providers and organizational reps did participate in both, but it was not very many. The vast majority were new because it was a pretty specific focus. To my knowledge, none of the peers or people with lived experience participated in both."

There was a notable difference between the delivery of the first and second journey maps with the second seeming much more focused and succinct. When queried about this participant 3C replied, "Oh, well, I'm very happy you found that. So, I was not involved in the first one. I was with the organization, but not on the project team. But they were different purposes. So, I think that's kind of something that I really took away loud and clear from doing that. The first thing you really want to do before you start the mapping is think about why am I doing this? Like, what am I going to be doing with this information? Because that really deeply impacts like the design of it, the types of questions you ask, and then what you inevitably put out into the world. So, in the first mapping, again, this is my understanding, not having been closely involved in the project team, but it was much more at a system level, it was trying to identify where are we going to put our system priorities and come up with recommendations for those versus the second initiative."

"It's like we knew what we wanted to do. We wanted to optimize out in primary care. So, we intentionally made it well, hopefully, a lot more reader friendly, a lot shorter. We have the [original] journey maps like the [first] ones you saw that are a bit messier [because] they go here than they go there. We have all that and we have all the notes, and we use that to design the

program because that was the purpose too; journey mapping to design a program and to share information with the ministry. But we didn't put those out because we're like, well, what is helpful for people? So, we called them experience maps versus journey maps that we put out. And it was less like, okay, this happens, that happens, that happens, that happens. And it was more like mapping a question. So that hopefully came through, the question of what matters to people on opiate treatments and what is the experience of a provider trying to do this for the first time and then a system level one. But it was different. It was intentionally different."

Speaking of the maps themselves, this organization used professional graphics to disseminate their findings. When querying what that was like and whether a visual facilitator attended the sessions or whether the data was sent to them later participant 3C responded, "Yeah, it's pretty incredible. What he brought, I think, was helpful because, there's the graphic design, but he was really part of our design team even before we did it. And it was some of the graphic facilitator's provocations that helped us to land on the questions. It's kind of like, so what? Like, what are you trying to map? I know traditional journey mapping is kind of like, take me through chronologically what happened. This was kind of chronological, but we were more interested in specific questions and experiences."

The next question was asked to expand on participant 3C's methodology, asking if they could describe any specific mapping journeys that were really impactful or powerful. They said, "My God, they really all were. I would say a huge distinction between the first and the second sessions was the first one was in person and the second one was entirely virtual. We had never done a virtual journey mapping session before so that was a pretty big distinction. And there's pros and cons. But it actually worked. I feel like we did the maximum amount of time you could do. I probably knocked off an hour of the day, but it totally worked in terms of like accessibility.

Like there's accessibility on both sides, right? Because for some people, they're not, technically savvy or if they don't have access to a computer. But what we were able to do is partner with local community-based organizations so that they could come in. They set them up on the computer with a peer support worker."

"It was a bit of a risk. And I was kind of worried about some of those safety considerations for people, because you're not there if they're, you know, they experience like a big emotional response. But we had a counselor there and whole mitigation plan. So anyway, there's always risk, right? It's always a balance of risks. But in terms of accessibility, we did hear from a lot of people, like being able to like have a cigarette, do what they needed to do, like not have to wait for a break, was actually a lot more comfortable for them to not be in a room with a bunch of people. The one thing that we did lose out on was the opportunity for the providers and the people lived in the experience to create relationships. So in the first session, that was one of the goals, that it was more like networking--relationship building. So if you want that, it's different. So again, understanding your goals is important. But back to your question, I can't say that there was one, it was, they were both, they were all incredible. And I would say the experiences that people have in living experience were incredible. And the providers as well, because the people working in this space are like okay, this isn't going away so I swear, they are badass. I've worked with providers across the continuum of care. And people who work in the substance use are a different breed. They are amazing. So many of them are just so amazing."

As in the Cormick et al. (2024) study, participant 3C's journey mapping also incorporated cultural safety as part of their trauma informed practices. They discussed, "Yeah. So that was like, they were both like really incredible. And I can't say I would pick up on one specific story because it really was many, but maybe one thing that this just prompted me to think about was

we divided people into groups just for workability. And we did have the people living experience who identified as Indigenous as a distinct group. And that was done like in consultation with our director of Indigenous health and with the peers themselves, like in conversation beforehand to talk through it, feel comfortable and the rationale for that. The rationale was not to segregate, to separate. It was to be able to recognize that it is a distinct experience. And at least here and I'm sure elsewhere, there are inequities in terms of they highly represent, like the high representation in terms of toxic drug harms. So just wanting to give that space for comfort for those who wanted it and also just be able to dive into some of the distinctions was why we made that choice."

When asked to expand on their trauma informed practices or what participant 3C referred to as a mitigation plan, they replied, "Yeah, so I would say thinking about it before, during and after. So beforehand, I had a conversation with every person who was going to participate. I have to go back and look at my notes but I'm pretty sure I talked to everyone on the phone. Maybe there were one-offs that were just email and they were at least offered a phone call. But I'm pretty confident that I spoke to like 99% of people on the phone beforehand just to introduce myself and share a little bit about what they can expect and mostly ask them the question specifically: what would make this a safe and meaningful experience for you? So we got to talk about things like access, and what actually came up most of all was the virtual, how to make use of the space and Zoom and things like that. And we did offer honorariums for their participation. So this was an offer, like they didn't have to say yes, but we did offer cash honorariums for time for the people living experience."

"For the providers, those who are salaried, they did it as part of their role. But if they were a practicing clinician that was stepping away from paid clinical time, we were able to

compensate them for their time. So that was lucky. That's not always the case to have funding to do that. But yeah, so that was part of it. And then I sent everyone the agenda and the questions they can expect in advance. So having that like written on paper as well, what's important. So all those things, I think beforehand, are almost more important or as important as what you do on a day. So then on the day, nothing was a surprise."

"There was at least one familiar face and they kind of knew what they were getting themselves into more. And then for people with higher needs, like for support, like I said, were actually joining from community-based organizations or a few people where there was a peer coordinator there that I was in touch with who was there with them. So that was really helpful. And for another person, they had a support person with them and that was totally fine. So, the virtual was kind of, again, pros and cons, right? But there were actually quite a few pros."

"And so then in terms of the safety plan, we had had a counselor on our virtual sessions before for different types of sessions we've done. We reached out to them and although we didn't have them there the whole time, we met with them in advance and they walked us through some mitigation plans: if this happens, if that happens, so they were there over lunchtime and people knew when they were going to be there. They were there for the lunch break, and they were there at the end of the day. And you could hop into breakout room if you needed to. We also had, written in the chat, some of the support lines and things you could reach out to. In the end, no one accessed the counselor, but I think it was less about people actually accessing them versus knowing that they were there. And we also had a First Nations elder open the day and stay with us throughout the day. They were in the breakout room with the Indigenous peers and then they closed at the end of the day. So, they were with us all day and available for people if they needed

it. But again, no one actually took those supports up, but I don't even think that's really the point always. It's just knowing it's there."

"Afterwards, I sent an email follow-up to people because people kind of scatter all around, but there was the opportunity to have a conversation afterwards with me. I think maybe one person took me up on it and then we were in touch by email, and they knew, again, they knew exactly what to expect. Like we were in touch by email monthly until it was published, and they had the opportunity to validate the draft before they went out."

The conversation then turned to funding. While seeking and securing funding was beyond the scope of this review, the question seemed important from the perspective of using this part of the review as a guide for others on how to move forward with journey mapping, on possibilities of securing funding as an evidenced based research method and perhaps as an indicator of journey mapping beginning to be seen as an acceptable method to funders. They replied, "We had provincial funding for this. I think the first two mappings were just from our base funding. We are a provincial government organization, so we get funding on three-year mandates. But for this project specifically, it was part of a primary care collaborative. It was about accelerating improvements in treatment care and primary care so that we actually received specific project-based funding for that whole project, not for just the journey mapping, but the mapping was a piece of it. And that was from the provincial government."

This question also brought up how care needs to be taken around honourariums for certain groups. They said, "And meanwhile- There's a lot of things around payments, specifically for peers. Not everyone might want it [payment] because we did ask that question at the end with specifically the peers, like around, how is this for you? The process of engagement was generally very positive. But one thing that we didn't anticipate was, one person said, this actually was a

very generous honorarium. Like they aren't always, so that's great. For some people receiving a lump sum of cash in hand can be triggering. I think that's important to ask people--to not make the assumption that that's what they want. So, it's like, what would you like? Is there something other than cash? Exactly. And of course, at the end of the day, people make the choices they're going to make. But that is why you ask people because they know better than you."

As reported earlier in this review, Flaherty & Garratt (2023) were uncomfortable around the ethics of journey mapping having therapeutic value for some participants. When discussing this with participant 3C and asking if they found that their participants, through the reflective nature of journey mapping, got a different sense of who they were. Along with potential therapeutic value, participant 3C was asked what other motivations might someone agree to embark on a journey mapping session other than an honourarium? They responded, "Well, I think for the peers and also the providers, everyone involved, it was just passionate people, wanting to make a difference. I think knowing where the information was going and how it was going to be used was the biggest motivator. So, us spending that time upfront asking, really, what can we commit to? Like, what are we going to do with this information and not over committing and over promising so people can make that choice." They continued, "There is a lot of diversity in terms of the people that are living experience that came. I didn't have conversations with all of them afterwards, but there were a few that actually stayed on board and supported the collaborative that's actually just finishing this September now and they joined our advisory group. There have been faculty, that have spoken at sessions, things like that. And one in particular, we originally met through the journey mapping and now he's just such an incredible partner to us. And he spoke a lot about how restorative being involved in quality improvement in these engagements are for his recovery. He's now six years removed from his opioid addiction.

And so he has shared a lot about the therapeutic value of this and the self-esteem and taking something that was a source of shame that he did everything in his power to not talk about. And then the irony of, I'm now centering my life around this, you're talking about this thing [that was not to be talked about before].

When asked if there was anything that participant 3C would do differently, they responded, "I think that I would have, because of the virtual nature of it, [shortened the day] but everyone hung in there. There was no attrition and there was positive feedback on how it went. But it took a bunch of facilitators on our team because we had three people in each breakout session. We had the verbal facilitator; we had a note taker, and we had someone doing the mapping. So, it took a lot. And then we had five different breakout sessions. It took a lot of members of our team. Checking in with them afterwards, I would have shortened it by maybe an hour. It was a long day for people, but I didn't actually hear that feedback from the participants."

"We're involved in supporting the community action teams here and also peer workers so to bring it back to the journey mapping, triggering people was a huge consideration because you're bringing people together to talk about, [substance use] and they're all at various points. It was important to us to have people from diverse backgrounds and diverse situations and at various points in their recovery. So how do we have that conversation for hours? You know, in a way that isn't going to cause them harm and they're going to feel like safe and comfortable. So that was a really big consideration for sure."

