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The At Home/ Chez Soi Project:

Sustainability of Housing and Support Programs Implemented at the Moncton Site

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The findings and analysis in this publication are those of the authors and are based on interviews conducted with project stakeholders. They do not necessarily reflect the opinions or positions of the organizations mentioned or of the Mental Health Commission of Canada.

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EXECUTIVE SUMMARY

The purpose of this report is to present the findings from the study on the sustainability of the Housing First program established in Moncton and the adjoining rural area over the period of October 2009 to March 2014 as part of the At Home/Chez Soi (AHCS) Demonstration Project.

After the AHCS Housing First Demonstration Project ended in March, 2014, the program transitioned to a new service. The funding for the program was provided by the two regional health authorities (RHAs) that each provided $500,000 (total $1 million) to fund the salaries of the service delivery team. This new service was delivered by a Functional Assertive Community Treatment (FACT) team to allow larger caseloads. Housing support was not provided directly by the program. Rather, the program worked with the Department of Social Development to obtain housing for former AHCS participants either through the continuation of rent supplements or moving into subsidized social housing in Moncton. The admission criteria to the program also changed with program recipients no longer required to be homeless or precariously housed.

The program in Moncton was partially sustained following the AHCS project, with consumers receiving support services delivered by a multidisciplinary team while not being guaranteed housing. The jurisdictional issues were a challenge as the mandate of the New Brunswick Department of Health did not include housing. The Department of Health funded the support services and the Department of Social Development funded the housing, but the separation of housing and support into different organizations complicated delivery of the program. The program lost some important positions on the team, such as the vocational coordinator, housing coordinator and physician and was relying on community resources to provide these services.

In terms of broader changes, the provincial mental health system has adopted some aspects of the AHCS project. For example, the province is working towards adopting community mental health teams in the form of FACT and is intending to include in them peer support workers. However, the mental health service system has not changed in terms of offering housing services and has not shifted to a Housing First model.

The findings highlight five lessons learned. The first is the importance of knowledge mobilization efforts targeted at the provincial government. Greater efforts to influence the decision-makers at the provincial level might have facilitated the maintenance of a Housing First program in Moncton. Second, the AHCS project in Moncton had partnerships with a number of community organizations that are supportive of Housing First. Mobilizing these organizations to advocate the provincial government for Housing First may be impactful. Third, Housing First programs could potentially be developed through

provincial departments other than Health, such as the Departments of Social Development, or Justice and Consumer Affairs. Fourth, it may be worthwhile to pilot a small Housing First program in Moncton that serves 20-40 individuals with mental health problems or illnesses and a chronic history of homelessness. The program could deliver rent supplements and support through case management. Finally, offering training based on lessons learned from AHCS to service providers during the transition period would have been helpful given the high staff turnover.

SUMMARY

The purpose of this report is to present the findings from the study on the sustainability of the Housing First program established in Moncton and the adjoining rural area over the period as part of the At Home/Chez Soi (AHCS) Demonstration Project. During the demonstration project, the Moncton site offered services to homeless individuals with persistent mental health problems or illnesses with moderate or high needs. The support services were delivered by an assertive community treatment (ACT) team. In addition to providing services in Moncton, the program operated a rural arm with three rural service providers situated in Shediac. The rural arm served consumers in Southeastern New Brunswick. Consumers also received subsidized housing and paid no more than 30% of their income towards rent. The housing services were supported by a housing worker. The AHCS Moncton site maintained good fidelity to the Housing First approach during the demonstration project. To determine whether the Housing First model was maintained following the end of the demonstration project, nine key informants, eight staff members and 15 former AHCS consumers participated in interviews or focus groups and shared their views on the sustainability of the demonstration program.

After the AHCS Housing First Demonstration Project ended in March 2014, the program transitioned to a new service. The funding for the program was provided by the two regional health authorities (RHAs) that each provided $500,000 to fund the salaries of the service delivery team. This new service was delivered by a Functional Assertive Community Treatment (FACT) team. Housing support was not provided directly by the program. Rather, the program worked with the Department of Social Development to obtain housing for former AHCS participants either through the continuation of rent supplements or moving into subsidized social housing in Moncton. The admission criteria to the program also changed with program recipients no longer required to be homeless or precariously housed.

Study findings on the sustainability of the demonstration program revealed the maintenance of several components of the Housing First model. The program retained many of the same clinical services offered by a multidisciplinary team. The program also continued to integrate aspects of the Housing First philosophy, such as services being consumer-focused, strengths-based and recovery-centred. While the housing services were no longer attached directly to the program, the team has sought to support consumers from the Department of Social Development to access housing when it was needed. The peer supportive housing program was continued by the Salvus Clinic and the United Way. Community support services also continued to be delivered to the rural region.

However, there were also significant changes to the model moving away from Housing First. The program no longer directly delivered housing services, resulting in clients having limited choice and opportunities to access adequate regular housing when they needed it. The admission criteria to the program also changed and potential program consumers were no longer required to be homeless or precariously housed. The support services were also delivered by a FACT team to enable services to be provided to a larger caseload. The staff struggled to transition to delivering services in a FACT model since the staff had not received specific training on how to work as a FACT team. Staff reported that it was more challenging to offer services to all clients consistently using the FACT model. As a result, by February 2015, the program was described by program staff in a focus group as returning to an ACT model. Although the program was multidisciplinary, the positions on the team had changed and no longer included a family physician, vocational coordinator and housing coordinator. As well, there was no designated clinical lead for the team and access to psychiatric support was more limited. Service intensity was perceived by program staff as having been affected with staff members not consistently developing recovery plans with consumers. As well, the frequency of contact with consumers was viewed as having been diminished.

In addition to the maintenance of and changes to the model, other sustainability outcomes were examined. Funding was retained for the salaries of the program team. In terms of staff retention, staff members were required to re-apply to their positions after the end of AHCS. Four of the staff members from AHCS remained on the team and peer workers continued to be involved in service delivery. The loss of team members affected the ability of the team to deliver Housing First services. The team had developed and maintained partnerships with other agencies in order to deliver services. Important partners included the Department of Social Development; community organizations, such as the Salvus Clinic; clinical services, such as the Mobile Crisis team and the psychiatrists; and others (e.g. landlords, the Greater Moncton Homelessness Steering Committee). The AHCS project was viewed as having influenced the delivery of mental health services in New Brunswick. Notably, provincial mental health services were now to include newly created community mental health teams, which are new to the province. The mental health system is also adding peer support positions. As well, the peer supportive housing program was maintained and expanded in Moncton to include two apartment blocks. New programs with a focus on housing were also being introduced. However, the Housing First model as a whole was not adopted within New Brunswick.

