The At Home/Chez Soi Project:

Year Two Project Implementation at the Vancouver, BC Site

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VANCOUVER IMPLEMENTATION REPORT

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EXECUTIVE SUMMARY

This report follows an earlier report which examined how members of the Vancouver site mobilized research, housing, and service provider teams to recruit, house and support participants in the first year of project implementation. The current report documents the implementation of housing and support interventions in the second year of project implementation, including the second round of intervention fidelity assessments. It describes the strengths of the housing and intervention teams and the ongoing and emerging challenges they faced as they carried out their programs from January 2011 to January 2012. A semi-structured interview guide was created in consultation with the National Qualitative Working Group. Interviews and focus groups were conducted in January and February of 2012.

The Fidelity Assessment team and all interviewed stakeholders noted a number of improvements to the implementation of services over the past year. The end of participant recruitment, along with time and experience, have allowed teams to develop more coherence and maturity, and these qualities are reflected in participant wellbeing and in the quality and diversity of external partnerships.

Respondents identified a number of challenges inherent in providing housing and support for formerly homeless adults with mental illness, and strengths that team members drew on to meet these challenges. Key **strengths** include the ability to develop partnerships with a wide variety of external agencies; collaboration; and healthy team cultures that allow space for creativity, reflection, and innovations. Ongoing **challenges** from the beginning of the project include consistently engaging a small group of participants in housing and support services, and maintaining stable staffing levels on the ACT and ICM teams. Emerging challenges have predictably included (re)engaging participants in work and educational endeavours and a variety of housing and rehousing issues. A number of implementation issues were also identified in relation to evictions, planned moves, and choice moves as well as participant choice and housing fit.

Respondents identified a range of factors that can either facilitate or obstruct stable housing and recovery processes, including characteristics of the parent service organization; participant experiences of isolation and loneliness; involvement in the criminal justice system; family reunification; and substance use.

Meaningfully involving people with lived experience of homelessness and mental illness continues to be a challenge. While all teams have engaged peers to some degree and the Peer Coordinator has consistently advocated for peer engagement throughout the project, there is an overall lack of structure and accountability for including peers.

Finally, two landlords/building managers who are involved in the Vancouver At Home Project were interviewed and described the importance of tenant-building fit as well as the challenge of leaving the “homeless lifestyle” for some participants.

KEY MESSAGES

This report follows an earlier report which examined how members of the Vancouver site mobilized research, housing, and service provider teams in order to recruit, house and support participants in the first year of project implementation. The current report documents the implementation of housing and support interventions in the second year of project implementation, including the second round of intervention fidelity assessments. It describes the strengths of the housing and intervention teams and the ongoing and emerging challenges they faced as they implemented and carried out their programs from January 2011 to January 2012.

In response to the growing population of people who are homeless in Vancouver with related health and social problems, several not-for-profit organizations have established housing and other supportive services, many of which are located in the Downtown Eastside (DTES). Despite the development of provincial Assertive Community Treatment (ACT) standards and the establishment of a Provincial Advisory Committee to implement ACT across the province, only three ACT teams existed in BC—none in Vancouver—before the initiation of the At Home project. Vancouver therefore lacks basic service components (i.e., Housing First, ACT, Intensive Case Management [ICM]). This dearth of services may help explain the tensions that arose during the planning and implementation of the At Home project; that is, not merely bringing people together around a common framework, but introducing key components of the framework at the same time.

In this report, qualitative methods were used to examine the challenges faced by the housing and intervention teams and the strengths they drew on to meet them; facilitators and barriers to housing and recovery; the involvement of people with lived experience of homelessness and mental illness; and the perspectives of landlords/building managers involved in the project. A semi-structured interview guide was created in consultation with the National Qualitative Working Group. Interviews with stakeholders were conducted during January and February of 2012. The final sample consisted of 23 individuals (five individual interviews; 18 individuals participating in one of three focus groups), all of whom were involved to some degree in the implementation of the project in Vancouver during the 2011 calendar year. Individual interviews were carried out with the Site Coordinator, the Housing Procurement Team (n=2), and landlords/building managers (n=2). Focus groups were held with each of the three intervention teams (n=18). One research assistant reviewed all transcripts and prepared a detailed summary of responses by question. The research assistant, along with two co-Investigators, then reviewed the summary and developed a list of key themes, which are summarized below.

The Intervention Teams: Strengths and Challenges

Respondents identified a number of challenges inherent in providing housing and support for adults with mental illness who were formerly homeless, and strengths that team members drew on to meet these challenges. All respondents observed a shift among the intervention teams from initial chaos, to semi-crisis, to stability, a state in which teams work effectively together and communicate with increasing confidence and maturity in all aspects of their operations. Another general shift has been from broad, oversight meetings to focused meetings that address important “on the ground” issues.

Key **strengths** include the ability to develop partnerships with a wide variety of external agencies, which has led to increased trust and a willingness to address difficult problems; collaboration; and healthy team cultures that allow space for creativity, reflection, and innovations. All respondents noted that the intervention teams have a stronger sense of how they fit into the broader system of services.

Ongoing **challenges** since the beginning of the project include the difficulties of housing and supporting a small group of participants, usually due to their personal challenges and/or preferences, and maintaining stable staffing levels on the ACT and ICM teams. Incidents of staff burnout have decreased since the end of the participant recruitment stage, but it is still difficult to cover staff leaves and to bring new members into the teams. Emerging challenges have predictably included (re)engaging participants in work and educational endeavours and a variety of housing and rehousing issues. While most planned moves and evictions have been successfully managed, a few participants have been difficult to rehouse.

Despite the low vacancy rate in Vancouver, the housing team successfully obtained a wide variety of good quality housing units in 22 different neighbourhoods across the city. The team attributed their success, in part, to the flexible rent cap and the level of support they have been able to provide for landlords (e.g., guaranteeing payment of rent, assuming responsibility for damages, using service providers who work from an outreach model, etc.). Compared with the recruitment phase of the study, the housing portfolio is now more limited and the focus of housing searches has shifted from quantity to quality (i.e., good participant-housing match).

Facilitators of and Barriers to Housing and Recovery

Respondents identified a range of factors that can either facilitate or obstruct stable housing and recovery processes, including characteristics of the parent service organization; participant experiences of isolation and loneliness; involvement in the criminal justice system; family reunification; and substance use.

Given their experience with the ACT, ICM and congregate service models, respondents were able to identify a number of ingredients that are critical to successfully working with adults with mental illness who have had long histories of homelessness and social exclusion. These key ingredients include applying the Housing First philosophy (immediate provision of housing; client choice; no discharge criteria; commitment to rehousing), hiring the right staff, and developing a strong team culture.

Other Key Themes

Meaningfully involving people with lived experience of homelessness and mental illness continues to be a challenge for the Vancouver At Home project. While all teams have engaged peers to some degree and the Peer Coordinator has consistently brought peer issues to various agendas, there is an overall lack of structure and accountability for the inclusion of peers.

Finally, two landlords/building managers who are involved in the At Home project in Vancouver were interviewed and described the importance of tenant-building fit, as well as the challenge of leaving the “homeless lifestyle” for some participants.