"We did give them quite a few breaks, but I would do no longer than what I did. We ended up doing seven hours with an hour break and at least two half hour breaks. So there were a lot of breaks. That would be like the maximum I would do. I would not push it any longer or do any less breaks. And then the only other thing I can think of, and I don't know, I would have

liked to have trialed it, having it over two days and having the second day, a half day of, let's come together and share and have providers and peers talking to each other. The next day, we did do that in person. I think it worked well, just virtually, we didn't think we could get people back but I wish we had tried. I wish we had tried that because I put out the offer to do that like a month later and got very low uptake. And so doing it right afterwards and pre-scheduling it in would have been good. I can't say how it would have went, but I think that would have been something I would do differently now."

Lastly, participant 3C was asked if they audio recorded any of the journey mapping sessions. They replied, "We did not record. We were taking notes. We had a note taker. We told them how we were using and saving the information, but no, we didn't record it. Honestly, if your participants are up for it and you don't think it's going to, impact what they'll share, then I think that's totally great. We had the person power, so we were able to have a note taker in the room typing. I'm sure their hands were very sore, but between them and the person doing the mapping and a facilitator debrief the next day, we were all able to share while it was fresh and talk about some of the themes and things that came up.

The three interviews conducted for this review provide valuable insights into the practical aspects of conducting journey mapping sessions, emphasizing the importance of careful planning, participant safety, and adapting methodologies to suit different needs. Their reflections on what worked well and what could be improved offer useful suggestions for others interested in implementing journey mapping in their own organizations or research projects.

Best Practices for Journey Mapping and Trauma Informed Care-General

1. Clearly define the purpose and goals of the journey mapping project.
2. Identify the target population and develop appropriate inclusion criteria.

3. Consider whether the participants will meet individually, as a group, online or in person.
4. Collaborate with community organizations and stakeholders to aid in recruitment and build trust.
5. Develop a flexible interview guide that allows for adaptation during sessions.
6. Create a safety plan and mitigation strategies for potential emotional triggers.
7. Arrange for support services (e.g., counselors, elders) to be available during and after sessions.
8. Plan for appropriate compensation or honorariums for participants.

Participant Engagement

1. Contact potential participants individually before the session to explain the process and address concerns.
2. Offer choices in how participants can engage (e.g., in-person, virtual, with support person present).
3. Provide clear information about the purpose of the study and how data will be used.
4. Emphasize that participants are the experts of their own experiences.
5. Allow participants to choose how they want to represent their journey (e.g., drawing, verbal description).
6. Be prepared to adapt the process for participants with different needs or abilities.

Conducting the Session

1. Start with relationship-building activities to establish trust and rapport.
2. Use simple, open-ended questions to encourage storytelling.
3. Employ visual aids (e.g., whiteboards, large paper) to map out journeys collaboratively.
4. Allow for breaks and flexibility in timing to accommodate participants' needs.

5. Be attentive to emotional responses and offer support as needed.
6. Focus on both challenges and strengths/resilience factors in participants' stories.
7. Involve participants in the interpretation of their journey maps.

Trauma-Informed Approach

1. Recognize and validate the potential for past trauma in participants' experiences.
2. Create a safe, non-judgmental environment for sharing.
3. Empower participants by giving them control over what and how much they share.
4. Be prepared to respond to disclosures of trauma with empathy and appropriate resources.
5. Avoid re-traumatization by allowing participants to skip or pause discussions as needed.
6. Incorporate cultural safety practices, especially when working with Indigenous participants.

Data Collection and Analysis

1. Use multiple methods to capture data (e.g., notes, visual mapping, audio recording if consented).
2. Involve multiple team members in data collection to capture different perspectives.
3. Conduct immediate debriefs with the research team after each session.
4. Use an iterative approach to identify themes and patterns across journey maps.
5. Involve participants in the validation of findings when possible.

Follow-up and Dissemination

1. Provide opportunities for participants to give feedback on their experience.
2. Offer follow-up support or debriefing sessions for participants who desire it.
3. Keep participants informed about the progress and outcomes of the research.
4. Present findings in accessible formats, including visual representations.

5. Use journey mapping results to inform concrete changes in policies or services.

Ethical Considerations

1. Obtain informed consent, emphasizing the voluntary nature of participation.
2. Protect participant confidentiality and anonymity in all stages of the research.
3. Be transparent about the potential benefits and risks of participation.
4. Consider the potential therapeutic value of the process without overpromising outcomes.
5. Be mindful of power dynamics and strive to create an equitable research environment.

Adaptability and Continuous Improvement

1. Reflect on the process after each session and be willing to adjust methods as needed.
2. Seek feedback from participants and team members to improve the journey mapping process.
3. Be open to unexpected insights or directions that may emerge from the mapping process.
4. Consider conducting multiple sessions or follow-ups to capture changes over time.

By following these best practices, organizations can conduct journey mapping in a way that is both effective and sensitive to the needs of participants who may have experienced trauma.

Best Practices from Participant Interviews

These recommendations are extracted from the above interviews with the three participants above, who have conducted journey mapping sessions with vulnerable populations. They supplement the general best practices guide by providing specific, experience-based insights.

Ethical Considerations and Participant Empowerment

1. Emphasize that the research is not extractive. Clearly communicate how the information will be used and that it won't be used against participants.

2. Explicitly state the purpose of the journey mapping and how it will lead to improvements.
3. Shift power dynamics by emphasizing that participants are the experts of their own lives.
4. Give participants control over what they share and how they share it.
5. Be aware of and address "story fatigue" - participants may have rehearsed stories they tell authorities.

Planning and Preparation

1. Start by building relationships with services and organizations that have existing connections with potential participants.
2. Develop a clear protocol outlining the purpose, expected outcomes, and how the journey mapping will inform policy and practice.
3. Consider conducting sessions over two interviews to build trust and allow for reflection.
4. Prepare a flexible interview guide that can adapt to different participant experiences.
5. Partner with local organizations to provide technical support and a safe space for participants.

Conducting the Sessions

1. Consider using a conversational "yarning" approach rather than structured questioning.
2. Start by asking about the person's current situation and what's important to them.
3. Use visual aids like whiteboards or butcher's paper for mapping, allowing easy modifications.
4. Offer participants the choice to draw their own map or have the researcher do it.
5. Use different colors to track changes or additions in follow-up sessions.
6. Focus on both challenges and positive experiences throughout the journey.
7. End with strength-based questions about potential improvements and advice for others.

Trauma-Informed Practices

1. Build in frequent breaks and opportunities for relationship building.
2. For virtual sessions, have a counselor available during breaks and at the end of the day.
3. Provide contact information for support services in the chat or handouts.
4. Consider having cultural support, such as an Indigenous elder, present throughout the session.
5. Be mindful of the diverse backgrounds and experiences of participants, including potential trauma.

Logistics and Accessibility

1. Seek ethical approval to conduct interviews in locations comfortable for participants, such as their homes.
2. For participants with children, consider providing childcare or activities during the session.
3. Be prepared to conduct sessions in various locations, including public spaces like fast food restaurants.
4. For virtual sessions, consider the pros (flexibility, comfort) and cons (less relationship building) carefully.

Data Collection and Analysis

1. Have multiple team members present: a facilitator, a note-taker, and someone managing the visual mapping.
2. Consider using professional graphic designers to create polished, accessible versions of the maps for dissemination.

3. Be rigorous in documenting methodological decisions and changes throughout the process.

Participant Compensation and Follow-up

1. Offer compensation but be mindful that cash payments may be triggering for some participants. Ask about preferred forms of compensation.
2. Follow up with participants after the session, offering opportunities for further conversation.
3. Keep participants informed about the progress of the project and give them a chance to validate findings before publication.

Recruitment and Sampling

1. Be clear about inclusion criteria to ensure participants match the target population.
2. Consider using purposeful sampling to ensure diversity of experiences.
3. Be prepared for each journey to be unique, especially when working with people who have experienced chronic issues.

Adapting the Method

1. Consider mapping specific questions or experiences rather than strictly chronological events.
2. Be willing to adapt the method as you learn, but document changes carefully.
3. For complex topics, consider creating multiple composite maps rather than trying to fit all experiences into one.

These recommendations provide practical, nuanced advice based on real-world experience with journey mapping. They highlight the importance of flexibility, participant empowerment, and trauma-informed practices when working with vulnerable populations.

The Maps

The visual representation of experiences is one of the greatest features of journey mapping, providing powerful insights into complex life trajectories and service interactions. Creating journey maps can be done in a variety of ways from very simple sticky notes on a wall, to hand drawn pictures on paper, to white boarding. As described in the literature, maps can be done individually or created as a group. They can also be created from previously collected data.

Crosier & Handford (2012) created composite journey maps that visually represented the experiences of visually impaired individuals navigating retail and transport services. Bearnot & Mitton (2020) developed two-dimensional graphs to illustrate the care pathways of patients with opioid use disorder and associated endocarditis. Flaherty et al. (2020) employed a unique "life mapping" approach, where participants drew their own housing histories across their lifespans. The British Columbia Patient and Safety Council (2019) produced professional graphics of multiple maps reflecting both general population and Indigenous perspectives on primary care engagement. These diverse mapping approaches demonstrate the flexibility and power of visual representations in journey mapping, each tailored to capture specific aspects of participant experiences and system interactions. The maps are presented in the same order as the articles in the review with links back to each article for ease of navigation.