The program staff that had been involved with AHCS completed a fidelity self-assessment. They rated the program as having good fidelity in terms of the separation of housing and services and the service philosophy. The fidelity in terms of the service array was good with the exception of the lack of medical

and physical health services on the team. The fidelity of the housing process and program structure was rated by program staff as being low. The fidelity of the team structure and human resources score were also judged as being low because of the low frequency of face-to-face contacts between staff and participants and because of limited participant input into program operations and policy.

Numerous factors affected the sustainability of the AHCS project in Moncton. The policy context was a challenge, in particular the separation of housing and health into two different departments. Housing was under the purview of the Department of Social Development and was not the responsibility of the Department of Health. Consequently, the Department of Health would not offer housing support. The provision of housing support by the Department of Social Development meant that some clients had to leave the private market housing that they had obtained during AHCS and move into social housing. Also, participants receiving Housing First in the demonstration project who lost their housing were relegated to the end of the Department of Social Development waiting list for social housing. The funding context was also a challenge, as New Brunswick was described as being financially constrained as a result of a large deficit.

The community context of high demand and long waitlists for support and housing services negatively impacted service availability for consumers. Organizations involved in supporting the program that were frequently mentioned included the Department of Health, the regional health authorities (i.e. Vitalité and Horizon) and the Department of Social Development. People who provided leadership to the project included the project leader, members of the local advisory committee, a team manager, program staff and the regional director for Social Development. However, key informants indicated that increased leadership to ensure the sustainability of the program after the end of AHCS would have been helpful. Other factors perceived as influencing the sustainability of the program included challenges with hiring staff, having clear exit criteria for participants in the program and the ambiguous research findings in terms of the program producing improvements in health outcomes.

In conclusion, the program in Moncton was partially sustained following the AHCS project, with consumers receiving community support services delivered by a multidisciplinary team, but without being guaranteed housing. There appears to be a gap between service system managers and program staff in terms of perceptions of the program, with service system managers unaware of the challenges faced by the program team. The jurisdictional issues were a challenge. The Department of Health funded the support services and the Department of Social Development funded the housing. It also appeared that unlike other parts of Canada with large cities, homelessness was not considered a major problem in New Brunswick. The program lost some important positions on the team, such as the vocational coordinator and physician and relied on community resources for these services.

In terms of broader changes, the provincial mental health system has adopted some aspects of the AHCS project. For example, the province is in the process of developing community mental health teams in the form of FACT that will include peer support workers. However, the system has not changed in terms of how housing services are delivered to people who are homeless and has not shifted to a Housing First model.

The findings highlight five lessons learned.

1. The importance of knowledge mobilization efforts targeted at the provincial government. Greater efforts to influence the decision-makers at the provincial level might have facilitated the maintenance of a Housing First program in Moncton.
2. The AHCS project in Moncton had partnerships with a number of community organizations that are supportive of Housing First. Mobilizing these organizations to advocate the provincial government for Housing First may be impactful.
3. Housing First programs could potentially be developed through provincial departments other than Health, such as the Departments of Social Development or Justice and Consumer Affairs.
4. It may be worthwhile to pilot a small Housing First program in Moncton that serves 20-40 individuals with mental health problems or illnesses and a chronic history of homelessness. The program could deliver rent supplements and support through case management.
5. Offering training based on lessons learned from AHCS to service providers during the transition period would have been helpful given the high staff turnover.

INTRODUCTION

The purpose of this report is to present the findings from a study on the sustainability of the Housing First program established in Moncton and the adjoining rural area over the period of October 2009 to March 2014 as part of the At Home/Chez Soi (AHCS) Demonstration Project. The AHCS Demonstration Project was planned to examine the implementation, effectiveness and cost-effectiveness of the Pathways to Housing model to Housing First (Tsemberis, 2010) in five cities across Canada, including Moncton (Goering et al., 2011). The project was intended to serve as a catalyst for facilitating multi-sectoral system change in how individuals with severe and persistent mental illness are assisted to exit homelessness and access needed health and social services.

The catchment area for the Moncton site comprises the tri-cities of Moncton, Dieppe and the Town of Riverview. The population in the Great Moncton tri-city area is over 138,000 (Statistics Canada, 2011). Approximately 70% of dwellings in the Greater Moncton region are owned with the remaining 30% being rental units. The vacancy rate at the time of conducting AHCS in Moncton was 4.3% (Canada Mortgage and Housing Corporation, 2013).

As well, there was a small arm added to the Moncton study that examined the delivery of Housing First in the adjoining rural region of South-East New Brunswick in the counties of Kent and Westmorland. The Southeast region is within a 60-minute drive of Greater Moncton and covers a region stretching over 2000 square kilometres. The region is made up of a variety of small municipalities and service districts that range in population from a few hundred up to four or five thousand. There are approximately 40,000 people living in the Southeast region of the province.

Based on existing sources of data, the number of homeless single individuals who received services from shelters in the Greater Moncton area in 2014 was 780 (Greater Moncton Homelessness Steering Committee, 2015). This outcome reflects the annual number of individuals served by the two largest shelters (in the City) for single adults. There are no data available that provide a profile of the characteristics of the homeless population in Moncton or the proportion presenting with severe and persistent mental illness and having a chronic history of homelessness.

The Community Plan 2011-2014 for the Homelessness Partnering Strategy (Human Resources and Skills Development Canada, 2011) identified over 10,000 individuals at potential risk of homelessness in the Greater Moncton area. These individuals were identified as living in substandard rental units (in core housing needs), as well as experiencing significant financial demands related to covering their basic shelter and living costs (approximately 50% of income dedicated to shelter/housing costs).

CONTEXT

Housing

In terms of housing, there are two organizations providing transitional housing: Crossroads for Women Second Stage Housing which has six units available for women leaving the Crossroads shelter for a period up to one year and Moncton Youth Residences which has two three-bed units available for at risk youth who can stay for up to one year (Greater Moncton Homelessness Steering Committee, 2008).

There are also two organizations providing long-term supportive housing: Alternative Residences Inc. which offers 30 units for mental health consumers that can accommodate up to 76 individuals (26 of the 30 units are apartments and the other four are 24-hour supervised residences; the maximum stay is set at two years) and Future Horizons Housing Inc. which has 12 units (3 two-bedrooms and 9 three-bedrooms) available for consumers of Headstart Inc. and offers a range of support services along with the housing (Greater Moncton Homelessness Steering Committee, 2008).