Lessons Learned

Respondents identified a number of lessons they learned, including the importance of establishing small committees to address “on the ground” problems promptly, rather than relying on higher-level meetings; the importance of ensuring a slower, more even rate of participant recruitment to ease the burden on staff teams in the scattered-site model; and the importance of building relationships with key community partners as soon as possible. A few lessons learned were specific to the design and staffing of the Bosman (e.g., dedicating floors to particular subgroups) and to the housing team (e.g., offering to reimburse landlords for repairs is more effective than providing an initial damage deposit).

All teams have faced issues related to staff burnout, particularly staff on the ACT and ICM teams, because they often work alone. Teams have experimented with different scheduling strategies as well as with pairing up colleagues. While working in pairs is helpful, it limits the number of participants who can be contacted each day. Both the ACT and ICM teams stated they have learned to "do more with less" and that current staffing models do not allow for good self-care.

Looking Forward

Although all teams have achieved a sense of stability and cohesion compared to the start-up phase of the project, perhaps the biggest challenges lie ahead. As the project moves into its final year of operation, it will be a challenge for all teams to maintain staff, team cohesion, and a continued sense of momentum and commitment. The sustainability of participant housing and support services is a concern for all teams and the uncertainty surrounding participants at the end of the project is already generating considerable anxiety for both participants and staff. All respondents expressed the hope that the scattered-site and congregate-care models will be continued and included in a full housing continuum.

PARTNERS AND COLLABORATORS

Researchers:

Providence Health Care

Simon Fraser University

University of British Columbia

Project Service Providers:

Coast Foundation

Motivation, Power & Achievement (MPA) Society

Portland Hotel Community Services Society (PHS)

RainCity Housing

Community Stakeholders:

BC Housing

BC Ministry of Health Services

BC Ministry of Social Development

City of Vancouver

Providence Health Care/St. Paul's Hospital

Street to Home Foundation

Vancouver Coastal Health

Vancouver Foundation

INTRODUCTION

Over the past 30 years, homelessness has emerged as a significant social problem across Canada, growing in both size and scope in urban, semi-urban and rural communities (Laird, 2007). Adults who are homeless suffer disproportionately from high rates of serious mental health and substance use problems compared with the general population. Co-occurring physical health problems are also very common in this demographic (see Frankish, Hwang & Quantz, 2005). Although individuals with mental disorders constitute a minority of the homeless population, research has shown that they are likely to experience more frequent and longer periods of homelessness as well as require more support from health and social services than individuals without mental disorders who are homeless.

Among other structural changes, the growth in the rate of homelessness has coincided with the deinstitutionalization of long-stay psychiatric institutions across North America. This significant downsizing in psychiatric care has been accompanied by inadequate investments in the expansion and integration of community programs that provide services for individuals with mental and substance use disorders, and reductions in welfare, criminal justice, and housing services. As a result, many cities across Canada, including Vancouver, have witnessed a significant increase in the number of individuals who are homeless and living with serious mental disorders (including substance use disorders). The housing and mental health-related needs of this population are not only diverse but are further complicated by physical health problems, trauma, and various social and occupational challenges.

While the research literature presents a complex relationship between homelessness and mental health, it is clear that untreated psychiatric and physical health conditions contribute to chronic homelessness. However, the services designed to address various psychiatric, substance use, physical and social issues are often segregated and inadequate. Mental issues and substance use disorders are most often addressed by diverse community-based, not-for-profit organizations, while physical health conditions tend to be treated in walk-in clinics and emergency departments where the continuity of follow-up care is limited. Community mental health teams and not-for-profit agencies are often too ill-equipped or under-resourced to address the complex and concurrent needs of individuals experiencing homelessness, and this inability often leads to incomplete care and further unmet needs. Given the high rates of behavioural and physical health problems among individuals who are homeless, and the inadequacy of services, there is a growing need for effective approaches that integrate housing with treatment and support services (Rosenheck et al., 2003).

A growing body of research demonstrates that supported housing has a positive impact on residential stability, regardless of the specific model of housing (Best, 2006; Rog, 2004). Recent research indicates that a Housing First approach, which provides permanent, independent housing that is dispersed throughout the community, is an effective approach for people who are homeless with mental disorders, including substance use (e.g., Tsemberis & Eisenberg, 2000). This model makes no treatment demands of clients, but offers intensive support services to help individuals integrate into their community. Despite these findings, researchers have not thoroughly examined the impact of supported housing on outcomes other than those related to residential stability and hospitalization, and existing studies have not yielded consistent results.

Recent research has established many characteristics of effective interventions for individuals with psychiatric symptoms who are also homeless, including the importance of perceived choice (Greenwood et al., 2005; Nelson et al., 2007). Assertive Community Treatment (ACT) is a model of care for people with severe mental illness in which a multidisciplinary team provides treatment and rehabilitation in addition to case management functions. An extensive body of research has shown that ACT is effective in reducing hospitalization and improving symptoms of mental illness as well as social functioning (see Ziguras & Stuart, 2000). Intensive Case Management (ICM) is another model of care for people with mental illness in which services are brokered to community agencies by a case manager rather than

delivered by a team (as in ACT). The evidence base for ICM is not as strong as that for ACT. However, ICM has been shown to be effective in improving symptoms of mental illness as well as social functioning (see Dixon & Goldman, 2003). Despite the body of evidence in favour of ACT and, to a lesser degree, ICM, little is known about the effectiveness of different intensities of intervention for individuals who are homeless and have differing levels of need.

In addition to the increase in homelessness and diverse service needs, many cities face a substantial shortage in the availability of affordable housing units. In light of limits to housing availability, the implementation of scattered-site housing may not offer the most efficient use of available service resources. Researchers have not adequately explored alternative strategies, including approaches that provide independent housing for individuals who are homeless and living with severe mental illness in congregate settings where neighbours would include other people living with severe mental illness (see He, O'Flaherty & Rosenheck, 2010; Walker & Seasons, 2002). Further, given the current economic recession, exploring the relative advantages and disadvantages of congregate-housing arrangements on people with severe mental disorders is timely.

Over the past 30 years, researchers in medicine and, more recently, public health, have adopted a model of evidence-based practice (see Des Jerlais et al., 2004). The randomized controlled trial (RCT) is usually seen as the strongest method for assessing the efficacy of interventions. Health Canada and the Mental Health Commission of Canada, the funding bodies for the At Home project, determined that an RCT would be the underlying design of the study, in this way implicitly supporting the move toward complex policy trials and multi-site RCTs as primary methods for developing policy-related knowledge. In this context, certain constraints, such as the random assignment of participants to intervention and control groups, as well as the lack of a clear sustainability plan, were inherent in the basic study design.

In light of the growth in both the size and scope of homeless populations and the increasing need for effective approaches that integrate housing with mental health and support services, as well as limitations in the research literature, it is essential to obtain a better understanding of how supported housing and services influence the broader context of individuals' lives. An improved knowledge of homelessness and the service needs of individuals is necessary for the development not only of long-term, community-based solutions, but for the formation of well-defined health and social policies.