Advocacy (Crosier & Handford (2012)

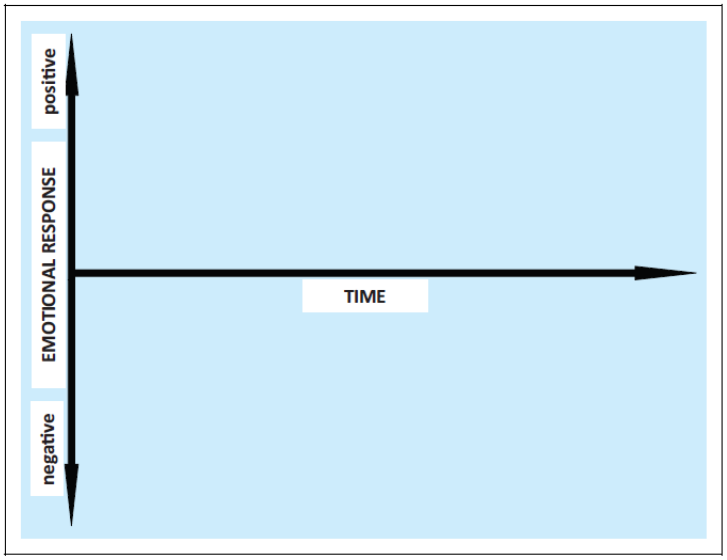
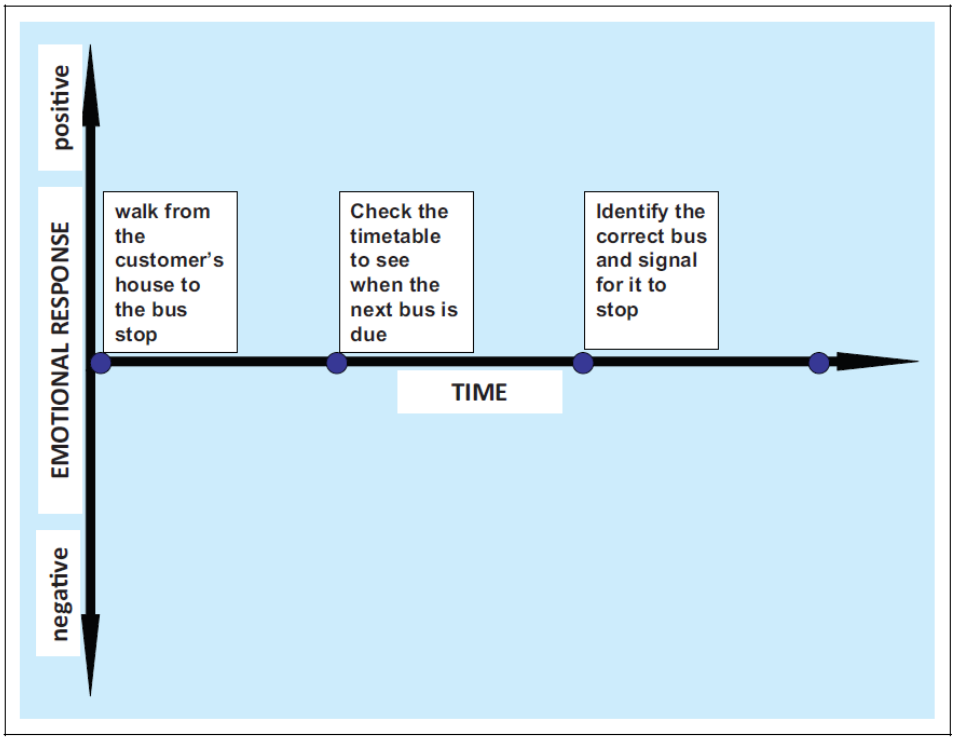


Figure 1. Step 1: A template for map showing axes for 'time' and 'emotion'.

Crosier & Handford (2012) began with a very simple template beginning with emotions and a timeframe that they layered with data as the study



progressed. **Figure 2.** Step 2: Events on the time line.

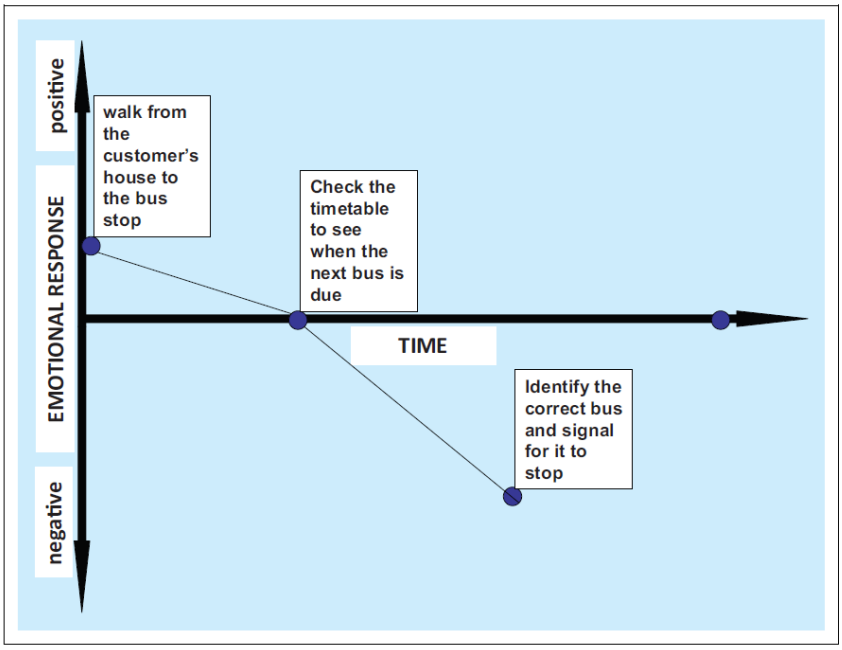
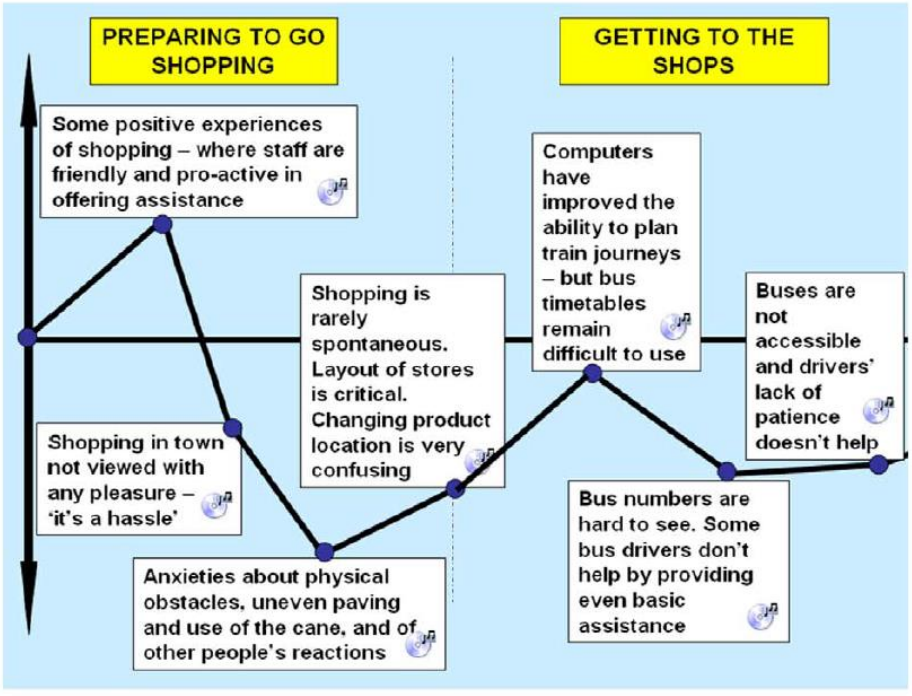


Figure 3. Step 3: Linked events with emotional response.

More data is placed on the map from participants showing negative and positive experiences



As the journey progresses from bus stop to the shops each barrier or enabler is plotted on the map

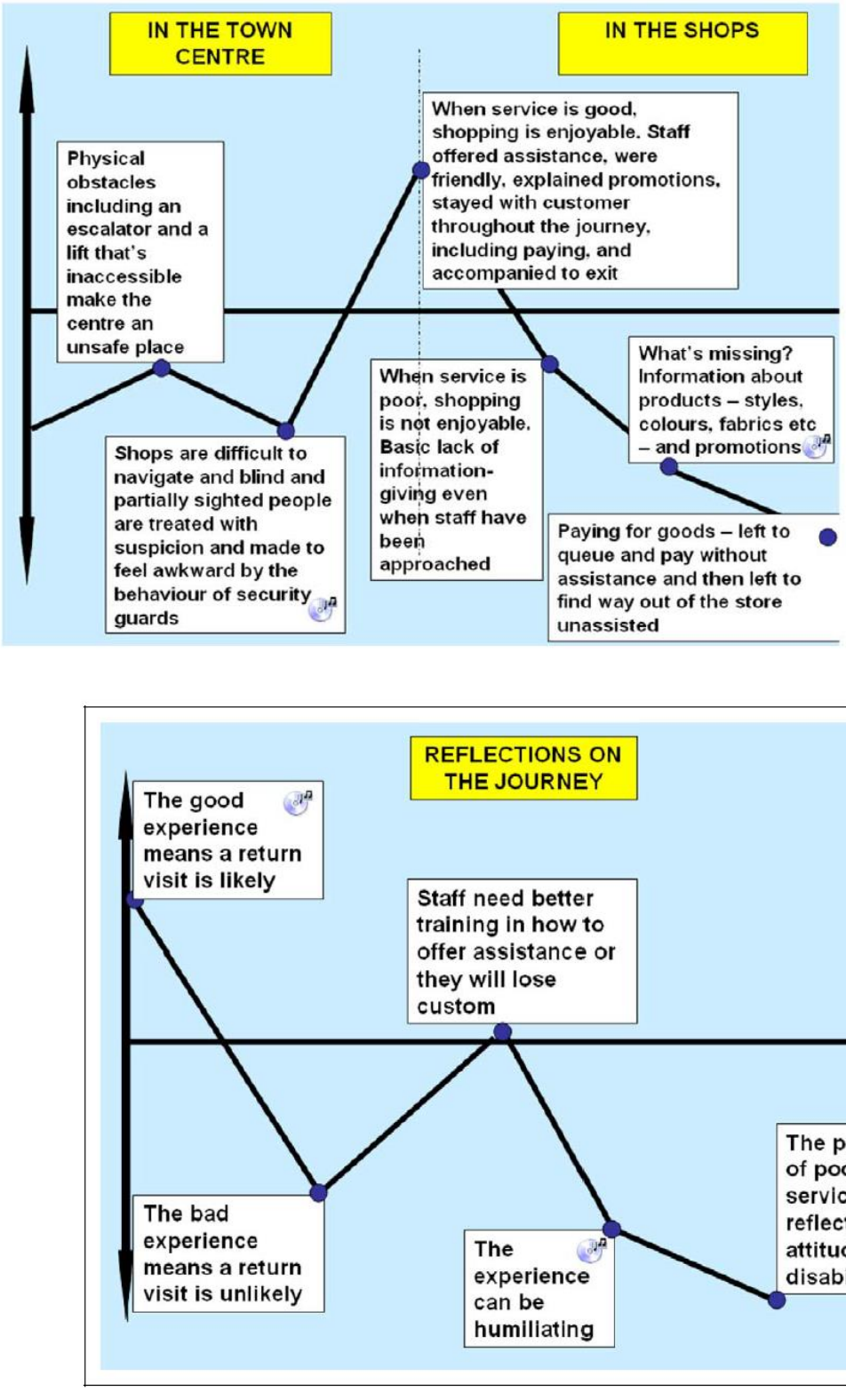


Figure 4. Illustration of customer journey map (CJM) for blind and partially sighted people shopping in Lincoln.

The journey is then analyzed for themes creating the foundation for change.

Healthcare and Addiction (Bearnot & Mitton 2020)

Bearnot & Mitton (2020) maps are somewhat more complicated as they depict a patient journey through multiple access points, barriers to treatment, and pathways through the hospital system.