The provincial Department of Social Development has 647 units of social housing available in Greater Moncton. As well, it provides rent supplements for another 669 units in the private housing market. There are no supports tied to any of these units. There were 671 individuals and families on the waiting list in 2007 for accessing these subsidized housing units (Greater Moncton Homelessness Steering Committee, 2008).

In addition to social housing made available by the provincial government, there are 999 units of non-profit housing in the Greater Moncton area, including 697 for families and 232 units for seniors owned and operated by Atlantic People's Housing Ltd.. Finally, there are also two halfway houses in Moncton for those exiting correctional services, namely Cannell House (20 beds for men) and Greenfield House (16 beds for men, five beds for women and one emergency bed) (Greater Moncton Homelessness Steering Committee, 2008). At the launch of the AHCS project in 2009, there were no Housing First programs in place.

Mental Health Services

Publicly-funded mental health services are delivered in Moncton through community mental health centres (CMHCs), tertiary and secondary facilities and psychiatrists in private practice. These services are managed and operated by two regional health authorities (RHAs), RHA Vitalité and RHA Horizon.

At the start of the AHCS project in Moncton, CMHC services delivered were organized under three core programs: acute services (i.e. 24-hour crisis intervention, short-term therapy prevention, consultation and service delivery coordination), child and adolescent services (i.e. individualized assessment and treatment, service provision for all family members) and adult long-term services (i.e. treatment, monitoring, psycho-social rehabilitation) (Health Systems Research and Consulting Unit, 2009).

The latter core programs involving adult long-term services were particularly relevant to the target population of the AHCS Demonstration Project, people experiencing moderate or severe and persistent mental illness and housing difficulties. Types of services delivered by these programs included case management services, community support services, and rehabilitation services (Health Systems Research and Consulting Unit, 2009). At the launch of the AHCS project in Moncton in 2009, there were no Assertive Community Treatment (ACT) or Intensive Case Management programs in New Brunswick.

Description of AHCS Program in Moncton and South-East New Brunswick

The Housing First program implemented at the Moncton site was a supported housing approach based on the Pathways to Housing approach originally developed in New York City (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005; Tsemberis, 1999; Tsemberis & Eisenberg, 2000; Tsemberis, Gulcur, & Nakae, 2004). Specifically, the intervention included a combination of ACT and subsidized housing in the private rental market.

ACT: The target population for ACT at the Moncton site was individuals with persistent mental health problems or illnesses with either moderate need or high need. The main objective of the ACT team was to provide consumers with needed treatment, rehabilitation or support services to facilitate their successful functioning in the community context.

Members of the ACT team were employees of the Horizon Health Network and Vitalité Health Network. For some positions, this required transfers within the RHAs from other public service departments or the hiring of new personnel. The staff composition was set at 10 FTE representing a

mix of mental health disciplines that included a nurse practitioner, psychiatric nurses, occupational health therapist, home economist, social worker, human resources counsellors, physician clinical director and consulting psychiatrists. The team also included a team leader with training in psychiatric rehabilitation who was available to deliver clinical services to consumers as needed.

The ACT team provided follow-up clinical services for 100 consumers in the Greater Moncton area. The ACT services operated with a consumer to staff ratio of 10:1 which is the standard for ACT allowing for the delivery of intensive services. Members of the ACT team collaborated and supported one another in the provision of daily services to consumers. This included sharing common roles and functioning interchangeably with respect to execution of case planning and service delivery activities while still respecting areas of specialization and limitations associated with professional competencies. All team members had responsibilities related to participation in delivery of core program services including outreach and consumer engagement, screening and comprehensive assessment, clinical treatment and counselling, case management and review, community service collaboration and consultation and file management.

In addition, there were three rural service providers located out of the mental health clinic in Shediac who work in close collaboration with the ACT team in Moncton. The rural service providers offered services and support for 24 consumers living in the Southeastern New Brunswick region. Prior to being admitted for services from the rural service provider, consumers lived either in Special Care Homes, with their families, in rooming houses or were homeless. Upon admission into the program, consumers in the rural region moved into their own housing to live independently.

The rural arm of the ACT team operated with a consumer to staff ratio of approximately 8:1 which is a common standard for delivering ACT services in rural regions. Members of the rural ACT team collaborated and supported one another in the provision of daily services to consumers. Each consumer was assigned a primary and secondary case manager from the rural ACT Team. The Physician Clinical Director located on the Moncton ACT team assumed primary responsibility for monitoring the status and response to treatment for rural consumers.

In line with ACT delivered in the Pathways model, the Moncton and rural members of the ACT team were expected to deliver a complete range of services, including treatment of psychiatric and medical conditions, rehabilitation, crisis intervention, integrated addiction treatment (harm reduction approach), vocational assistance, as well as any other needs identified by the patient. The service approach was informed by recovery principles assisting consumers to adopt valued social roles and become integrated in the community. Although the ACT team assisted consumers in accessing needed

resources in the community, they assumed primary responsibility and were expected to provide most of the mental health services required by consumers.

Upon admission to the ACT program, a service plan was developed in collaboration with the consumer at the first meeting. The ACT team worked closely with a housing worker to help consumers quickly find housing that they choose and can afford with the rent supplement. Although the housing worker was not a formal member of the ACT team, he or she worked closely with the team to assist consumers with selecting housing, negotiating with landlords, moving into housing and adapting to the new living situation as a tenant. The housing worker was also involved in assisting consumers with mediating with landlords when housing problems are encountered.

In line with the Pathways program, consumers were required to have a minimum of one visit per week from an ACT team member; however, they could choose whether or not to participate in treatment and a harm reduction approach to substance use was adopted as consumers were not expected to stay abstinent. Clinical services were organized around an individual's service plan developed in collaboration with the consumer to assist them in the direction of recovery.

Staff services were available from 8:30 a.m. until 10 p.m. seven days a week. Evening hours included provision of outreach and crisis response that were supported by the existing Mental Health Mobile Crisis Unit of the RHA and the crisis intervention centre. The ACT team office for the Greater Moncton area was located in close proximity to the downtown core. The selected site was in a convenient central location to facilitate team members' contact with consumers. The office for the rural service providers was located at the Shediac mental health clinic.

The ACT team held daily organizational meetings to review consumers' progress and the outcomes of the most recent staff-consumer interactions including appointments, informal visits or emergency after-hours responses. In addition, members collaborated to develop a team work schedule to coordinate key treatment and support activities for consumers. This organizational meeting was held at the beginning of each work day and lasted for approximately one hour. The daily team work schedule provided a summary of all consumer activities to be completed for the given day. Members of the rural team participated in these meetings through teleconference.