PURPOSE

This report follows an earlier report (Schmidt & Patterson, 2011) which examined how members of the Vancouver site mobilized research, housing, and service provider teams to recruit, house and support participants in the first year of project implementation (October 2009 to January 2011). The current report documents the progress of the Vancouver At Home housing and support interventions in the second year of project implementation, including the second round of intervention fidelity assessments. It describes the ongoing and emerging challenges faced by the housing and intervention teams and the strengths they drew on to meet these challenges as they implemented their programs from January 2011 to January 2012.

More specifically, this report focuses on the following:

- Year two fidelity assessments
- Ongoing and emerging challenges and sources of strength
- Housing and rehousing issues
- Facilitators of and barriers to housing and recovery
- Involvement of people with lived experience
- Engagement of landlords and building managers

LOCAL CONTEXT

In Vancouver, the overlap between mental disorders, substance use, and homelessness has become a civic crisis. Compared with the rest of British Columbia and Canada, Vancouver is unique in terms of the heterogeneity, multi-morbidity and concentration of its homeless population. Researchers have well documented the extent of chronic medical conditions, including infectious disease, among Vancouver's homeless population (Acorn, 1993; Wood, Kerr et al., 2003). Furthermore, many individuals who are homeless in Vancouver are not connected to the formal health care system, and are thus at elevated risk of adverse medical outcomes, including drug overdose (Kerr et al., 2005).

The 2008 Metro Vancouver Homeless Count found 1,372 people who were homeless in the City of Vancouver.[1] This number represents a 23 per cent increase from the previous count in 2005. Notably, between 2005 and 2008, the percentage of people who experienced homelessness for one year or more increased by 65 per cent, representing 48 per cent of people counted in 2008. In addition to the significant increase in the rate of homelessness, self-reported rates of mental illness and addictions have also increased significantly, by 86 per cent and 63 per cent respectively. A 2007 provincial estimate of the population of adults with severe mental disorders (including substance use disorders) contended that 1,800 adults in Vancouver are absolutely homeless and an additional 2,280 adults are at risk for homelessness (Somers, 2008). These reports suggest not only a significant increase in the rates and severity of homelessness in Vancouver, but that a substantial number of people are affected.

The Downtown Eastside (DTES) community, home to approximately 16,000 individuals, is unique to the Vancouver context. Many individuals in the DTES are homeless or live in unstable housing conditions, resulting in high rates of health and social service needs in the area. Vancouver Coastal Health (n.d.a.) estimated that 3,200 individuals in the DTES have significant health problems and an additional 2,100 have more substantive disturbances that require intensive support and services. Other estimates suggest an even greater level of need. For example, Eby and Misura (2006) estimated that 5,000 injection drug users in the DTES are infected with Hepatitis C or HIV/AIDS. Unfortunately, many individuals do not receive treatment for their conditions other than medical care through emergency departments (Kerr et al, 2005).

Although estimates vary widely of the clinical, social and housing service needs within the population of people who are homeless with mental disorders, it is clear that the variability and severity of needs within the homeless population requires interventions that respond to individuals with both high and moderate levels of need. In response to the growing levels of homelessness in Vancouver and related issues in health and social problems, several not-for-profit organizations have established housing and other supportive services, many of which are located in the DTES. However, while provincial ACT standards have been developed and a Provincial Advisory Committee has been established to implement ACT province-wide, there is currently only one ACT team in Vancouver (created within the past year), and only three province-wide. Vancouver therefore lacks basic service components (i.e., Housing First, ACT, ICM). This dearth of services may help explain the complexities of planning and implementing the At Home project (i.e., not merely bringing people together around a common framework, but introducing key components of the framework at the same time).

The high concentration of Single Room Occupancy (SRO) hotels is also unique to downtown Vancouver. A considerable demand for low income housing is evidenced by the 0.5 per cent vacancy rate for bachelor suites in Vancouver. As a result, affordable housing is far beyond the shelter allowance of people receiving income assistance. The average rent

[1] The 2008 Metro Vancouver Homeless Count also identified an additional 1,037 individuals who were homeless in suburban areas adjacent to the City of Vancouver.

for a bachelor apartment is $736 per month, almost double the $375 monthly shelter allowance. In general, housing in Vancouver for people living with substance use and other mental disorders has been in congregate settings, and this trend continues with the purchase and renovation of a number of SROs and the development of congregate housing on 12 City sites.

Growing civic commitment and public concern in Vancouver has been directed toward improving the health, autonomy, and quality of life among those who are homeless and have mental disorders. In November 2008, the Mayor of Vancouver, Gregor Robertson, created a Task Force to address the issue of homelessness. Numerous city- and province-led initiatives have recently addressed challenges related to homelessness, including reforms to the justice system (e.g., Community Court), expanded mental health services (e.g., Burnaby Centre for Mental Health and Addiction), access to income assistance (e.g., Homeless Outreach Teams), and investments to stabilize housing stock (e.g., purchase of SROs and development of additional supportive housing). If these initiatives continue, they will significantly improve the standard of "usual care" for people with mental disorders who are homeless in Vancouver.

In summary, the At Home project addresses a critical gap in the research evidence about housing and services for a growing population of vulnerable individuals. While service agencies and institutions have struggled to overcome differences of organizational cultures, mandates and styles of work, the At Home project has encouraged diverse stakeholder groups to come together and establish a common framework. The development of a philosophy of shared leadership among high performance teams that can transcend organizational boundaries is vital, not only for the success of the project, but for the country to acquire the necessary knowledge to provide effective housing, health, and social services to individuals in need.

METHODOLOGY

Qualitative methods were utilized in order to examine how the Vancouver At Home study service provider teams implemented the housing and support interventions in the second year of the project. A semi-structured, qualitative interview guide for both individual interviews and focus groups was developed in consultation with the National Qualitative Working Group. Consultation with the National Qualitative Working Group ensured that the interview guide was generally consistent across all study sites, and that it adequately addressed key implementation issues raised in the first year.

Interviews with stakeholders were conducted during January and February 2012. The Site Coordinator and the Team Leaders for the housing procurement and three intervention teams were contacted by email to schedule an interview or focus group. Three landlords were contacted by telephone. All interviews and focus groups occurred in person, except for the interviews with landlords (n=2) which were conducted over the telephone. See Table 1 for a summary of individual interviews and focus groups by gender.

Table 1. Number of individual interview and focus group participants by gender

	TOTAL	GENDER	
		MALES	FEMALES
Individual	5	1	4
Site Coordinator	1	-	1
Service Provider	2	1	1
Landlords	2	-	2
Focus Groups	3	6	12
ICM	8	1	7
ACT	7	3	4
CONGREGATE	3	2	1

The final sample consisted of 23 individuals (five individual interviews and three focus groups), all of whom were involved to some degree in the implementation of the project during the 2011 calendar year. Twenty individuals identified as service providers, one individual participated as the Site Coordinator, and two individuals participated as landlords/building managers. A few staff members from the ACT and congregate teams were unable to attend the focus group sessions due to staffing rotations and prior commitments.

