



Mental Health
Commission
of Canada

Commission de
la santé mentale
du Canada

Follow-up Implementation and Fidelity Evaluation of the Mental Health Commission of Canada's At Home/Chez Soi Project:

CROSS-SITE REPORT

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May 27, 2013

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Production of this document is made possible through a financial contribution from Health Canada. The views represented herein solely represent the views of the Mental Health Commission of Canada.

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KEY MESSAGES

- A study was undertaken at the five sites for the Mental Health Commission of Canada's At Home/Chez Soi project to determine if the program was implemented as intended, the reasons for implementation challenges and strengths, staff perspectives on the Housing First theory of change, landlord and caretaker experiences with program implementation, and issues regarding program sustainability.
- External Quality Assurance teams conducted site visits and rated 10 programs on 38 fidelity items. Overall, fidelity to the Housing First model is strong and improving with more than 78 per cent of program ingredients rated above three on a four-point scale, compared with 71 per cent from an earlier fidelity evaluation.
- Qualitative site reports indicated the following implementation strengths: partnerships, housing and rehousing participants, and specialist staff.
- Challenges included staff turnover, the scattered-site model of housing not working for everyone, participant isolation, the need to further enhance peer support and consumer participation, housing/rehousing issues and the need to develop more vocational and educational opportunities for participants.
- Regarding the Housing First theory of change, obtaining stable housing was the primary outcome during the first year of participation in the program, while family reunification, a greater willingness to engage in treatment and vocational outcomes were observed more in the second year of participation.
- Participants who displayed a greater "readiness" for change and connection with treatment services were thought to be those who improved the most.
- Critical ingredients of the Housing First model included: staff values that promoted acceptance of participants, team communication, consumer choice and rehousing.
- Landlords and caretakers commented on positive relationships that they had developed both with staff from clinical and housing teams (especially around property damage and moves) and with participants.
- Landlords and caretakers expressed concerns about tenant behaviours (e.g., property damage, visitors, drug use) and payment of rent.
- Both clinical and housing team staff and participants expressed anxiety about the sustainability of the services.
- Coordinated national and local strategies to promote sustainability included: knowledge transfer and raising public awareness, especially through the release of an Interim Report on findings, educating and working with politicians and civil servants regarding ongoing funding, and attempting to "mainstream" project services into existing structures. This mainstreaming raised concerns about program drift from the original model.
- Cross-cutting themes include: the growth and maturing of clinical and housing teams; enhanced staff proficiency in the Housing First model; the ongoing need to strengthen staff capacity; the importance of attending to the diverse needs of participants; an emerging sense of community, ownership, and belonging; the importance of developing relationships with partners; and the importance of organizational context for implementation and sustainability.
- The legacy of At Home/Chez Soi is that it works, that it can be successfully implemented with a high degree of fidelity and that it can be adapted to local contexts.

EXECUTIVE SUMMARY

This report presents the overall findings from an implementation and fidelity evaluation of the At Home/Chez Soi initiative, a pan-Canadian Housing First demonstration project that was implemented in Moncton, Montréal, Toronto, Winnipeg and Vancouver. The present study examined the second phase of implementation, using a mixed methods strategy. The quantitative data were gathered by an external Quality Assurance team, which produced 10 fidelity reports for the five sites (excluding site-specific arms). Program fidelity ratings are based on 89 staff interviews, 11 consumer focus groups and 102 chart reviews. In addition, five site qualitative implementation evaluation reports were produced and interviews with members of the QA team were conducted. These reports are based on 36 key informant interviews, 17 staff focus groups and 57 interviews with landlords and caretakers. The present report synthesizes the fidelity reports and qualitative reports, and presents findings related to: (1) ongoing and emerging fidelity strengths and challenges; (2) stakeholder perceptions of what accounts for fidelity strengths and challenges; (3) lessons learned about the Housing First theory of change; (4) landlord/caretaker issues; and (5) issues regarding sustainability and the future of the project. Cross-cutting themes and lessons learned are also identified.

External Quality Assurance teams conducted site visits and rated 10 programs on 38 fidelity items covering several domains (e.g., Housing Choice and Structure). Overall, fidelity to the Housing First model was strong and improved with more than 78 per cent of program ingredients rated above three on a four-point scale, where four indicates the highest level of fidelity, compared with 71 per cent for the earlier implementation evaluation. The strongest fidelity ratings were reported for the domain of Separation of Housing and Services. For the domain of Housing Choice and Structure, the items of permanent housing tenure, affordable housing, integrated housing and privacy were all rated a four. The majority of items of the Service Philosophy domain were also rated quite high, as was housing support for the Service Array domain. Most of the items for the Program Structure domain were also rated quite high.

Several implementation challenges were noted across the five sites. Housing availability was a problem in all five sites, and housing choice was a challenge in some of the sites. In the domain of Service Philosophy, person-centred planning and motivational interviewing were challenges for several sites, and assertive engagement was a challenge for two of the sites. For the domain of Program Structure, participant representation in the programs was a challenge at all of the sites, and contact with participants emerged as a problem at three of the sites. By far, the most challenges were observed for the Service Array domain. The items of psychiatric services, substance abuse treatment, employment and educational services, nursing/medical care, social integration, 24-hour coverage and staff involvement regarding discharge from inpatient treatment were challenges for the majority of sites. Service Array issues were more of a problem for the Intensive Case Management (ICM) teams than for the Assertive Community Treatment (ACT) teams. This is likely because ICM teams did not have control over whether there was an array of services in the community that they could broker for consumer participants.