The organizational team meetings provided a daily opportunity for primary case managers to receive peer feedback, consultation and supervision from the full ACT team. In addition, the primary case managers were responsible for maintaining accurate consumer records, detailing information about the consumers' mental health condition (e.g. onset, course, diagnosis, target symptoms), current assessment results, treatment and rehabilitation plans, as well as support services provided.

Following the organizational staff meeting, team members departed into the community to fulfill their assigned support and treatment related activities. The ACT Team Manager was responsible for monitoring the work activities of the various team members and for modifying the schedule to address unplanned consumer needs or crisis type situations. The Physician Clinical Director, in collaboration with the Team Manager, assumed primary responsibility for monitoring the status and response to treatment for each consumer. In addition, they provided operational and clinical supervision of all team members.

Subsidized housing: Recipients of the AHCS Housing First program at the Moncton site were provided with rent supplements to help pay rent on private market housing. This aspect of service was coordinated by a Housing Worker who was located at the United Way of Greater Moncton and Southeastern New Brunswick.

In particular, the Housing Worker delivered this service component through the following steps:

1. Identifying private market housing that meet the needs of consumers based on their personal preference.
2. Accompanying consumers to visit available apartments.
3. Negotiating lease agreements with landlords.
4. Helping consumers move in and set up their apartments.
5. Providing necessary support to assist consumers to adapt to their new living situation.
6. Serving as a mediator between landlords and tenants if problems are encountered. The Housing Worker also attended ACT team meetings as necessary to participate in service planning for tenants.

A key feature of the Housing First approach was the provision of a rent supplement to ensure that participants paid a maximum of 30% of their income for housing. Given the housing situation in Moncton included a relatively high vacancy rate and a long waiting list for social housing, all of the consumers of the program moved into private market housing. The delivery of housing and support services was provided without any pre-conditions of housing readiness; however, consumers must have been willing to have a reasonable portion of their monthly income allocated directly to cover rent expenses. They must also have agreed to meet with an ACT team member program staff at least once a week to discuss their current housing situation and any areas of need or concern.

Fidelity of the AHCS Program in Moncton

Overall, the findings of the first implementation evaluation revealed the successful implementation of the AHCS program in Moncton and Southeastern New Brunswick. There was consensus among the program stakeholders that the program was delivering timely and effective multidisciplinary support to participants. The Mental Health Commission of Canada has invested significantly in the training of program staff, helping them to adapt to new roles and responsibilities associated with delivering ACT services within a Housing First approach. Despite this early implementation success, there was recognition among program stakeholders of the importance of further program development so that more targeted interventions could be delivered in the areas of addictions treatment and vocational/educational support.

The first fidelity assessment, conducted approximately 10 months after the program was launched, found the Moncton site to already show a high level of fidelity to the Pathways Housing First model. The average score across the 37 items on the fidelity scale was 3.47 on a 4-point scale. Sixty-five per cent of the items had fidelity rating scores of 3.5 or higher. The site was assessed as having high fidelity in four of the five domains, namely Housing Choice and Structure (3.75), Separation of Housing and Services (3.90), Service Philosophy (3.50) and Program Structure (3.50). Lower levels of fidelity were found on the items in the Service Array domain (2.85). Particular challenges noted in the fidelity assessment were the small landlord network, the limited housing stock available, the need for staff training in motivational interviewing and substance abuse treatment and the lack of meaningful involvement of the Housing First participants in the programme.

The second fidelity assessment, conducted 27 months after the start of the program, found high levels of fidelity (3.5 or higher) on 78% of the items and an overall average score of 3.74. Again, the site was assessed as having high fidelity in four of the five domains, namely Housing Choice and Structure (4.00), Separation of Housing and Services (4.00), Service Philosophy (3.55) and Program Structure (3.50). The level of fidelity in the Service Array (3.38) had improved from the first fidelity assessment. Notable program areas identified in the second fidelity assessment as requiring further development included: the integration of substance abuse treatment into services delivered by the ACT team, the use of individualized service planning focusing on recovery goals and the addition of a peer specialist to the ACT team.

METHODOLOGY

Description of the Sample

Staff members of the multidisciplinary service team were invited to participate in a focus group, whereas key informants and select consumers were invited to participate in interviews. A focus group was conducted in February 2015, and was attended by eight staff members and two team managers. The two team managers also participated in key informant interviews. Nine semi-structured key informant interviews were conducted over the telephone between March and August 2015. Key informant interviewees included service system managers from the two RHAs overseeing the services, the previous Clinical Director of the Housing First ACT team and policy developers and program managers from the New Brunswick Department of Health and the New Brunswick Department of Social Development. Six key informants declined to participate in an interview, either because they believed that they had insufficient knowledge of the sustainability of the demonstration project or for unknown reasons.

A fidelity self-assessment was conducted in February, 2015. Four service providers on the multidisciplinary team completed the Housing First Fidelity Survey measure. These individuals were staff members during the demonstration project. First, they completed the self-assessment survey independently. Then they met as a group, along with an interviewer, and reviewed their responses. Differences in responses were discussed until consensus ratings on all the items of the fidelity measure were achieved.

Fifteen consumer participants in the AHCS project were interviewed in person between February and May 2015. Interviews were conducted in either English (N = 8) or French (N = 7). Six consumers were originally living in Moncton and nine were originally living in the rural region. Consumers were asked about their lives since their last qualitative interview that occurred 18 months after they joined the program.

Methodological Steps

Several steps were taken to ensure the quality of the data collection. Prior to the interviews and focus group, the local team reviewed the interview protocol questions regarding their relevance to the local program and redundancy of the items. The protocol underwent minor modifications. The local team also consulted with the national qualitative team leads to clarify items. The interviewers made adjustments during the interviews based on the qualitative data provided by respondents. All interviews were transcribed.

A team approach was taken for the initial analysis of the data. During this process the team identified topics, themes and sub-themes. The team also verified that the category themes were relevant. The local team then adjusted the coding manual based on discussions. The analysis team involved three of the interviewers and one person who was "fresh to the scene." The team did have "insider knowledge" of the project. Three of the four team members had been involved in previous evaluations of the Moncton site of the AHCS project and the other team member had been involved at the national level.

Analytic Approach

Our analytic approach was guided by a general inductive approach as outlined by Saldana (2009). The data were analyzed using a series of steps, specifically, First Cycle and Second Cycle. First Cycle coding involves an initial review of the data and the development of preliminary codes. Second Cycle coding reorganizes and reanalyzes codes developed through First Cycle coding. The goal is to develop "a coherent synthesis of the data corpus" (Saldana, 2009, p. 149). As a result, a series of themes are developed. Specific steps of the data analysis are described below.