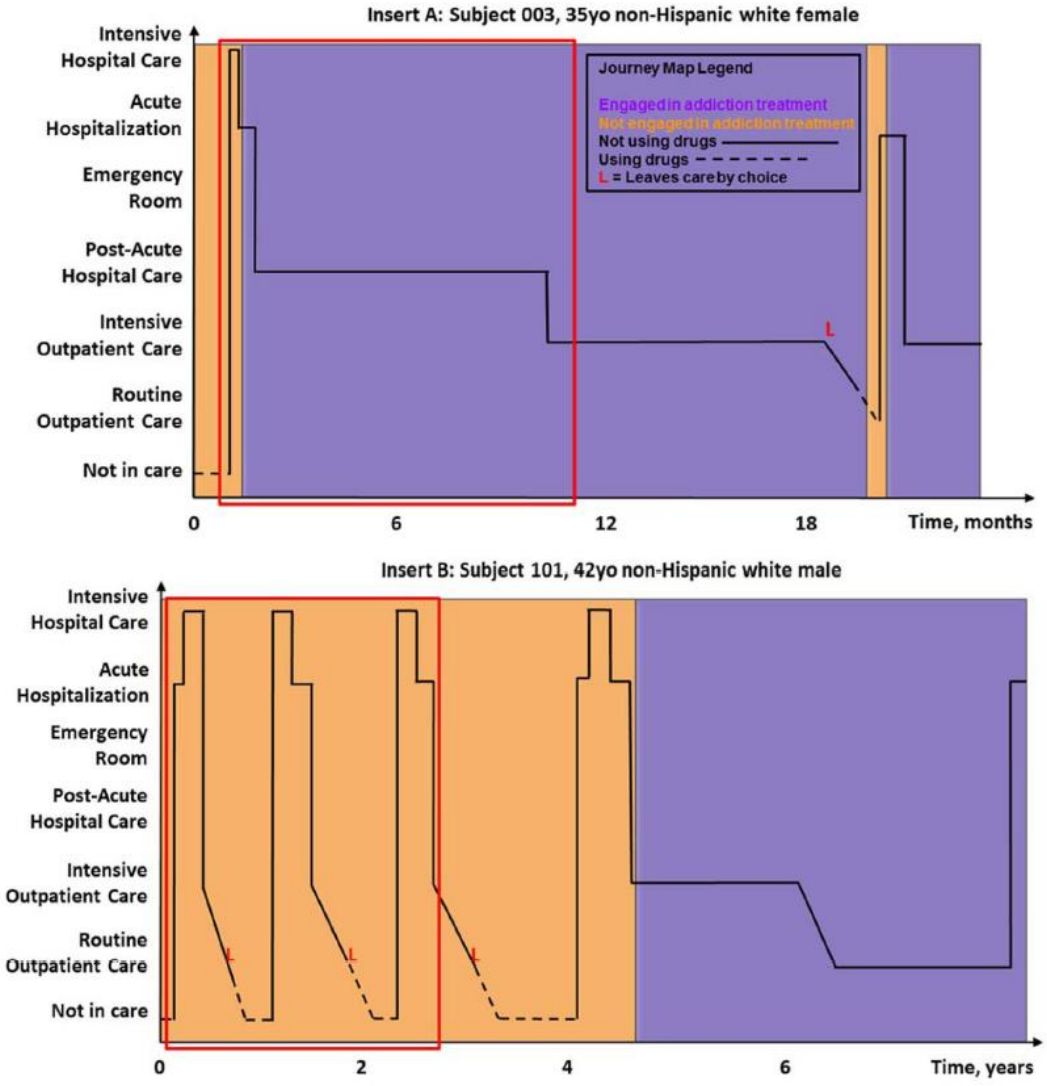


Figure 1: Journey Maps Illustrative of Theme 1:
Two common patterns of care emerge, with early addiction treatment and intensive outpatient care observed to precede periods without re-hospitalization.

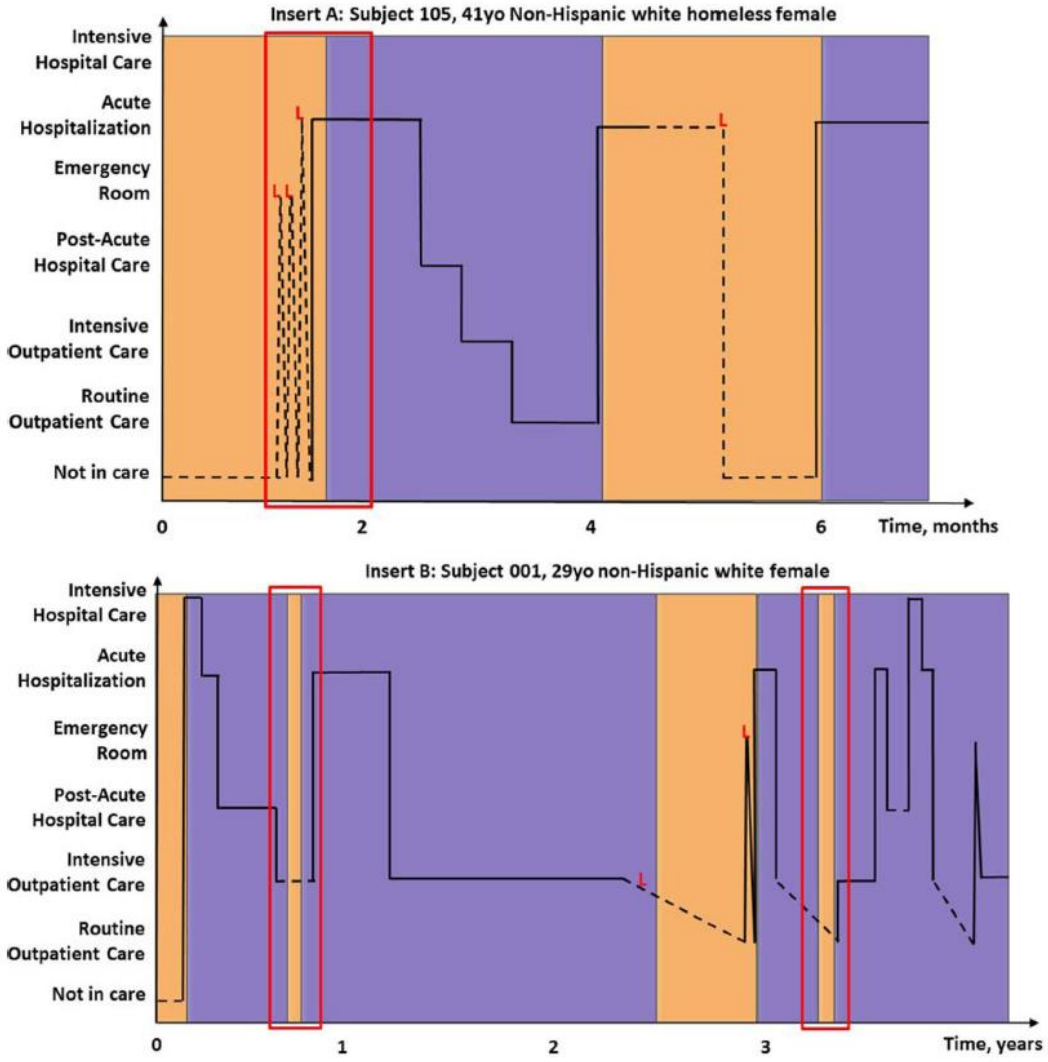


Figure 2: Journey Maps Illustrative of Theme 2:
Participants purposefully leave and re-engage in care.

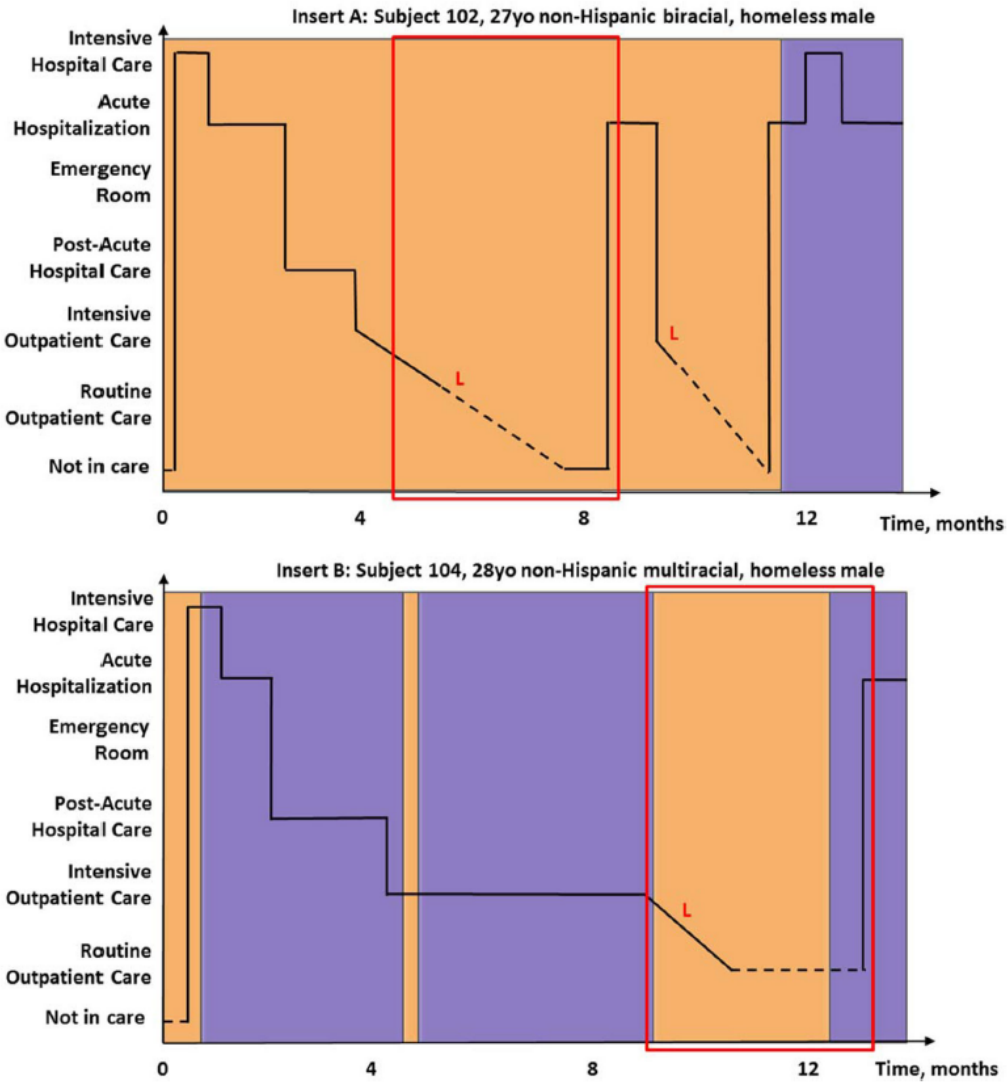


Figure 3: Journey Maps Illustrative of Theme 3:
Leaving intensive outpatient care and returning to substance use often directly precede re-hospitalization.