A university researcher, who is also the Research Coordinator for the project, conducted, recorded, and transcribed the interviews and reviewed and coded the transcripts. One other research assistant independently reviewed the transcripts and identified key themes. In order to reach a consensus on key themes, the two coders held two meetings to review each other's coding and to discuss interpretations and recurrent themes. Once they had reached a consensus, they prepared a summary document of findings by question. Notes from the Fidelity Assessment feedback sessions held with each service team and the Fidelity Assessment Report provided to each team were also used as context for the interviews and focus groups.

FINDINGS

Year Two Fidelity Assessments: Overview

Overall, respondents from all teams reported that the Fidelity Assessments (FA), conducted on December 6 and 7, 2011, accurately reflected their strengths and weaknesses, and no significant discrepancies were noted. In addition, all respondents reported that the second FA was proactive and constructive in highlighting areas for further attention and service development. Compared with the first round of FA, teams found the process of the second FA more collaborative and the feedback more focused and useful.

The **ACT team** was recognized for its exceptional level of internal communication, philosophy of care, and commitment to social justice. In particular, the FA team highlighted the effectiveness of the team's morning meetings, level of assertive engagement, commitment to creating choice for clients, and the number and variety of goals developed with clients. Technical assistance from the FA team included suggestions for expanding their supported employment practice and addressing isolation and loneliness among participants.

The **ICM team** was recognized for its resilience and strong team culture despite significant staff turnover in the past year. In addition, the FA team noted that the ICM team has created strong partnerships in the community and has employed creative harm reduction and motivational interviewing techniques. While FA team members noted that the ICM team has identified a broad range of goals with participants, they would like to see clearer documentation of the team's work in case notes. Technical assistance included ways to increase employment, specific case conferencing, and ways to develop the team's peer support services.

The **Congregate team** (known as the Bosman Hotel Community) was recognized for its commitment to social justice and therapeutic care without imposing its values on residents. The FA team noted that the Bosman staff have done an excellent job in a challenging role that incorporates both housing provider and case management team. The Bosman team houses participants at all stages of recovery and staff regularly engage in motivational interviewing, harm reduction, and conflict transformation practices. Technical assistance focused on educating the FA team about the Bosman approach, particularly conflict resolution and restorative justice practices.

Improvements

The FA team and stakeholders who were interviewed noted a number of improvements to the ways in which services were delivered over the course of the past year. The conclusion of participant recruitment, along with time and experience, have allowed teams to develop more cohesion and maturity, which is reflected both in participant outcomes and in the quality and diversity of external partnerships.

Team Maturity

The FA team and all stakeholders who were interviewed observed a shift among the intervention teams from initial chaos, to semi-crisis, to stability, a state in which teams work effectively together and communicate with an increasing confidence and maturity in all aspects of their operations. Respondents frequently noted that the conclusion of participant recruitment allowed teams to pause and assess their caseloads and available resources, and to focus on participants' goals rather than on the time-consuming work of assessing and housing new participants. For example, according to one respondent:

> *"There's considerable stress associated with not knowing who you're going to get or when. Teams now know what they need to have in place to be effective and are putting that in place."*

There has also been improvement to the ways in which teams recognize and accept their limitations, and the ways in which they build on their strengths. In addition, teams have been more intentional about soliciting feedback from participants about their services and have shown more creativity in addressing service gaps.

Another general shift noted by many stakeholders has been from broad, oversight meetings to more focused meetings that address "on the ground" issues. For example, a number of respondents noted that the weekly meetings of the intervention and housing teams have allowed space for communication about key housing and rehousing issues and space to find solutions to these problems. These meetings evolved over time in response to a need for specific problem solving of challenging participant and housing situations.

Partnerships

The FA team also noted that the intervention teams have developed crucial partnerships with community agencies and raised awareness and promoted receptivity of the Housing First and multi-disciplinary service teams in key systems. For example, according to one respondent:

> *"It's no longer a question of whether scattered site is needed or that a non-profit can be effective [at] delivery services."*

All teams have found it easier to navigate the broader system of care over the past year. A more collaborative relationship has developed with many key agencies, due to processes that enable people from different agencies to get to know each other and share information. This sharing has resulted in increased trust where partners "do what they said they'd do" and a willingness to accommodate and problem solve from both sides. For example, staff from the Bosman (congregate) team participate in a Neighbourhood Advisory Committee that meets quarterly. According to Bosman staff, neighbourhood complaints have decreased significantly, as has the NIMBY (not in my backyard) attitude of local businesses and stratas that was palpable at the beginning of the project. Similarly, staff from the ACT, ICM and housing teams meet regularly with BC Housing and have developed an effective partnership with that organization.

All teams have been joined for periods of time by practicum students from various disciplines, including nursing, family practice, psychiatry, social work, and addictions counselling. This has exposed students in diverse fields to a unique model of community-based care and has helped to create bridges with the professional community.

Participants' Wellbeing

All teams reported remarkable changes among many participants over the past year. While there is a group of participants within each team that has not engaged with the project and/or whose health has deteriorated, most participants have engaged with the teams, have remained stably housed, and are working towards identified goals (e.g., family reunification, substance use reduction, money management, etc.). All teams noted a marked reduction in criminal justice involvement and probation, and several participants have significantly reduced their substance use. In addition, some participants who entered the project with untreated psychosis have stabilized remarkably well and have engaged with the teams on medication compliance.

Housing Procurement

Despite low vacancy rates and the challenges inherent in finding affordable rental units in the Vancouver housing market, the housing team was very successful at engaging a range of landlords and property management companies. The housing team obtained a wide variety of good quality housing units in 22 different neighbourhoods. Only one

property management company has left the project and three participants continue to live in its building. A few smaller landlords have left the project due to challenges with individual participants.

The housing team attributes their success, in part, to the level of support that they are able to provide to landlords. The Housing Procurement Lead is very clear with landlords regarding expectations and the level of support available through the project. He responds promptly to landlords' needs, helps them troubleshoot issues with particular tenants, and generally liaises between tenants' support teams and landlords. The housing team's ability to offer prompt and concrete help to landlords has allowed the development of mutual trust and a good reputation for the project in the community. Being able to offer to pay for damages was seen as particularly important for gaining trust and building relationships with landlords. According to the housing team, the provision of tenant insurance helped sell the project to landlords initially but is not necessary for their continued support. However, guaranteed rent is a strong incentive for many landlords, especially smaller firms which cannot afford vacancies in their units.

> *"Compared to other landlords, those in our project get a great deal of support ... We underestimated how important that support is. It's like an extra set of hands helping them do their job."*

A flexible rent cap allows the housing team to access a range of units from $750 to $1,350 in monthly rent; this is preferable to a static rent cap, which would likely restrict access to any but the poorest neighbourhoods and poor quality buildings. Moreover, static rent caps often result in tenants using their support allowance for rent, which affects quality of life and ultimately residential stability.

Another key factor in the success of the housing team was the strong relationships and mutual trust that the housing team developed with the service teams, resulting in an integrated and collaborative approach. Finally, the housing team was situated in a mental health organization and was staffed by people who have extensive backgrounds in mental health and homelessness, as well as strong business skills.