The First Cycle of data analysis involved the open coding of data. Each response was read line-by-line and codes were developed for segments of the data. As initial codes should stick closely to the data (Charmaz, 2006), in vivo coding, or the words spoken by the participants, was used as often as possible. Following open coding, Second Cycle coding was completed. This type of coding allows data to be synthesized and placed into meaningful themes and sub-themes. The main themes for the current analysis were created based upon the topics of the interview and focus group guides, whereas the sub-themes were developed through the synthesis of the coded data. Disconfirming data were continuously sought out throughout the coding process in order to increase validity (Maxwell, 1998) and to highlight any differences among the groups of respondents (key informants, program staff and consumers).

Members of the analysis team, comprised of four researchers, each independently coded one of the transcripts. Once the coding was completed, the team met and discussed the themes and sub-themes (codes) in order to establish consensus and develop consistency in the coding process. From this process, a manual was created with definitions of overarching themes. After these initial steps, the research team members were assigned specific thematic areas and independently coded the remainder of the transcripts. Once this process was completed, team members discussed and verified their results in pairs. The team then met as a whole to identify any cross-cutting themes and develop recommendations.

FINDINGS

Narrative Summary

The AHCS Housing First demonstration project at the Moncton site officially ended March 31, 2014. The transition to a new service involving a Functional Assertive Community Treatment (FACT) (van Veldhuizen, 2007) team took place over the subsequent 12 months. The program worked closely with the Department of Social Development over this transition period to ensure that participants receiving Housing First, who were housed at the end of the project, would remain housed either through the continuation of receiving a rent supplement or moving into subsidized social housing in Moncton.

Administratively, the program was moved from being managed by the Salvus Clinic during the demonstration phase to being integrated into and managed directly by the New Brunswick Department of Health. As well, it was physically moved from the Manse, a large old house located on Queen Street next to the Central United Church in Moncton, to the main offices of the New Brunswick Department of Mental Health services in Moncton, located on Albert Street.

The transition process also included the internal posting of positions for the FACT team in the New Brunswick Department of Health. Only four of the service provider positions on the FACT team were filled by individuals who were part of the original AHCS ACT team. The ACT team gradually evolved into a FACT team after the transition year, continuing with consumers originally served in the demonstration project and admitting new consumers. The FACT team included two new administrative leads, one each from each of the RHAs (Vitalité and Horizon). These individuals were tasked to provide the direction for transitioning the team from offering ACT to delivering FACT. There was no clinical lead at the time of the sustainability study.

In line with a FACT model (van Veldhuizen, 2007), the plan was to offer intensive case management to consumers during periods of functioning stability. Each consumer would have a designated case manager who would provide these services. They would move to a wraparound team approach consistent with ACT during crisis episodes and other periods when consumers were experiencing difficulties. It was expected that this type of community support could enable a staff to client ratio of 1:16 to 1:20 in order to maintain high fidelity on a FACT fidelity scale. Two peer support providers, who were initially trained and hired in the latter stage of the AHCS project, were formally hired to be part of the FACT team and supplement the support it provided to consumers.

Aside from the housing organized for the original consumers of the AHCS project in Moncton by the Department of Social Development, the FACT team did not have access to housing resources such as

rent supplements or subsidized social housing for new consumers admitted to the program. In fact, the eligibility criteria for the program no longer included being homeless or at risk of becoming homeless. In addition, if original participants in the AHCS program lost their housing, then they would be relegated to the end of the Department of Social Development waiting list for subsidized housing in Moncton.

Sustainability Outcomes

Consistency of practice to the Housing First model

The Moncton site experienced a great deal of variation with regards to the consistency of their Housing First practice. The two major outcomes were: a shift to a FACT model from the ACT model and a de-emphasis of housing in the delivery of the program, including a change in program admission criteria. As a result of these changes, several key informants and staff noted that Moncton was no longer offering Housing First services. Despite these challenges, all of the key informants and staff members, and some of the consumers, stated that clinical services were still being offered at a high level. This section will first describe how the program maintained consistency to the Housing First model and then discuss changes that were made to the model.

1. Maintenance of the model

Clinical services and program organization - Several of the key informants and focus group participants stated that the program was generally maintaining the clinical services offered to the consumers. This included some support from psychiatrists, however the level of support was contingent upon, and variable between, the RHAs.

The majority of the consumers were satisfied with the level of support being provided by the staff. Some consumers noted that they were still in regular contact with program staff. This continued contact was beneficial, as one consumer stated, “I enjoy having them [the FACT team]…If it wouldn’t be for them, a lot of times I think I would [have] gave up.”

A key informant noted that the program was still having daily meetings where they discussed challenging consumers, which fell in line with the new FACT model. Program staff later clarified that they were now discussing all the consumers during these morning meetings and not just the challenging ones.

Staff composition - Despite the loss of specific positions, key informants and focus group participants stated that the multidisciplinary nature of the team was kept intact. One noteworthy element was the maintenance of the peer specialist role. Several of the key informants noted that this was a very important and unique role, particularly within the context of Moncton and New Brunswick. One of the consumers spoke of the special relationship she developed with one of the peer specialists. The consumer stated that the peer specialist, "understood [me] and she didn't judge me and I felt comfortable talking to her."

Program philosophy - The program maintained several key elements of the Housing First philosophy in their daily work. For example, the program continued to offer consumer-centred services that were strengths-based. One staff member stated that, "even though we lost the whole housing component…I think the philosophy has still stayed as to the need of the client." Consumers determined the frequency of contact with program staff and the staff was described as being flexible in responding to consumer needs. Program staff also expressed that they were continuing a harm reduction approach, however a key informant noted that this element could be enhanced.

Housing - Despite changes to how the program delivered housing services, key informants and program staff described that the majority of consumers maintained some form of housing. For example, key informants noted that some consumers who were provided with housing from the demonstration project were still in the same housing and that they were still being supported. This occurred, in large part, because of the good relationships that were developed with landlords and the continuation of rent supplements provided by the Department of Social Development. The supplements were no longer portable and were instead tied to the housing unit, limiting the consumers' choice in housing.

Lastly, the peer supportive housing building, a unique element of the Moncton site, was maintained and a second peer supportive apartment block was opened with both houses administered by the Salvus Clinic. However, the peer supportive houses were no longer exclusively for participants of the AHCS Demonstration Project. As described by one of the program staff, the house was now a "community resource."