Life Drawing maps (Flaherty et al., 2020)

Flaherty et al., (2020) opted to use large sheets of paper where participants could sit and choose from multiple-coloured markers. They originally used a white board but found that some participants were unable to stand for the length of time required due to disabilities. Flaherty also described journey mapping from an ethical perspective which is in the **ethics and trauma informed care section below.**

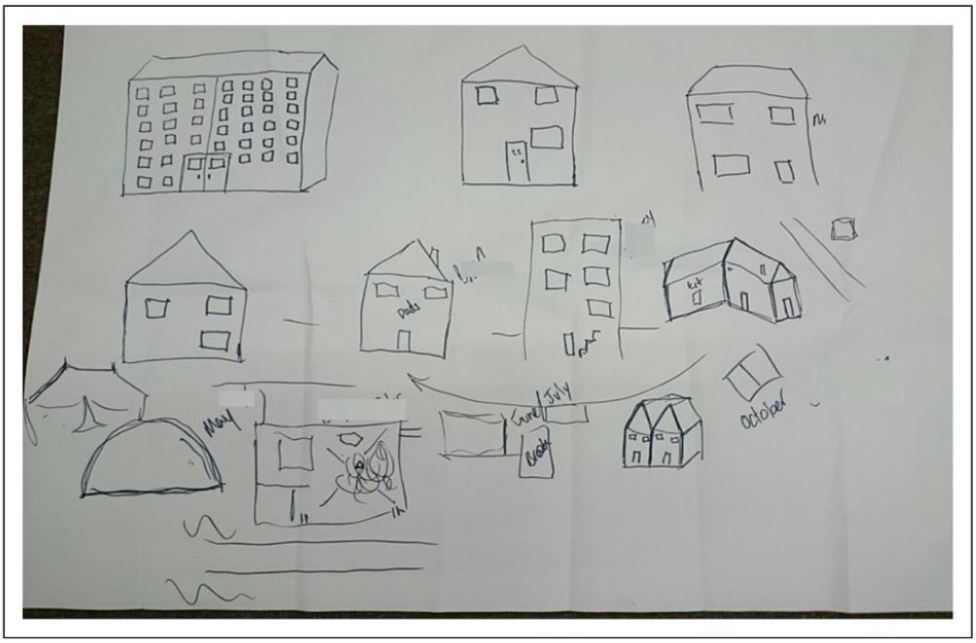


Figure 1. Ryan's life map shows detail in depicting different housing and homelessness transitions, including his tent in a local park (the dome), with a diagram to the right of this showing its position in the bushes, chosen for safety.

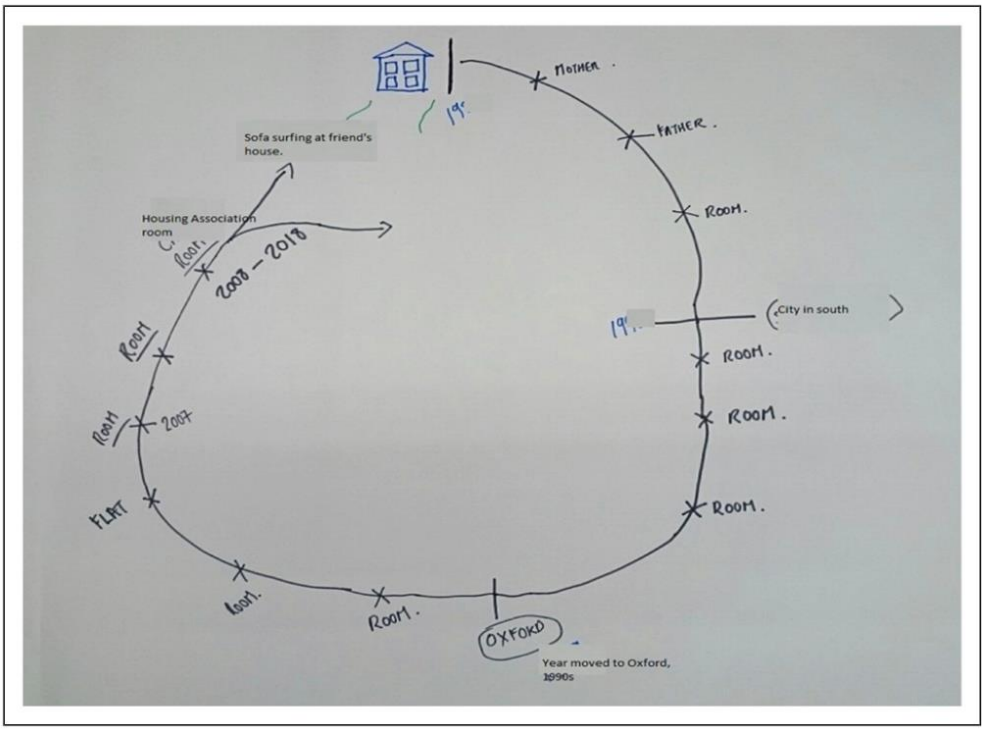


Figure 2. Emma's life map is an example of a more abstract interpretation. However, that she drew her childhood house (but not others) is probably significant to her life history and, in this way, mappings can feed into analysis.

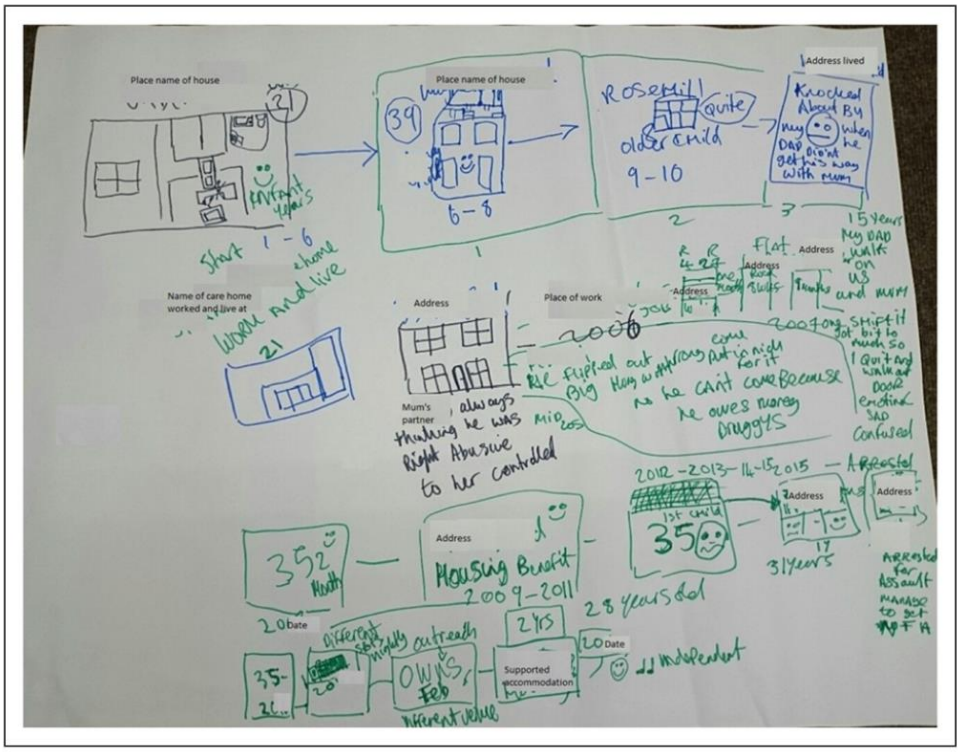


Figure 3. Daniel's life map contains extensive writing to show his age at certain events, many traumatic. He includes pictorial representations of his emotional states, adding another layer to the mapping. He ends with a picture captioned 'independent' to show he is standing on his own 'two feet'.

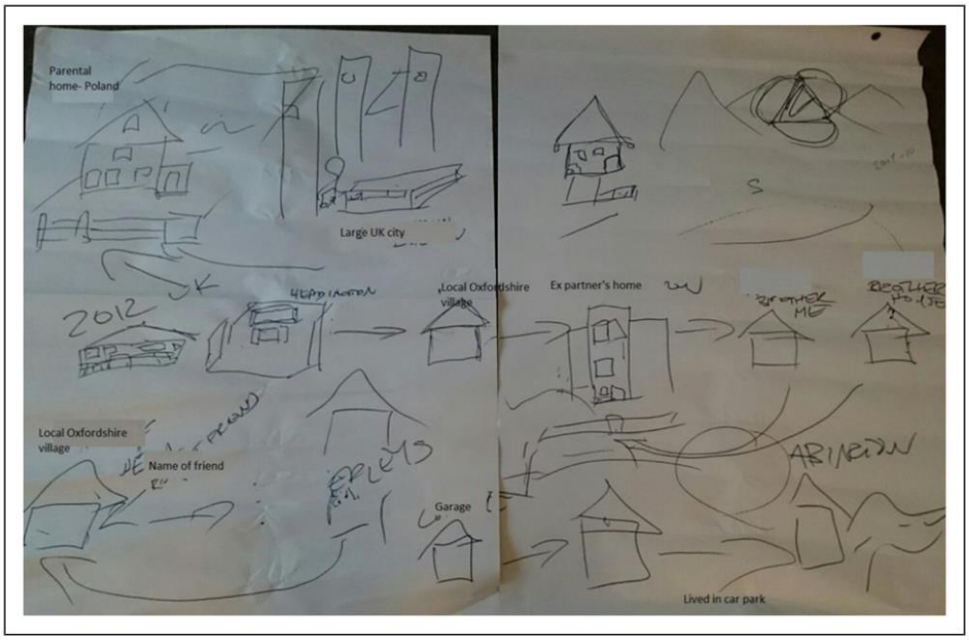


Figure 4. Jakob's life map includes arrows representing returns to the parental home and to his ex-partner's house between unstable housing and homelessness situations.