Compared with the recruitment phase of the project, the housing team's housing portfolio is now more limited. The focus of housing procurement has shifted from broad searches (quantity) to more specific housing searches that match individual participants' needs (quality). Several units that were not working well for various reasons have now been dropped, which represents a shift from "taking whatever we could get" to "being more selective." The housing team noted that, in future, they would like to engage larger property management companies, perhaps as project sponsors, as well as the private condominium market.

Ongoing and Emerging Sources of Strength

Key strengths include the teams' ability to develop partnerships with a wide variety of external agencies; collaborative models of work; and healthy team cultures that allow space for creativity, reflection, and innovations.

Partnerships

All respondents noted that the intervention teams have a stronger sense of how they fit into the broader system of services. All teams noted that, at first, they felt somewhat isolated from the broader system but have now built stronger relationships with other organizations and are successfully navigating the health care, social service, and criminal justice systems. This change was attributed largely to time and to the development of collaborative relationships on the part of the staff and leadership teams. For example, a monthly breakfast meeting allows for regular communication and problem solving between the intervention teams and staff from BC Housing. By being responsive to BC Housing's concerns, the At Home Project has cultivated a sense of shared achievement and trust. The teams have respected constraints that BC Housing has imposed in certain buildings (e.g., tenant mix, age) and related decisions around client fit. Further, some participants from the ACT team gave a presentation about the Housing First ACT model to

BC Housing managers, which helped the model "come to life" for this organization. The service teams continue to be client-centred but have also learned to be flexible and appreciate the perspectives and limitations of landlords and other organizations. According to one respondent:

> *"I think the project has done a lot to foster collaboration within the sector rather than an Us versus Them attitude."*

The creation of strong partnerships with other organizations has allowed for the development of progressive and innovative practices. For example, the ACT team noted that, in addition to maintaining a strong recovery and clinical orientation, they have incorporated unique approaches such as narrative therapy and aboriginal spiritual practices into their work. One of the ICM case managers visits a French-speaking participant along with a worker from a francophone organization who has a longstanding relationship with the client. Similarly, the Bosman (congregate) staff have developed important relationships with people in a wide range of organizations, including lawyers who understand mental health and addiction issues, staff in the local emergency department, and medical specialists. Working with other organizations and initiating case conferences across disciplines has helped to foster a collaborative approach which improves care for participants and provides support for staff.

> *"We had to work hard to build these relationships but now they have opened up creative opportunities around how to really work with people rather than slotting them into a program."*

Team Culture

All teams described a healthy team and work culture that is reflective, tolerant, and maintains deep respect for individual clients regardless of their history or behaviour in the project. This culture allows teams to be nimble and flexible in their work, and to balance authoritarian with lenient approaches. All teams noted that working with At Home participants is very challenging and observed that adequate staff resources are critical to a well-functioning team. For example, the ICM team replaced designated primary workers with a shared model, a move that reduced the burden on individual case managers who had been carrying a caseload of 16 to 20 clients. All ICM participants are reviewed in a weekly meeting so that all case managers are aware of relevant issues and can provide suggestions, support, and a consistent approach to care.

While both the ACT and ICM teams have experienced considerable staff turnover, the Bosman (congregate) team has had a stable staff complement over the course of the project, other than several maternity leaves. Staff from the Bosman team attributed the team's stability to a very supportive management group, effective team meetings, and an interdisciplinary approach to the work. According to respondents from the Bosman team:

> *"Staff are very curious and the environment in the building and in [the parent organization] allows for integrated care and [the] sharing of ideas, skills and even jobs. We've taken interdisciplinary to a new level. No one has huge egos here. We're humble and curious."*

> *"I've never worked in such a supportive and collaborative place. The team is so committed to what it does and I think it's reflected in our communication and in the changes we've seen in our clients."*

Ongoing and Emerging Challenges

Ongoing challenges from the beginning of the project include housing and supporting a small but particularly challenging group of participants, and maintaining stable staffing levels on the ACT and ICM teams. Emerging challenges have predictably included (re)engaging participants in work and educational endeavours and a variety of housing and rehousing issues.

Housing Fit

For a small group of participants on each team, there have been sustained delays in housing, usually related to personal challenges and/or preferences. Scattered-site market housing is not a good fit for everyone, especially participants with complex physical and mental health problems (e.g., older participants with incontinence and mobility issues; older participants with dementia who are smokers). In these cases, the required care load (i.e., daily or twice daily visits) is much greater than the team's capacity for support. Some participants are not able to live independently and yet the teams are only able to offer one model rather than a range of step up/step down options. In a few cases, the teams have tried to find alternative accommodation, such as small nursing homes or abstinence-based supportive housing, to meet individual needs. However, given that the project is viewed by other agencies as having access to many resources, it is often hard to secure alternative resources for project participants.

While teams have succeeded in getting most participants to engage with the project, a small number are difficult to engage with in any fashion, despite consistent and creative efforts. The ACT and ICM teams hold a weekly meeting with the housing team to discuss "on the ground" challenges and creative solutions. In addition, teams have consulted and worked creatively with other organizations that work with particularly challenging clients. Some respondents noted that they might have identified this group of "non-engagers" more quickly, but they did not want to make too many assumptions about individuals because many participants who were initially challenging have since engaged with the teams and remain stably housed. According to one respondent:

> *"We identified non-engagers in a more gradual way, and I think it's an open question around whether to move fast or more gradually on this."*

Staffing Issues

Incidents of staff burnout have notably decreased since participant recruitment concluded in June 2011. Nevertheless, as noted above, there has been substantial staff turnover on both the ACT and ICM teams, although senior team leadership has remained stable. Staff on all teams are ethically minded. They are deeply committed to the Housing First model and to changing the broader system for people who are marginalized. Due to the demands of their roles, they often work through breaks and lunches which makes it difficult, at times, to maintain energy and motivation. The ACT team noted that finding staff coverage is challenging because most casuals do not have experience with the model; as a result, it is not uncommon for the team to be shortstaffed, which creates a particular strain during crises. Similarly, the staff budgets do not allow for "backfill" of staff; bringing a new person into an outreach team is a challenge given that they do not know the clients and new members need to work in pairs for a considerable period of time.

In addition, many participants in scattered-site housing do not have phones, which makes it challenging for outreach staff to contact them and creates considerable excess work that does not always result in client contact. Another standing challenge arises from "cheque day," the third Wednesday of each month when income assistance cheques are issued. Since cheques are issued on the same day for all income assistance recipients, it is challenging to support all participants simultaneously. Nevertheless, all teams noted that the stress and staff burden associated with cheque day has subsided over the past six months.

Vocational and Educational Goals

The FA team encouraged the ACT and ICM teams to engage in more conversations with participants about work and education. Given participants' stages of recovery, the ACT team had also identified this subject as a focus for the team. While the team works in this domain with individual participants, the vocational specialist tries to meet with potential employers and to create a pool of resources in order to respond to participants' needs. According to the ACT team, however, it is challenging to find the time to develop a systematic approach to vocational support. Despite having a

dedicated vocational specialist on the team, “the urgent often overtakes the important”; when there are crises, all staff need to respond, and long-term goals tend to be postponed.