Rural - The rural arm of the program was generally thought to be maintained, despite some structural changes. Program staff and key informants stated that rural consumers were still being supported by the program and the consumers provided corroboration of this continuation. The distance of the rural regions from Moncton created some difficulties, as staff

was no longer situated within the rural regions, but still had access to the satellite offices in the rural regions. Interestingly, one of the key informants was under the impression that staff from other programs in the rural areas were the ones supporting the rural consumers involved in the demonstration project.

2. Changes to the model

Housing - As outlined in previous sections, perhaps the most significant change that took place after the end of the demonstration project was the de-emphasis of housing as a major focus of services. Several key informants and program staff stated that as a result of this change, the program could no longer be considered a Housing First program. As stated by one key informant, "there's been no new housing that has come up that we can consider as Housing First under the program. So it hasn't really been able to be sustained and transferred to other people. So that's a bit upsetting."

This change to the housing component of the program resulted in very limited choice in where consumers could live. A program staff member stated, "And in hindsight, some were coerced into taking things that [they] were clearly not keen on and we knew it as we were offering them the one and only option they had." If consumers did not like their housing, difficult decisions had to be made as the rent supplements were no longer portable in this new system. Instead, the rent supplements were tied to the specific unit. As a result, some consumers were living in accommodations, such as rooming houses, where they were paying more for rent than they would in a Housing First program that provided a rent supplement or living in Special Care Homes, which are not typical accommodations for Housing First programs.

Some consumers spoke of the difficulties that occurred as a result of this change in housing. One consumer, currently residing in a Special Care Home, felt like he did not belong with the rest of the residents. Other consumers spoke of the relative lack of choice they had in acquiring housing attached to NB Housing. One consumer stated:

> "No, they picked the place for me…I didn't want to live there at first because of the drugs. The first building they showed me, I said no. I turned down NB Housing, I said no because the people upstairs…I don't want drug people…and [the program] said you know, would want to trade with [someone else] and he traded with me so I [got] in the other building, away from that."

A second consumer stated:

> "I wasn't involved with the finding of this one which was what made me upset because like I said, I really liked where I was. The landlord, every time something would break he was right there to fix it, like I had no problems. And when she told me she found me an NB Housing, she made me feel like I had no choice."

The staff also felt the pressures of letting consumers know that their housing was going to change, as illustrated by the following quote:

> "We've had to repeat many times, that 'no, we don't have housing no more. We don't have nothing to offer you no more, so if you move out of here, I know you don't like this place, but we have nothing to offer'…We have nothing else."

ACT to FACT - The second major change after the end of the demonstration project was the shift from an ACT service delivery model to a FACT service delivery model. The FACT model allowed for larger caseloads. One key informant thought this change to FACT was to "try not to compromise the fidelity of the model, but also get the maximum capacity in terms of helping people." The switch to a FACT model resulted in changes to the size of caseloads. There were also some initial difficulties reported by program staff in the switch to the FACT model and program staff later stated in the focus group that they had returned to delivering services in more of a shared caseload in line with ACT.

The change in the service delivery model resulted in higher caseloads for program staff. Instead of the traditional 1:10 staff to client ratio of ACT, the program was expected to eventually reach a staff to client ratio of up to 1:16 to 1:20. Some key informants noted that these ratios would have to be flexible depending upon the needs of the consumers. Program staff stated that there were 14 FTE and the program had a capacity of 220 consumers. In February, 2015, there were approximately 130 to 140 consumers in the program. Of these individuals, it was estimated by program staff that 50 were consumers from the original demonstration project.

Program staff noted some challenges with the transition to the FACT model. For example, a staff member discussed that several consumers had fallen through the cracks. Another staff

member said it was difficult to follow-up with consumers due to this shift in service delivery, as indicated in the following quote:

> "What we noticed too when we had case managers, sometimes the client would even call, and if the case manager in particular wasn't there, we had no idea. We just had little bits of pieces here and there of how the client was doing and what his needs were and all that. So with case management, I think, we didn't have a big picture."

As a result of these challenges, program staff stated that they had returned to more of an ACT model of service with shared caseloads.

Change in criteria of program admission - After the end of the demonstration project, the criteria for program admission were changed. Addressing homelessness was no longer a focus of the program as housing services were not considered under the purview of the Department of Health. It was stated repeatedly by one key informant that homelessness was no longer a criterion for entry into the program and other key informants and program staff confirmed this change. As a result of this change, key informants noted that a majority of new patients admitted to the program were housed.

Staff composition - Another major change to the program was the loss of several key staff positions and reductions in others. Program staff explained that the program team used to have a medical doctor, a psychiatrist, a vocational coordinator and a housing coordinator. The role of the clinical lead was replaced by the role of two team managers (one from each of the RHAs), something which program staff noted as a weakness because the manager role does not allow for much clinical leadership to be provided to program staff. One key informant stated the lack of a clinical lead presented challenges, as "maintenant ils ont une gestionnaire d'équipe puis ça, le rôle a changé drastiquement, que l'équipe se sent souvent, hum… seule et dépourvue et sans leadership."

As mentioned previously, the program had limited psychiatric support. This psychiatric support was contingent upon the RHA. One of the RHAs had a psychiatrist who regularly consulted with the program, whereas the other RHA could not provide such a relationship. Patients of the latter RHA accessed psychiatric care through the Emergency Department. The program also lost their administrative support, which program staff described as stressful.

Service planning - Program staff expressed that they were having difficulties developing recovery plans and following service plans. It was also challenging to share service plans with

other staff members during the team meetings, as staff felt that there was not enough time to run through each consumer's service plan. In a subsequent interview in August 2015, a key informant described that the program had begun to develop recovery plans more frequently and that the plans were in line with the goals of the consumers.

Service intensity - Some key informants and program staff felt that the frequency and intensity of contact with consumers had decreased. A key informant attributed this reduction in contact with consumers to higher caseloads and the diminished need for services by some of the consumers who were doing well. Another key informant thought this decrease in service intensity was the result of the changing composition of the team. Specific services, such as transportation of consumers to non-medical related appointments, were no longer offered.

Some consumers also reported a decrease in service intensity. One consumer felt that the staff was slow to react to his needs. For example, he stated, "When I ask for help, I'm asking for help, why don't they give me the help right away. But no, they wait, they wait, they wait, and then I get the help somewhere else. It conflicts, you know?" This sentiment was also reflected by a second consumer and they mentioned the impact of the changing team composition. This consumer noted that there was a decrease in multidisciplinary service offerings.

Funding/budget

Key informants reported that funding has been allocated toward the continuation of some services following the conclusion of the AHCS demonstration project. The funding for mental health supports came from the two RHAs, via the Department of Health. Each of the two RHAs provided $500,000 for a total of 1 million dollars annually. This funding was dedicated to the salaries of the clinical staff members of the FACT team. Key informants also noted that consumers who were original participants in the demonstration project had some access to housing, funded through the Department of Social Development. However, no new funding was available to specifically support the housing needs of consumers of the program.