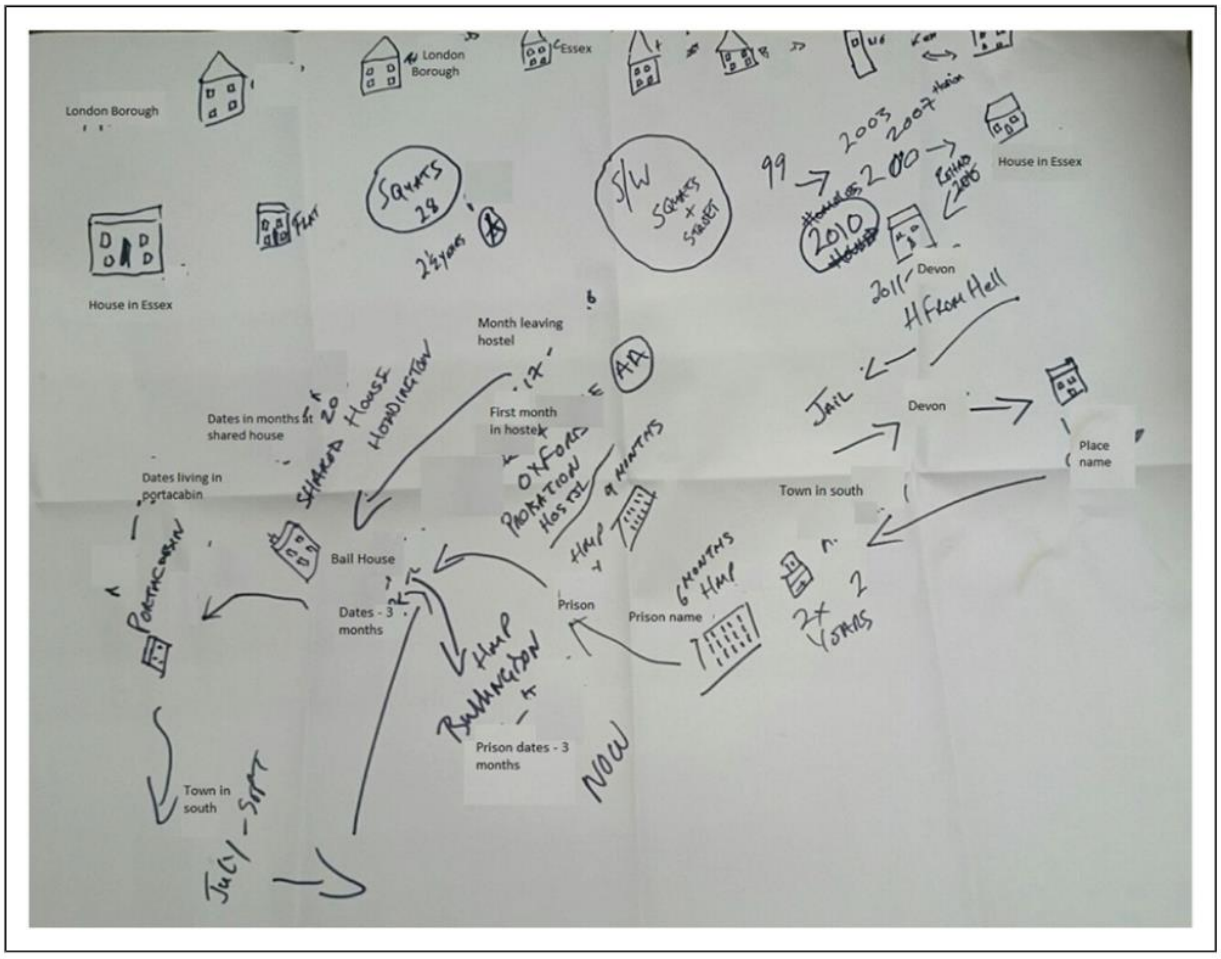
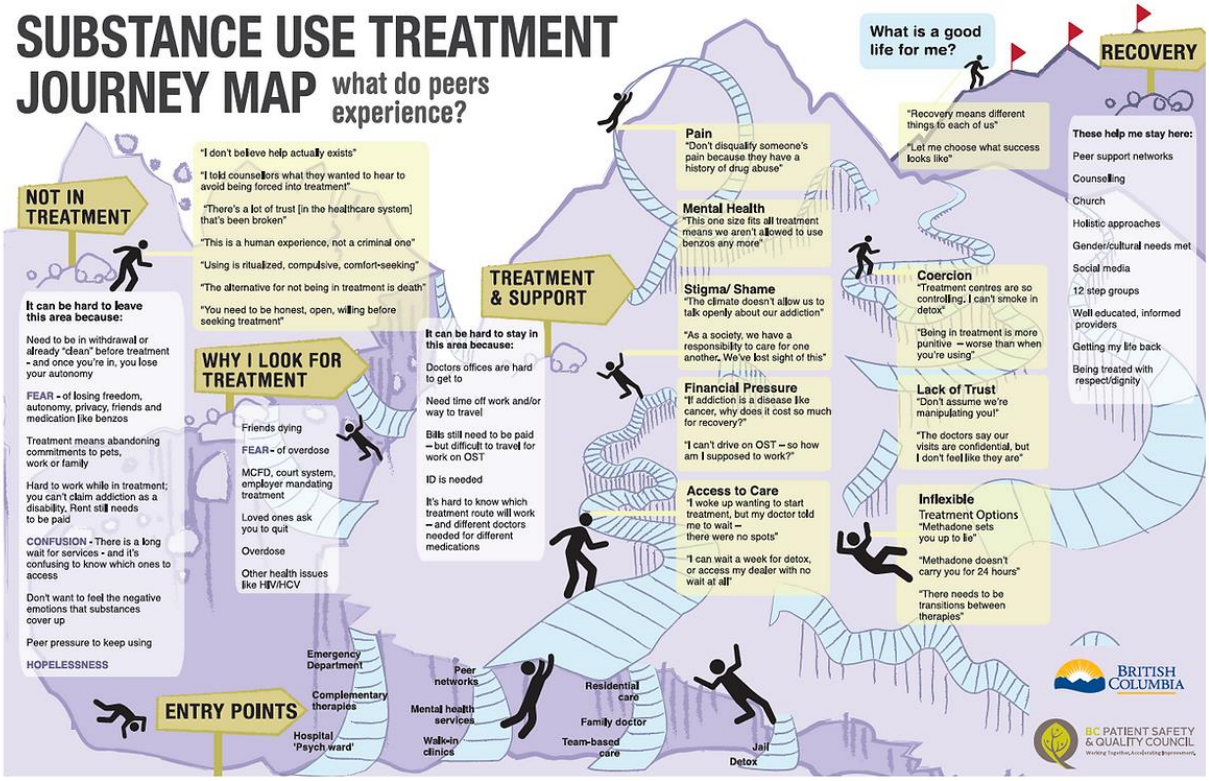


Figure 5. Jason's life map illustrating periods of housing, squatting, prison and rough sleeping. He wrote 2010 and circled this to record the time he identified as feeling homeless and wanted to be housed.

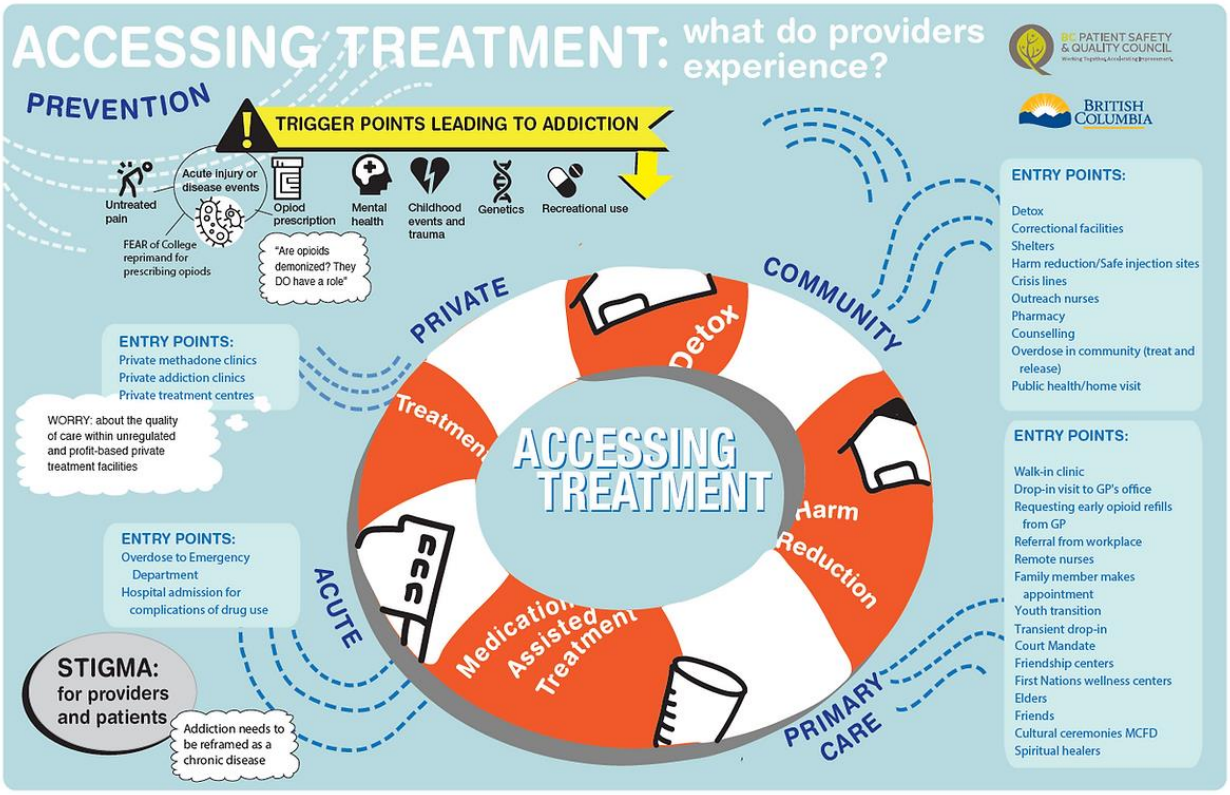
The British Columbia Patient and Safety Council (2019) Graphically designed journey maps originating from sticky notes.