Due to the congregate living arrangements at the Bosman, staff have been able to create a number of work and volunteer opportunities for participants, including meal preparation, street gum removal, laundry assistance, plant care, and so forth. However, engaging participants in meaningful paid and volunteer work in the broader community continues to be challenging.

Housing Procurement

In the first FA, the housing team was encouraged to look for units in areas outside of the city. In response, the team procured units in Burnaby and on the North Shore, but was met with resistance by the service teams who had difficulty servicing these areas, especially after hours. Still, to the greatest extent possible, the housing team tries to honour a participant’s choice of neighbourhood. This tends to be easier for ICM participants because the team brokers services rather than providing them directly. It has also been suggested that the housing team obtain more housing in the Downtown Eastside (DTES); however, very little good quality and affordable housing is available in this area (rental units are very expensive; cooperative buildings and social/supported housing units are full). The housing and intervention teams agreed that about 10 per cent of participants would choose to live in the DTES if good quality housing were available there.

In addition to the challenges posed by the low vacancy rate in the Vancouver rental market, many available units are non-smoking (additionally, smoking is increasingly prohibited on balconies). Since most participants seek units that allow smoking, the available stock is further limited. Several participants request units that allow pets, which also restricts choice; however, pet owners tend to be quite flexible about where they want to live.

Housing and Rehousing Issues

Respondents identified a number of implementation issues in relation to evictions, planned moves, and choice moves as well as participant choice and housing fit.

Evictions, Planned Moves and Moves by Choice

All respondents are strongly committed to rehousing participants, a commitment based on the principle that safe and secure housing is a human right and necessary for recovery from mental illness, trauma, and substance use. However, all respondents recognized that housing is not a panacea and that it is important to normalize challenges for participants, including evictions, so they are not interpreted as failures. According to the housing team, moves tend to fall into three categories: (1) evictions or forced moves; (2) planned moves that attempt to prevent eviction and address issues that have arisen in the participant’s current housing situation; and (3) moves by choice that are initiated by the participant. According to respondents, all three types of move have been, for the most part, collaborative and successful. Many participants in their first apartments disturbed neighbours by allowing friends from the street to live with them. With help from the teams, many of these participants have learned how to manage guests and other situations, whether through problem-solving strategies or changes to their lifestyle, neighbourhood, and/or medications. When a participant moves, the teams engage in non-judgmental conversations about “what will be different” in the next apartment, as well as the financial consequences of moving. Notably, the ACT team has developed a non-punitive way of responding to evictions by writing letters to participants which focus on the natural consequences of eviction and a joint commitment to change—“what will be different”—next time. Teams have also developed support groups to provide participants with the space to talk to each other about strategies to retain housing. As a result, the number of evictions and planned moves has dropped significantly over the course of the

project (i.e., 30 per cent of ACT and ICM participants are living in their second unit; 10 per cent in their third unit; and only one per cent in their fourth or greater).

If participants are evicted multiple times, their choice of housing options diminishes. Both staff and participants have learned how to thoughtfully navigate these natural consequences. This has been a learning experience for many team members since offering participants reduced housing options seems to contradict one of the key principles of the Housing First philosophy. The ICM team noted that having access to transitional suites has been very useful as they allow participants to reflect on their last residence and prepare for their next move. The ACT and ICM teams reported that respite care is very difficult to access, as existing services tend to have very low tolerance for difficult behaviours; therefore, teams have had to use homeless shelters in place of respite care.

A primary, albeit rare, challenge occurs when a participant refuses to leave a building after eviction. Frequently, this type of challenge involves participants who have not, for various reasons, engaged with service teams. Even though the project continues to pay the participant's rent, the refusal is expensive and stressful for the landlord. Respondents stated that "the best prevention is early intervention" and noted that if a landlord complains about a participant, the team responds immediately. No participants have been evicted from the Bosman; however, 14 participants have moved out for various reasons including moving into substance abstinence-based housing, women's housing, or more independent housing; and moving out of town. Several participants have "no go orders" for the Bosman site and therefore live elsewhere. The majority of these participants continue to receive case management and medication support from the Bosman team on an outreach basis.

Choice and Housing Fit

All respondents noted that the teams are committed to giving participants real choices, not just when they move into their first apartment, but after they are housed as well. The ACT and ICM teams noted that the choice of housing stock has diminished over the past year, particularly in more affluent neighbourhoods (e.g., Kitsilano, the West End). They also noted that most participants tend to take the first apartment they see, even if the neighbourhood, access to amenities, and/or building environment are not a good match. Teams are now trying to help participants clarify their needs and preferences in order to find a good housing match. Working together, the housing and intervention teams have been able to find some creative options for particular individuals. For example, laneway housing was secured for a participant who makes noise during the night (disrupting his neighbours). The owners have sold their house but have agreed to ask the new owners to keep the tenant in his suite. Further examples include finding concrete buildings and carpeted floors for people who pace, ground floor units for people who are in wheelchairs or have difficulty with stairs and elevators, and upper-level units for people with safety concerns. Efforts to accommodate family members, romantic partners, and roommates have also been made by the housing and intervention teams.

Many participants who have been stably housed through the At Home project now have their own references and can look for their own housing. One respondent stated:

> *"For me, that is a defining moment of real independence. To see that someone can fill out his own credit check and references. They don't need us as much anymore."*

Although most participants view their apartment as "home" and make choices to maintain it, a substantial minority have not invested in their residence. Respondents suggested that this lack of investment may be due to a range of reasons, including the finite nature of the project and the fact that the project pays the damage deposit.

Facilitators of and Barriers to Housing and Recovery

Respondents identified a range of factors that can either facilitate or obstruct stable housing and recovery, including characteristics of the parent service organization like team structure, and organization structure and philosophy; participant experiences of isolation and loneliness; involvement in the criminal justice system; family reunification; and substance use.

Parent Organizations

The three service teams and the housing procurement team are all part of not-for-profit agencies that serve people experiencing homelessness in Vancouver. Several respondents emphasized the importance of the service organizations' openness to "doing things differently." According to respondents, all four teams are part of organizations that support "pushing the envelope" in a way that creates space to work creatively with minimal hierarchy or bureaucracy. Developing the At Home service teams was a risk for all organizations involved because there was no precedent for these models in Vancouver. All teams have developed their own blend of skillsets and competencies, philosophy and attitudes, and organizational culture.

Participant Isolation and Loneliness

All respondents noted that isolation and loneliness are significant barriers to recovery for many participants, particularly those in scattered-site housing. The ACT and ICM teams have initiated weekly meeting groups which have been somewhat successful at helping people develop a sense of community in their new neighbourhoods and connect with fellow participants. Learning to deal with loneliness is a process and an ongoing challenge for many participants, especially for those in more affluent neighbourhoods. Teams have tried to connect participants with libraries, with community, aquatic, and education centres, and other neighbourhood resources with mixed results. Several participants who live in the same building or neighbourhood have connected and share meals together occasionally. Some participants go downtown to socialize and return to their homes in the evening. It was noted that many women want someone to live with and struggle with living alone. Many participants spend considerable time watching television. One respondent stated:

> *"While living alone can be very lonely for some people, home can also open a space to invite others as well as to cope with feelings of loneliness."*

In the congregate setting of the Bosman, isolation is less of an acute issue; however, many residents continue to struggle with loneliness and a few self-isolate. In such a setting, these individuals can quickly be identified and gently encouraged to leave their rooms.