Key informants commented that significant, long-term funding investments were necessary for the sustainability of the program. It was considered encouraging that the investments toward the FACT team had been made and maintained, indicating the success of the program and the commitment of the government. However, some key informants noted that the funding was limited, leading to the loss of certain roles on the clinical support team and the loss of some programming. Staff salaries were

considered the main funding priority, rather than the maintenance of Housing First model services per se.

Staff retention

One important sustainability outcome pertains to the program's retention of the staff members originally involved in the AHCS Demonstration Project. Program staff and key informants explained that when the demonstration project concluded, staff members were required to re-apply to positions in the program. Some staff members lost their jobs and were replaced by new hires. In other cases, certain positions or roles on the team were eliminated. There were differing opinions among key informants and program staff about the extent to which original staff members had been retained. One key informant perceived minimal staff turnover, saying:

> "We've been fortunate in that I think in our particular case we kept pretty much probably 75 percent of the staff that were on the demonstration model."

Another key informant drew a different conclusion, saying, "Les postes ont dû être réaffichés alors il y a eu un gros mouvement en terme de personnel… L'équipe était presque toute nouvelle."

There were also varying perspectives about the extent to which the structure and composition of the program team was consistent with that of the original team. Key informants and program staff specifically mentioned that the peer support workers involved in the original demonstration project continued into the program, offering valuable support to consumers. However, other roles on the original team were not similarly maintained. Program staff members in particular noted that, "we've lost some very important components, including a physician, psychiatrist, vocational coordinator, housing coordinator, and administrative support staff."

Both program staff and key informants also mentioned the loss of the clinical team leader role. This role, which was considered critical to the functioning of the team, had been replaced by managerial/administrative team leaders from the two RHAs. A key informant commented that the team leader "occupe vraiment un rôle plus administratif qui aurait été avant un rôle plus clinique. Le rôle du team leader a changé, il a pas vraiment un team leader dans l'équipe." Program staff described the lack of a clinical team leader as a "new challenge," resulting in disorganization and lack of direction.

The importance of staff retention to the sustainability and continuity of services was acknowledged by key informants and program staff. A lack of staff retention had reportedly led to challenges, including a sense of disruption and loss of cohesion. New staff members were described as lacking training or

training that they received consisted of an introduction to FACT and to the differences between ACT and FACT. Given the turnover of staff, several had not even received that training. This lack of training was thought to impact the ability of the team to deliver services in a model consistent with FACT.

Speaking about the lack of training in the FACT model, a key informant reported, "/ž]vlžolÍ
šÍ[vP]vÍ[š]P}ÍEvÍ[vP}Áv." It was
thought it would be helpful to have further support around how to deliver FACT. Staff also had not received training on the Housing First model since the end of AHCS, thus the majority of the staff members had never been trained in this model during their time with the team. The lack of training was viewed as a contrast to the period of the demonstration project when staff received training around Housing First and how to working with individuals with severe mental illness.

Other Factors Influencing Sustainability

Difficulties in hiring staff

Key informants and program staff described challenges in hiring staff who were familiar with the Housing First philosophy and prepared to work in an innovative team environment. The FACT team was considered unique and different from the traditional way of offering services to consumers in the mental health field. Staff perform a wide array of duties and take on interchangeable team roles, "We're pushed out of our comfort zone in terms of our profession, sometimes." Program staff explained that filling positions was difficult as staff are offering service in the community, which is different from how services are typically delivered and working with consumers with high levels of needs.

Program exit criteria

Key informants and program staff also suggested that the program's exit criteria was a factor influencing its sustainability. A lack of clarity around exit criteria was cited by one key informant. Program staff explained that consumers are reluctant to leave the service, even when they are doing better or when the service is "not a good fit" for their needs. In some instances, consumers who had been discharged experienced a period of crisis and were re-admitted to the program without going through the referral and intake processes. Program staff discussed the importance of directing consumers back to "natural support systems" whenever possible. Long wait lists for support services in Moncton also impacted the exit criteria of the program. One key informant explained:

> "Because there are wait lists for treatment teams so we have to work on, so if we are going to start the step down process, when do we do that, because we don't want to do that, and have them be on a wait list again, and then they're not seeing anybody."

Research findings

The research findings of the AHCS Demonstration Project were referred to as another factor influencing the program's sustainability. There were comments about the limited extent to which the findings were influential within the Department of Health in particular. Program staff and key informants wondered how far "up the chain" the research findings had reached. One key informant recalled the "fishy" way that the results were presented to support the funding announcement for the program. One key informant expressed disappointment with the findings:

> "There really wasn't that much of a marked difference between the control group and participants in terms of things that were important to the health authority, so visits to ER, whether or not they were still being seen for group sessions here, so was there sort of duplication of the service. Those kinds of things didn't really resonate with me as being sort of fundamentally the reason why we said we had to remain in this area."

Other key informants and program staff viewed the research findings as being positive and helpful in securing more funding and facilitating the sustainability of the program. Ongoing efforts to research and evaluate the FACT model in the program were described, and were partly attributed to the positive experience with research during the AHCS project. One key informant recalled using the research findings to advocate for Housing First politically:

> "The information that flowed from that all sort of helped to facilitate the advancement of a policy direction that we wanted to focus on in the community in New Brunswick. Politicians love stories, right? Specifically those that resonate with them. They talk to the citizens who elect them and they deal with stories, so they really get stories and so to me I used the data from At Home/Chez Soi as part of a story about where we want public policy to go and the administrations that I was fortunate enough to work with over the years were quite open and receptive to that."

CONCLUSION

Cross-Cutting Themes or Issues

Partial sustainability of the program. The program in Moncton has been partially sustained since the end of the demonstration project. Support services, which are client-centred and delivered by a multidisciplinary team, continue to be offered to AHCS consumers and new consumers of the program. Despite this positive development, the program is not offering the most critical ingredient of Housing First: housing. This shift in program philosophy was the direct result of policy and funding changes and met with disappointment by all of the program staff, some of the key informants and many of the consumers.

Gap between perceptions of service system managers and program staff. There appeared to be a gap between service system managers and program staff regarding their perceptions of the program. For example, some key informants noted little difficulty in the transition of program staff after the demonstration project, whereas program staff noted experiencing significant difficulties with this transition. There were also differences in how the Housing First model was perceived. Some key informants did not see the merit of providing housing services, whereas program staff were acutely aware of the importance of housing in the lives of the consumers.