The peer mapping group identified four key stages in their journeys: experiences outside treatment, motivations and entry points for seeking treatment, experiences within treatment, and recovery. The map below illustrates the frequent, often unexpected barriers and challenges between these areas, describing them as, "confusing," "unpredictable," "hostile," and "hopeless." These challenges make it easy to relapse, as participants noted the lack of available treatment options and the risk of reverting to the start with a single misstep. Yellow text boxes highlight

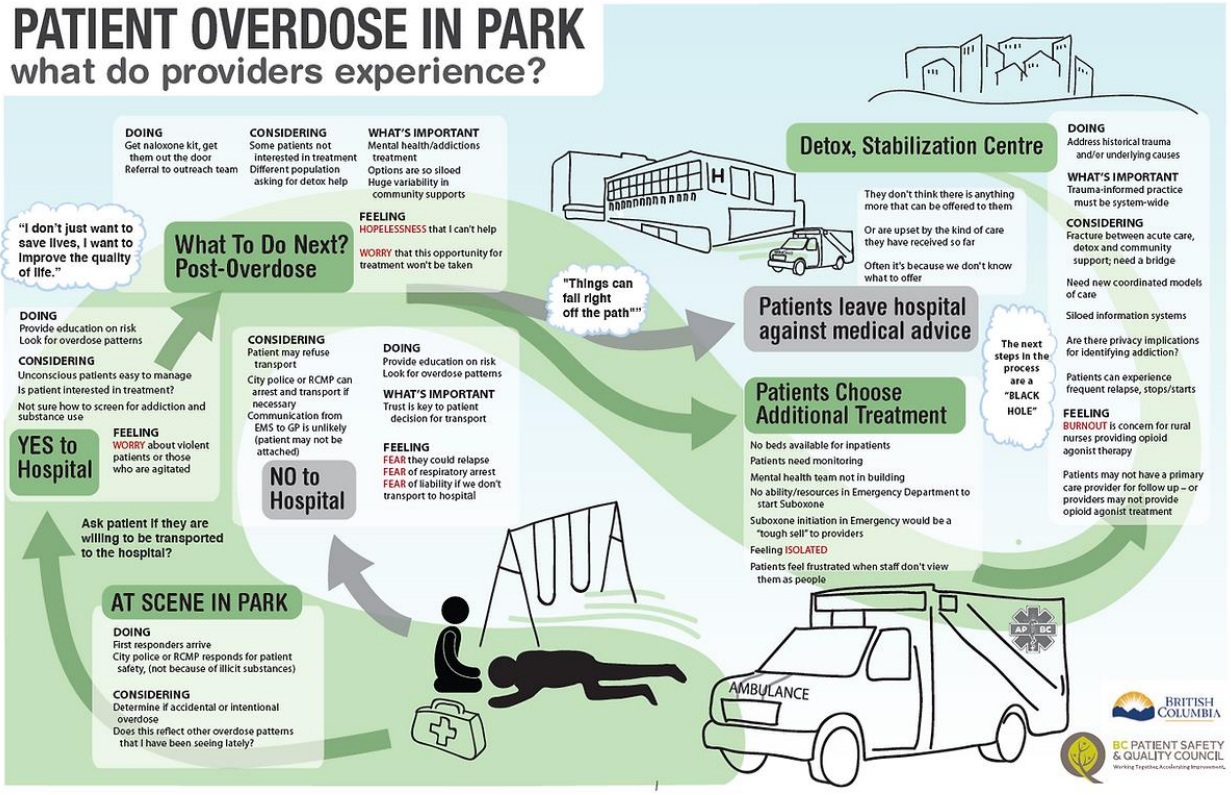
experiences that "ejected" participants from treatment, while grey boxes summarize key findings at each stage.



The provider mapping exercise began by discussing the multiple ways patients can access treatment, identifying private, community, primary care, and acute entry points as part of a "life ring" of services. The illustration's fluid, non-linear design emphasizes the fragmented nature of these services, which often leads to provider frustration and confusion as they attempt to advocate for their patients. Many providers expressed distrust in the current health system, describing it as "siloed," "inaccessible," "under-regulated," or "unresponsive" to patient needs.

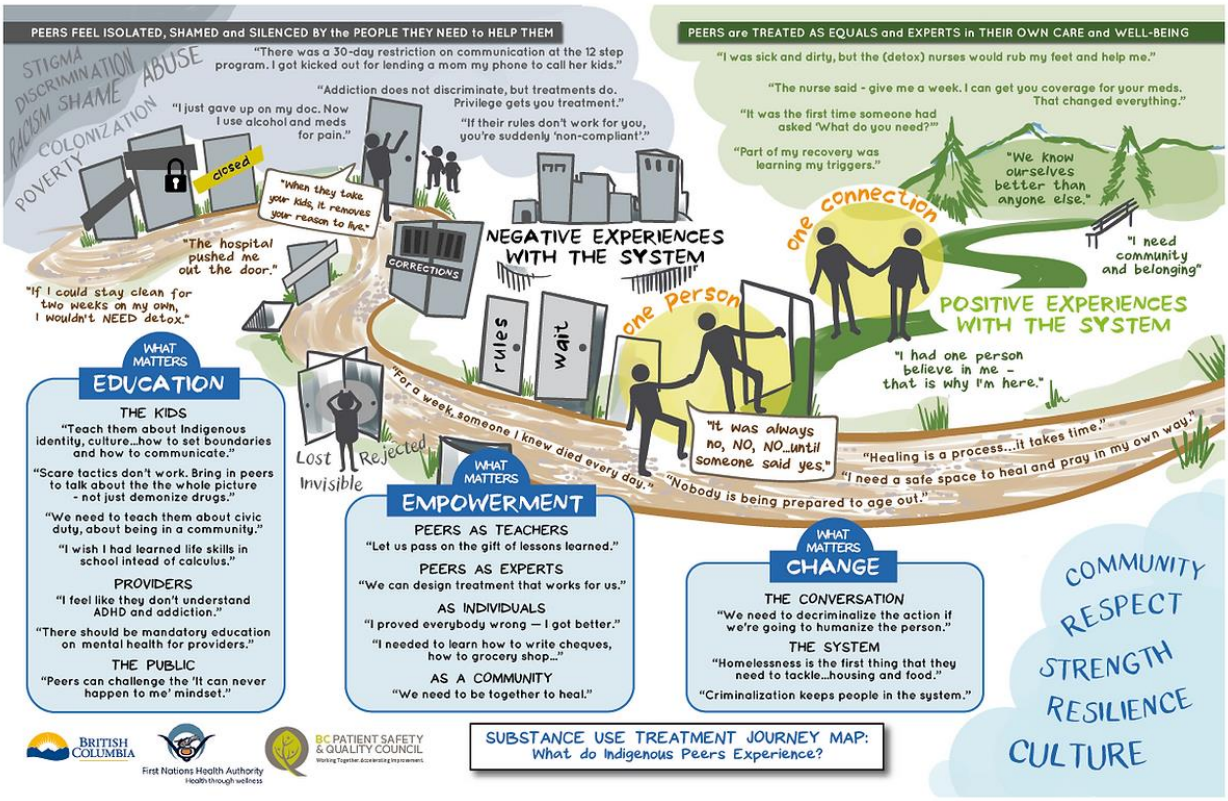


Two case studies were developed by service providers, the second (shown below) focusing on the experiences of providers as a patient navigates the emergency and acute care health systems. Starting with a scene in a fictional park, the map traces the patient's journey through emergency services, acute care wards, and discharge planning. Providers highlighted the difficulties of offering substance use treatment beyond life-saving interventions in the emergency department. They described their limited awareness of effective community treatment options post-discharge as a "black hole."

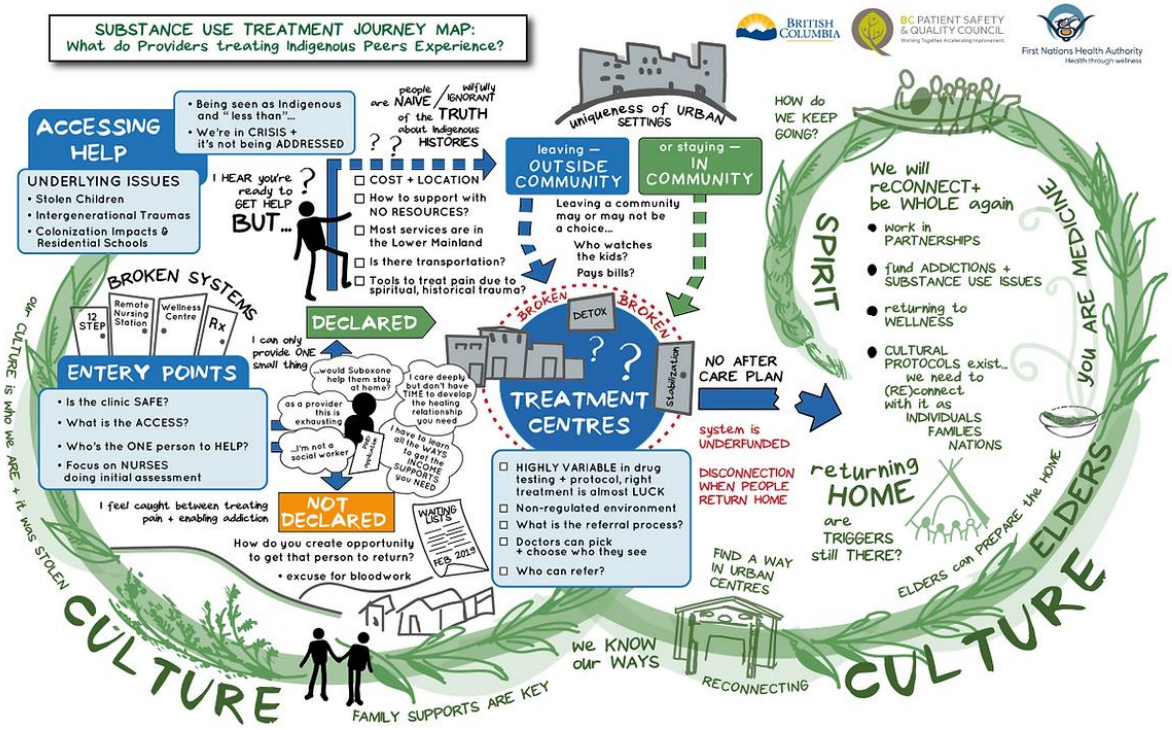


Indigenous Perspectives

The Indigenous peer mapping session began with informal small group discussions, where peers used sticky notes to capture ideas that were later transferred to a large wall for the main mapping session. A central metaphor of "doors" emerged, symbolizing experiences of being "locked out," having doors "shut in their face," facing "revolving doors," or accessing treatment only when someone else "held open" a door. This metaphor was reflected in the digital journey map. Key themes included the role of education, empowerment, and change in long-term recovery, the harmful effects of stigma, racism, and poverty, and the presence of trust and human connection in nearly all positive interactions with the substance use treatment system.



In the mapping session, providers acknowledged that colonization, trauma, intergenerational trauma, and internalized racism have exacerbated the opioid overdose crisis among First Nations in BC. The journey map illustrates the barriers providers face in delivering effective substance use treatment, especially in rural or remote areas lacking local treatment options. It highlights the challenges posed by inconsistent referral protocols, entrance requirements, treatment options, and discharge arrangements, which complicate referrals to appropriate care. The map also underscores the importance of traditional healing and culture in the treatment process and the potential for integrating traditional medicines into the primary health care system.



Methods

In this study, an exhaustive literature review was conducted to identify and synthesize themes from existing research on client journey mapping. Supplementary interviews were then carried out with select researchers and organizations who had completed successful journey mapping initiatives to gain deeper insights and context. This combined approach allowed for a comprehensive understanding of journey mapping and trauma informed practices, drawing on both secondary and primary qualitative data. The research question, "What is most effective way to undertake client journey mapping, being mindful of the trauma that people have endured, to understand people's experiences that may have resulted in them experiencing homelessness, with the goal of improving services and upstream interventions" was peripherally informed by two journey mapping studies specific to homelessness, with the other studies focusing on issues that often intersect with homelessness.