Involvement with the Justice System

All teams have strong working relationships with the members of the City's justice system, including mental health workers in the Vancouver jails, lawyers, and the Downtown Community Court. Since there is often a significant time lapse between charges, trial, and incarceration, a participant could make substantial gains through the project only to be incarcerated. One ICM participant who had been stably housed for 18 months and had reconnected with his family after many years is now in jail for three years. Some judges have given participants a conditional sentence in order to allow them to take advantage of the At Home project. For participants who have been incarcerated for shorter periods of time, it has been very helpful for them to be able to reconnect with their At Home team rather than adjust to a new team. Teams noted that while most participants' involvement with the justice system has decreased over the course of the At Home project, there are a few participants who recidivate frequently and shortly after release.

Family Reunification

According to the service teams, reconnecting with family is a goal for many participants and helping them meet it is an inspiring part of the work for many team members. In most cases, participants set themselves this goal once a sense of pride in their home has replaced feelings of shame at living on the street or in a poor quality building. Many participants have made trips to visit family members and have reconnected with their children. According to respondents, these connections with family motivate many participants to continue working toward recovery and to maintain their housing. When there are ongoing tensions between a participant and family members, the teams have been able to mediate and support reunification. All teams noted that they have connected with many participants' family members and have spent a lot of time listening, providing empathy and support, and educating families about a wide variety of issues related to homelessness. Several teams noted that the quality of life for family members has improved because they need no longer worry about the safety of their loved ones.

Substance Use

Teams noted that the majority of participants frequently use substances, falling towards one end of the spectrum of substance use, which runs from abstinence to occasional use, reduced use, relapse, and continued use. All teams take a harm reduction approach to substance use and stated that their non-judgmental approach and persistence "no matter what happens" has allowed a number of participants to make significant strides towards reduced substance use. For example:

> *"We try to be there to help clients think through and deal with the consequences [of substance use] but without being too worried or attached to an outcome. You have to use a light touch, stay positive about next steps, and not fret if it didn't work out."*

All teams noted that it is easier for participants to manage triggers for substance use, since they are no longer facing stressors related to living on the street. Respondents noted that the frequent use of stimulants, such as crack cocaine and crystal methamphetamine, tends to lead to more problematic behaviours and evictions, while opioids tend not to interfere as much with housing and recovery. According to the ICM team, participants who retain stable housing despite frequent and heavy substance use usually have strong relationships with at least one service provider and/or with a community of users with whom they can identify.

Critical Ingredients

Drawing on their experience with the ACT, ICM and Bosman/congregate service models, respondents identified a number of ingredients that are essential for working successfully with adults with mental illness who have long histories of homelessness and social exclusion. These key ingredients include the application of Housing First principles (immediate provision of housing; client choice; no discharge criteria; commitment to rehousing), the appointment of the right staff, and the development of a strong team culture.

Housing First Philosophy

All respondents commented that it is difficult to dissect their work and identify key ingredients; however, they all agreed that the team philosophy and team culture are probably the most important factors. For example, all respondents contended that an integral ingredient of successful housing and recovery is the provision of choice. As noted above, providing choice includes taking the time to ensure a participant is invested in his unit rather than just taking the first place he sees, as well as helping participants to identify their housing needs and matching those needs to the available housing stock. It was also noted that the Housing First principle of moving people into housing quickly is critical for building trust with participants and for initiating recovery. For example:

> *"If we had more elaborate housing applications or had to do our own searches, it would slow the process down and impede our ability to engage people."*

Both housing and service teams emphasized the importance of being responsive to issues, such as the deterioration of a participant's mental health, tension with other service agencies, or landlords' concerns, and of addressing them promptly. All teams noted that when participants are provided with a home that allows for safety, a sense of dignity, and support around various health and psychosocial issues, remarkable changes can occur. For example:

> *"When you're alongside people as they've moved from the streets into housing, when you stand by through that process of ups and downs, it creates a bond and a trust that you can't create in other ways. This is really different from other outreach work."*

All teams try to meet clients on their own terms and to take into account the broader individual context (e.g., family, friends and associates, neighbours and landlords, other agencies). The ability to engage in outreach work was seen as critical by all respondents. The intimacy created by meeting people in their own homes also facilitated engagement with participants and important change.

Team Culture

All service teams emphasized the importance of hiring dedicated and passionate people who have a deep respect for and curiosity about people. Several respondents noted that a team's culture is just as, if not more, important than its intervention model. Good team communication cannot be underestimated and requires multiple tools (e.g., databases, electronic medical records, team notes, communication by telephone, texting and email). Strong communication skills, combined with a positive attitude among team members, enables flexibility, collaboration, continuity of care, and recovery planning. Another essential characteristic for team members is the ability to work amid chaos. Several respondents noted that chaos arises in the absence of bureaucracy and allows for innovation and efficiency. However, it is a very different work environment than one in an institution with defined protocols and policy manuals. As one respondent said:

> *"It's been amazing to have such a rich, interdisciplinary staff and to try out a new model of care. This is such a better model for primary care. I see 20 to 25 people a day compared to 10 to 15 at a Community Health Clinic. I have pretty much 100 per cent follow-up which I never would have at other clinics."*

While opinions differ within and among teams, all respondents agreed that the primary focus is not clinical or medical. Rather, teams focus on helping participants identify and work toward their own needs, whether they are medical or of biological, psychological, social or spiritual origin. Similarly, all respondents noted the importance of the teams' ability to work with participants regardless of the circumstances. For example, several participants who were incarcerated, who "fired" the teams, left the province, or otherwise disengaged, have been welcomed back into the project. There are no discharge criteria or expectations that a participant achieve a particular outcome. Having the ability and time to demonstrate that the "door is always open" is important when working with people with long histories of marginalization. However, several respondents noted that, given the need for persistent engagement with participants, the project's timeframe may not be long enough to fully realize the benefits of this approach.

Involvement of People with Lived Experience (PWLE)

Although involvement of PWLE was included as a key objective for the At Home/Chez Soi project locally, it was not perceived to be a high priority at a national level. For example, with regard to the involvement of peers on the service teams, there were no requirements from the national team regarding peer roles other than the recommended peer specialist on ACT teams. From the outset, clear expectations, leadership, and comparable funding should have been

devoted to peer engagement on all service teams as well as the research team. Instead, there has been inconsistent engagement of peers, missed opportunities for engagement, and no explicit accountability. It has been challenging to involve peers in advisory capacities when the resources and accountability are not in place to meaningfully engage them in the project.