Jurisdictional issues are a challenging obstacle. Jurisdictional issues hindered the sustainability efforts in Moncton and had not been resolved by the demonstration project. The continuation of the support services was made possible by funding through the Department of Health, but this funding did not allot funds for housing. The Department of Social Development was helpful in moving AHCS consumers into New Brunswick Housing; however the policies and procedures followed by New Brunswick Housing were in contrast to many Housing First principles, such as the portability of rent supplements. This switch to New Brunswick Housing was met with frustration by some consumers of AHCS, as they were faced with having to move into sometimes less desirable units.

Homelessness is not considered a major problem in New Brunswick or a government priority. The "problem" of homelessness in Moncton was not discussed in great detail by the key informants or program staff. It may reflect that it is perceived as less of a problem and given less priority in a small city as compared to larger cities. It was acknowledged that there were long waitlists for social housing and generic support services, but the magnitude of homelessness was not discussed. A positive development was representation from the Department of Health on the Greater Moncton Homelessness Steering Committee.

Loss of fidelity necessitates external partnerships. The loss of fidelity to the Housing First model contributed to a less intensive and diminished array of services from the program. As a result, the program staff was reported to access community resources to fill these gaps more frequently than during AHCS. These included housing, employment and medical resources.

Systems change in supports but not housing. The demonstration project has produced some provincial system changes as it relates to the delivery of mental health services. The province is now working on expanding the FACT model and including peer support workers throughout the rest of the province. Conversely, there is no evidence of system change as it relates to housing. There was no indication that the Housing First approach would replace the more traditional continuum model of housing, where consumers progressively graduate to more independent housing. As well, the province continues to rely on Special Care Homes for housing individuals with severe and persistent mental illness.

Program staff adoption of the Housing First philosophy. Despite changes in the program model away from Housing First, staff remained committed to Housing First values in their support of AHCS and new consumers. The staff were cognizant of the importance of recovery plans, individualized services and the importance of housing. They have also put effort into maintaining relationships with landlords and sought out community resources when the program changed its mandate to exclude housing.

Reflections and Lessons Learned

1. Increase knowledge transfer efforts about the project at the provincial level. Much of the knowledge mobilization efforts over the course of the AHCS project in Moncton were conducted at the local and regional levels. Although the New Brunswick Department of Health was very supportive of the demonstration project, it appears that insufficient knowledge mobilization on Housing First at the provincial level may have contributed to the resulting partial implementation of the model, notably the continuation of a community support team. Greater knowledge mobilization targeting both the Department of Health and Department of Social Development in Fredericton may have facilitated the adoption of Housing First post-demonstration project.

2. Mobilize Community Advocates for the Housing First Approach. The AHCS project in Moncton was successful in developing a large number of partnering community organizations that work with the homeless population. These organizations were very supportive of Housing First and witnessed the benefits experienced by their consumers who were recipients of the service. The mobilization of these organizations to advocate the municipal, provincial, and federal governments for the development of Housing First in Moncton is worth considering in the context of the change in focus of the federal homelessness initiative (Homelessness Partnering Strategy).

3. Consider the development of Housing First programs through provincial departments other than health. Interviews with key informants in the sustainability study highlighted the jurisdictional obstacles of combining housing with health services in New Brunswick. Consequently, it may prove worthwhile to explore the development of Housing First programs through other provincial departments that deliver programs to people who are homeless. In particular, the Department of Social Development and the Department of Justice and Consumer Affairs are two provincial departments in New Brunswick that provide support for people with mental health difficulties and housing problems. The delivery of Housing First programs as an alternative to the more costly Special Care Homes is also worth considering.

4. Consider a small pilot Housing First program in Moncton that targets those individuals with mental health problems or illnesses and chronic histories of homelessness. In line with the direction taken by other small cities across Canada, it may be worthwhile to pilot a small Housing First program that serves 20-30 individuals with mental health problems and a chronic history of homelessness. The program could deliver rent supplements and community support in the form of case management. The small scale and the provision of case management instead of ACT would facilitate the feasibility of accessing the necessary funding for the pilot.

5. Provide training on based on lessons learned in At Home/Chez Soi to service providers after the demonstration project. The sustainability research project revealed significant turnover in the team of service providers subsequent to the demonstration project. As a result, many lessons learned in the AHCS project about service provision were not carried over to the new community support team. In retrospect, it would seem that providing training based on the AHCS project to the staff during the transition period would have been beneficial.

6. Integrate Department of Social Development personnel into FACT teams. The loss of housing as a target of intervention by the FACT team represents a significant departure from the Housing First model developed in the demonstration project. Similar to the arrangement on the ACT team during the demonstration project, it would be worthwhile to make arrangements for specific personnel from the Department of Social Development to be assigned to the FACT team in order to address the housing needs of consumers

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APPENDIX:

Fidelity Self-Assessment Scores for Moncton

Items	Program score	Potential Scores
Housing Process and Structure		
Housing choice	4	1-4
Neighbourhood choice	4	1-4
Furniture assistance	2	1-4
Housing subsidies	2	1-4
% income towards rent	1	1-4
Time to move into housing	1	1-4
% in different types of housing	1	1-4
Sub-total	**15**	**7-28**
Separation of Housing and Services		
% sharing bedroom	4	1-4
Requirements for gaining access to an apartment	6	1-6
Requirements for staying in apartment	5	1-5
Lease	2	1-2
Provisions of lease agreement	3	1-3
Rehousing when lose housing	2	1-4
Services when lose housing	4	1-4
Sub-total	**26**	**7-28**
Service Philosophy		
Determination of services	3	1-4
Requirements for psychiatric treatment	4	1-4
Requirements for substance use treatment	4	1-4
Approach to substance use	4	1-4
Activities to promote treatment adherence	7	1-8

How treatment goals are set	10	1-10
Life areas targeted for treatment	7	1-7
Sub-total	**39**	**7-41**
Service Array		
Help to maintain housing	4	1-4
Psychiatric services	3	1-4
Substance use treatment	4	1-5
Employment	5	1-5
Education	5	1-5
Volunteering	5	1-5
Physical health	1	1-5
Peer specialist	4	1-4
Social integration	5	1-5
Sub-total	**36**	**9-42**
Team Structure/Human Resources		
Targets chronically homeless with mental illness & addictions	6	1-6
Client:staff ratio	3	1-4
Face-to-face client/staff contacts per month	2	1-4
Regular staff meetings	4	1-4
Function of staff meetings	4	1-6
Client input	2	1-6
Sub--total	21	6-30
Total	**137**	**36-169**

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