Specific answers regarding interventions that could help people earlier in their housing path to prevent them from experiencing homelessness, gaps in the local housing/health/social/employment/criminal justice systems that people have fallen into and have resulted in their experiences of homelessness, and an inquiry on the services and interventions that have enabled people to become successfully housed again were less fruitful and are discussed in the limitations section. While the research questions are not answered fully by any study due to so little research in this area, the result of this review is regardless, a comprehensive understanding of journey mapping from a variety of perspectives.

This study was conducted as a systematic literature review. Searches in Trent University Bata Library, Google Scholar, Research Rabbit, and Scite.ai identified 43 peer reviewed articles, and 2 book chapters for analysis. Not one article was retrieved using the search terms, "client journey mapping homelessness." Because of the absence of literature regarding both homelessness/housing and client journey mapping the search was expanded to include, journey mapping, patient journey mapping, clinical pathways, case tracking, customer journey mapping, process journey mapping, concept mapping and life mapping. Articles that focused on clinical pathways were excluded due to little reference or usable information on journey mapping and how it may be adapted to homelessness. The majority of journey mapping articles came out of the health care industry, some of which were referenced, however, articles that focused on addictions, mental health and disability were favoured as these issues are often co-concurrent with people who are unhoused. Each article's references were mined for other articles featuring journey mapping of any kind that resulted in a rich and diverse selection of related articles. Research Rabbit delivered the latest dated articles including all the articles that had housing-related journey maps. No articles referred to "trauma informed care" directly but most conveyed

an awareness of its importance with the Cormick et al. (2024) article and the interviews being most informative.

Scite.ai was also queried resulting in four more articles that were also mined for related journey mapping research. However, this data mining returned only previously reviewed studies that were already included in the first searches both online and within article references. All article titles and reference data were copied into Zotero for alphabetization and easy retrieval. All articles were loaded into Scholarcy to be summarized and categorized. Each article was then organized into a Trello workspace and categorized into type of journey mapping, scope, author and date. Eg. Case tracking., disability and addiction/mental health., organization level., Barton, 2019. Articles were then selected that aligned closest with the research question that precipitated this study. Chosen articles were loaded into Claude.ai and asked to determine themes. While Claude.ai came up with the most obvious themes, (versatility, adaptability, holistic, stigma) the researcher found that the themes of advocacy, agency, collaboration, multi-level application of mapping, cultural safety, and the transformative power of journey mapping were not mentioned so were incorporated as these themes best described the relationship between journey mapping, homelessness and trauma informed practices.

Grey literature was sourced directly from the academic peer reviewed articles references. For example, the province of BC's Counsil (2019) journey mapping was published by academic researchers resulting in the organization initiating their own mapping journeys, one of which is posted in the Grey Literature reference section as a downloadable file. Cormick et al. (2024) developed journey mapping tools for Indigenous cultural safety in health care in Australia. Their research referenced Lowitja Institute directly who also has downloadable tools for journey

mapping that can be adapted to housing transitions. All grey literature is listed in the Grey Literature References section with a short description and links for easy access.

Institutional Review Board Statement: Ethics approval was provided by Trent University Research Ethics Board, Peterborough On, Canada.

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Acknowledgments: Thank you to the participants and organizations for committing their knowledge and time to this research. Thank you to Trent University for enabling this research and thank you to the community-based organization who allowed this researcher to conduct the study.

Conflicts of Interest: The author declares no conflict of interest.

Limitations

This study aimed to discover interventions that could help people earlier in their housing path to prevent them from experiencing homelessness which is not well reported in the context of journey mapping due to limited research in the field. Also, this review was to inform of gaps in the local housing/health/social/ employment/criminal justice systems that people have fallen into and have resulted in their experiences of homelessness. Again, due to limited research within journey mapping, there is little to report. Lastly, the question of services and interventions that have enabled people to become successfully housed also bore little fruit in this investigation due to lack of research in this area specifically from a journey mapping perspective. However, there are plenty studies completed within the field of homelessness and housing outside of journey mapping studies that can be used to inform next steps. Creating composite journey maps from housing specific literature to apply to these questions prior to mapping individuals currently

experiencing housing transitions may be very useful. Because there is so little research on journey mapping and homelessness that also includes a trauma informed approach, this review reveals a knowledge gap in these areas within the homelessness sector as it relates to journey mapping.

Another limitation is that there are sometimes subtle and sometimes acute differences in how journey mapping is used and for what purposes. For example, while the papers used in this review exemplified journey mapping's accessibility and versatility, of the two housing specific articles used in this review, only Thompson et al., (2020) referred specifically to journey mapping. Conversely, Flaherty & Garratt's (2023) study also collected data by visually mapping the journeys of people who experienced homelessness but focused on the whole life cycle of individuals, taking on the name life mapping. The most recent journey mapping literature reviews, including those by Folstad & Kvale (2018), Madathil (2020), and Davies et al., (2022) agree that journey mapping terminology and methodology, is highly fragmented. While these articles are not previously discussed in this literature review due to their lack of focus on homelessness or other intersecting marginalized groups, they did highlight significant inconsistencies in terminology and a lack of standard methodologies for client journey mapping across different sectors as limitations. These reviews also identify challenges in reporting and assessing the success of journey mapping initiatives. The participant interviews conducted in this review also identified the lack of standardized methodologies or guides as challenges and barriers to keeping data organized. Cormick et al. (2024) whose study is featured in this review, also confirmed the lack of consistent methodology and reporting guidelines in their study that used journey mapping to address racism and promote cultural safety for Australian Indigenous people accessing the health system. Because the selected studies primarily showcase what appear

to be successful applications of journey mapping, there may potentially be a selection bias. Due to so little research in this area, there is a lack of critical perspectives or studies that highlight unsuccessful applications of the method.

Next Steps for Journey Mapping in Homelessness Research

Research Question:

What is the most effective way to undertake client journey mapping, being mindful of the trauma that people have endured, to understand people's experiences that may have resulted in them experiencing homelessness, with the goal of improving services and upstream interventions?

Given the current limitations in research on journey mapping and homelessness, the following steps are recommended to advance this area of study and/or conduct your first journey mapping initiative:

1. Develop Journey Mapping as a Trauma-Informed Care Research Method

- Task: Conduct a comprehensive literature review on trauma-informed care principles and practices.
- Action: Synthesize findings to create a framework for adapting journey mapping to align with trauma-informed care.
- Outcome: Produce a report outlining how journey mapping can be modified to be inherently trauma informed.

2. Create Composite Maps of Housing Transitions

- Task: Review peer-reviewed literature on housing transitions and pathways to homelessness.

- Action: Develop composite journey maps based on common patterns and experiences identified in the literature.
- Outcome: Produce a set of visual composite maps representing typical housing transition journeys.

3. Develop a Trauma-Informed Protocol

- Task: Review peer-reviewed literature on trauma-informed research methods and ethical considerations when working with vulnerable populations.
- Action: Synthesize findings to create a comprehensive trauma-informed protocol for conducting journey mapping sessions.
- Outcome: Produce a detailed protocol document outlining best practices for trauma-informed journey mapping.

4. Synthesize Information to Create a Proposed Methodology

- Task: Integrate findings from steps 1-3 to develop a comprehensive methodology.
- Action: Create a proposed methodology that encompasses both housing transitions and trauma-informed care within the context of journey mapping.
- Outcome: Produce a methodological guide for conducting trauma-informed journey mapping focused on housing transitions and homelessness.

5. Use Composites for Triangulation

- Task: Design a research study that incorporates the composite maps developed in step 2.
- Action: Conduct journey mapping sessions with individuals who are currently unhoused or have experienced homelessness.

- Outcome: Analyze the data to identify similarities and differences between the composite maps and individual experiences, refining the understanding of housing transition journeys.

6. <u>Choose a Theoretical Framework (Optional)</u>

- Task: Review relevant theoretical frameworks that could inform the research, such as Targeted Universalism or Equity Centered Design and/or Indigenous Perspectives.
- Action: Select a universal theory that best aligns with the goals of the research and the complex nature of homelessness.
- Outcome: Produce a rationale for the chosen theoretical framework and how it will guide the research process.

7. <u>Ethical Considerations and Community Engagement</u>

- Throughout all stages, ensure that ethical considerations are at the forefront of the research design.
- Engage with community organizations and individuals with lived experience of homelessness to ensure the research is relevant, respectful, and beneficial to the community.

8. <u>Dissemination and Implementation</u>

- Plan for how the findings and developed methodology will be shared with academic and practitioner communities.
- Consider how the results can be translated into practical improvements in services and upstream interventions to prevent homelessness.

By following these next steps, researchers can significantly contribute to the development of journey mapping as a trauma-informed method for understanding experiences of homelessness, ultimately leading to improved services and interventions.

Grey Literature Resources

On the Way Home Podcast and Blue Door (York Region-Toronto, Ontario)

https://onthewayhome.ca/en/

"On the Way Home is a weekly Canadian national podcast produced by Blue Door. Formerly known as “Out Of The Blue”, “On the Way Home” invites guests and experts in the field of housing and homelessness to educate and create awareness around some of the gaps and challenges individuals and organizations face across Canada. Your host, Michael Braithwaite openly speak with diverse guests each week, to discuss innovative programs, stories of hope and hardship and new perspectives on ending homelessness in Canada."

Blue Door

"Blue Door, located in York Region, provides safe and supportive emergency housing, and housing services and supports for people who are at risk of or experiencing homelessness to attain and retain affordable housing. With help from generous companies, last year (2023) Blue Door provided: 40,000+ nights of safety, 115,000+ meals, 925+ youth, families, adults, and seniors with safety and support to escape homelessness.

In 2023, Blue Door released a three-year strategic plan that will tackle homelessness by focusing on Housing, Health, and Employment. Through Evaluation, Leadership, Innovation, and Advocacy, Blue Door will work towards ensuring that all Canadians have access to dignified housing. https://onthewayhome.ca/en/

Trauma informed toolkit (Manitoba)

"This toolkit was developed by Manitoba Trauma Informed Education Center (MTIEC) and aims to provide knowledge to service providers working with adults who have experienced or been affected by trauma. It will also help service providers and organizations to work from a trauma-informed perspective and develop trauma-informed relationships that cultivate safety, trust and compassion" (MTIEC, 2024).

The Trauma Toolkit (2013) **https://trauma-informed.ca/recovery/resources/**

Nick Falvo Consulting

Introduction to homelessness in high-income countries: An open access e-textbook.

"Dr. Nick Falvo is writing an open access interdisciplinary textbook intended to provide an introduction to homelessness for students, service providers, researchers and advocates. New chapters will be uploaded as they become available." **https://nickfalvo.ca/book/**

Lowitja Institute (Australia)

Lowitja Institute has used journey mapping to improve health care for Aboriginal People in Australia. By signing up to their membership, access is granted to a free course on journey mapping that includes downloadable forms for possible adaptation to housing transitions.

https://www.lowitja.org.au/tools/

British Columbia Safety and Quality Council **https://healthqualitybc.ca/**

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