Despite these structural challenges, there are examples of successful PWLE involvement on all teams. The ACT team has a peer specialist who is highly valued by the team. The team attributed their success in engaging a peer specialist to the not-for-profit culture of equality and lack of hierarchy. The Bosman/congregate site has engaged participants in a variety of jobs, including cleaning, preparing meals, and caring for plants, as well as in special projects such as fundraising and street gum removal. The Bosman site also has two peer coordinators who work with the team one day per week and run a participant-led group. The ICM team has developed a Participant Advisory Group to elicit feedback from participants on a wide range of topics.

Teams have also collectively embraced a Speaker's Bureau which is comprised of participants and is intentionally non-therapeutic and peer-led. The Speaker's Bureau gives voice to participants' experiences and enables them to take control of the ways in which they and their community are talked about; for many, this is a critical piece of the recovery process. Finally, the Peer Coordinator for the project in Vancouver has been instrumental in keeping the involvement of PWLE on the project agenda; she also initiated a conversation and designed a survey to examine what peer support means for this population.

Engagement of Landlords

Two landlords who have been involved in the project for over one year were interviewed by telephone. Both landlords reported having a very positive experience with the At Home project, although they described a number of problems. Both landlords noted the importance of matching tenants with the building culture. For example, one landlord stated that in larger buildings (over 100 units), she prefers mature tenants over the age of 35 who are quiet. Both landlords noted that young people who engage in frequent noise making (e.g., holding parties, playing loud music, etc.) are the most challenging tenants, especially in buildings with more mature tenants.

Both landlords agreed that they treat At Home participants differently compared with other tenants. At Home tenants take longer to adjust to the building than typical tenants and may need frequent reminders about locating and operating amenities and living with other people. However, a key moment for both landlords was realizing that two people in the program can be very different, which helped them see people who are homeless as individuals, just like everyone else: "Sometimes you get good tenants, and sometimes you don't."

According to landlords, problems are rare but tend to centre on disrespect for the building or for neighbours and "not being finished with their previous life." They cited examples such as participants bringing street friends into the building and allowing them to sleep in their rooms or in hallways, partying, and dealing drugs from their apartment. However, even when they have had to issue eviction notices, both landlords noted that tenants have been respectful: "Everyone has been respectful and has made an effort. I can see that, but there is a line I need to enforce."

Lessons Learned and Reflections

Respondents identified a number of lessons learned:

- Establish problem-solving groups promptly. At a broader level, it was noted that opportunities for small groups to meet and solve specific problems could have been created sooner, rather than relying on higher-level meetings that focus on general operations. It was also recommended that consumer and family not-for-profit organizations

could have been engaged in the project much earlier. Finally, it was noted that more opportunities could have been created for research and service teams to collaborate and share their findings.

- Recruit participants at a manageable rate. For the teams that relied on scattered-site housing (ACT and ICM), the rate of participant recruitment created considerable operational strain and affected the quality of care available to participants. For example, participants could not be housed as quickly and housed participants could not receive as much attention from staff struggling to assess and house so many new participants. Once a stable caseload had been established, teams were able to assess participant needs and balance crises and stability more effectively.

- Start relationship-building promptly. All teams noted that they could have started to build relationships and clarify expectations with external partners such as the Mental Health Teams, BC Housing, hospital inpatient units, justice programs, landlords and building managers more promptly.

- Staff training. Several respondents suggested that staff training and education should focus on more practical issues, such as dealing with pests, hoarding, charting systems, and the Residential Tenancy Act. All teams contended that formal training for new staff, rather than a "learn as you go" model, would be more effective.

- The Bosman/congregate site staff stated that, in future, they would organize the building differently, designating half a floor for women only with fob entry; designating a floor for alcohol and drug-free participants; and perhaps designating a floor for individuals with significant cognitive impairment or other factors that make them particularly vulnerable to others. Since participants were assigned to teams with very little collateral information, it took time for teams to learn about their participants' needs. The Bosman team also noted several limitations inherent in the building structure and design. For example, a purpose-built concrete building would be much easier to maintain than an older building with carpet.

  Finally, the Bosman staff noted a number of lessons learned with regard to clinical services: complementary nursing shifts have been more effective than overlapping shifts; an autoclave for sterilizing would allow for more onsite procedures; and having access to electronic medical records and an onsite pharmacy from the beginning would have been very helpful.

- The housing team noted that providing a full month's damage deposit has not been as effective as anticipated, and that offering to cover repairs has been more effective. Similarly, the team concluded that the provision of tenant insurance (originally intended to be property liability insurance) was unnecessary, although it helped initially sell the projects to landlords. Finally, the housing team noted that they would stagger the intake of participants in some buildings rather than moving several individuals into one building at the same time.

Reflections on Self-Care

Now that teams are more stable and are not dealing with as many crises as they were in the first year of implementation, they are starting to think more about self-care. The work is challenging and all teams have experienced issues related to burnout. As one respondent stated:

> *"Our clients are so diverse. You see severe mental illness, addiction, trauma, chronic physical conditions. You can't be an expert in everything. I'm constantly changing hats—counselor, educator, mom, advocate. I've grown and learned so much but it can be very tiring. It's good to pair up sometimes, even just to have someone witness what you've seen. Sometimes what we see is so dark*

and heavy and out of this world. You have to debrief with someone because you can't take this work home to someone who doesn't know this world. It's so complex you can't explain it."

The work is particularly challenging for ACT and ICM staff because individuals often work alone and don't always have access to the support of the larger team. Teams have experimented with different scheduling strategies as well as pairing up colleagues. While pairing up is helpful, it reduces the number of participants who can be contacted each day. Both the ACT and ICM teams stated that they have learned to "do more with less" and that the staffing models do not allow for good self-care.

Respondents noted that self-care develops slowly, with experience, and requires a great deal of self-reflection, such as examining one's boundaries and self-expectations and the expectations one has of others. For example, according to one respondent:

"I have to ask myself, where am I operating from at this moment? Am I making this about me, my boss, or my client? If I'm feeling a lot of discord, when I dig deep, it's often because I've made the situation about something else, unconsciously. It's natural. But, if I'm able to recognize it and step out of it, I can gain perspective. I have to constantly re-evaluate and shift my own desired outcomes."

Looking Forward

Compared with the start-up phase of the project, all teams have reached a state of stability and cohesion. However, significant challenges lie ahead. As the project moves into its final year, all teams will find it a challenge to maintain a sense of momentum and commitment. Sustainability is a concern for all teams and the uncertainty surrounding participants at the end of the project is already generating considerable anxiety. Staff have made BC Housing applications for all participants who are interested and are trying to help more stably housed participants transition to community care agencies. However, there are few options available for many participants. Without the rental subsidy and case management support provided through the project, many participants will not be able to retain their housing. Many participants have tried in the past to connect with mental health teams and community health clinics, but the office-based model has not worked well for them and difficult or challenging behaviours are often not tolerated.

All respondents expressed the hope that the scattered-site and congregate-care models will continue to operate and will be included in a full housing continuum. Individuals with long histories of homelessness and social marginalization, as well as mental illness and complex health problems, have not been well served by the existing housing continuum. Options with more intensive supports, including interdisciplinary outreach models, are needed to ensure this population is stably housed.

"There's a real danger in giving people a home but no support services. Support services are critical. You need to help link people up to the community."

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