Qualitative site reports indicated the following implementation strengths: partnerships, housing and rehousing participants, and specialist staff providing valuable services. Challenges included staff turnover, the scattered-site model of housing not working for everyone, participant isolation, the need to further enhance peer support and consumer participation, housing/rehousing issues and the need to develop more vocational and educational opportunities for participants.

Regarding the Housing First theory of change, obtaining stable housing was the primary outcome during the first year of participation in the program, while family reunification, a greater willingness to engage in treatment and vocational outcomes were observed more in the second year of participation. Participants who displayed a greater “readiness” for change and connection with treatment services were thought to be those who improved the most. Critical ingredients of the Housing First model included: staff values that promoted acceptance of participants, team communication, consumer choice and rehousing.

Landlords and caretakers commented on positive relationships that they had developed both with staff from clinical and housing teams (especially around property damage and moves) and with participants. Landlords and caretakers expressed concerns about tenant behaviours (e.g., property damage, visitors, drug use) and payment of rent.

Regarding project sustainability, both clinical and housing team staff and participants expressed anxiety about the sustainability of the services. Coordinated national and local strategies to promote sustainability included: knowledge transfer and raising public awareness, especially through the release of an Interim Report on findings; educating and working with politicians and civil servants regarding ongoing funding; and attempting to “mainstream” project services into existing structures. This mainstreaming raised concerns about program drift from the original model.

There were several cross-cutting themes. First, stakeholders commented on the growth and maturing of clinical and housing teams. Staff members, individually and collectively, developed a sense of confidence and expertise in implementing the model, and showed a resilience that gradually replaced the fragility that they experienced earlier in the project. This maturity was related to getting over the hump of recruitment, when the unpredictable caseloads of that phase were compounded by learning curve issues associated with adopting the model without having a base of expertise upon which to build. Seeing the benefits of Housing First, especially with participants who may have been written off in the past, was a particularly powerful force that enabled staff to buy in to an approach that may have initially been met with skepticism. Watching participants benefit also helped staff to unlearn previous attitudes and approaches that came out of working unsuccessfully with similar participants in the past.

A second theme that is related to the first theme is improved team capacity for addressing needs and impacting key outcomes. Overall, respondents talked about how the model itself, and staff’s growing proficiency in the model, were associated with significant gains in wellbeing for project participants. The housing and support provided enabled participants to achieve both clinical and housing stability. Further, by accessing specialist resources and developing and sharing their skills, the teams collectively became better at addressing the complex needs of participants (e.g., concurrent or multiple disorders, trauma, etc.).

A third theme is that despite this sense of growing maturity, expertise and staff proficiency in the Housing First model, sites nonetheless acknowledged the need to continue to address staff capacity challenges. Given the loss of skills represented by staff turnover, formal training for new staff rather than a learn-as-you-go model was recommended. Key informants also noted, however, that staff turnover could sometimes be an opportunity to replace staff, including team leaders, who were not well suited to the Housing First model. Also, staff turnover is a common challenge in these types of programs.

A fourth theme is attending to the diverse needs and characteristics of participants. Despite improvement, some challenges remained. Sites were challenged to find solutions for the small number of participants who hadn’t yet achieved housing stability within scattered-site apartments. Each site also experienced challenges with participants with unique needs.

A fifth theme is the emerging sense of commitment, ownership and belonging regarding the Housing First approach. Key informants suggested that a sense of ownership and belonging to the program existed within the participants themselves, and they further noted the remarkable sense of dedication to the project that continued within the project’s staff, despite the difficulty and complexity of the work. Respondents also suggested that there was a growing sense of joint commitment to the model of the various teams within each site, and by agencies and individuals within the wider mental health and social services system who have worked with and benefitted from the project (e.g., income assistance and employment workers). There was also a sense that the project as a whole was valued and achieved a sense of belonging within a wider group of stakeholders, such as the landlords who rented to participants, and the police and criminal justice system professionals who appreciated how the support provided to participants alleviated some of their work. This sense of commitment to and ownership of the project by those who were closely involved, and the sense of belonging the project earned within the wider community, translated into improved program capacity, greater ability to meet the needs of participants and improved prospects for sustainability.

A sixth theme is the critical importance of relationship development with partners to program success. There was a general consensus that building relationships and clarifying expectations earlier on would have been beneficial.

A seventh theme is that organizational context was important for implementation. The findings attest to the importance not only of team leadership, but of the host agency leadership. Stable and strong host agency leadership helped with the logistical aspects of implementation, and could help teams withstand turnover of team leaders. A congruent host agency culture was also instrumental for ensuring that the philosophical aspects of the model were implemented and maintained. Moving beyond the team environment, respondents noted the importance of having a strong Site Coordinator, especially one who could hold the space necessary for bringing in the multiple players, helping them negotiate differences and creating a shared vision. The overarching context of the central project leadership and resources was also acknowledged as instrumental to implementation. National key informants in particular suggested that the fidelity process and the feedback and training that came out of it (and was taken up by the teams) was an essential part of the teams' continued improvement.

The legacy of At Home/Chez Soi is that it works, that it can be successfully implemented with a high degree of fidelity and that it can be adapted to local contexts.

ACKNOWLEDGMENTS

This cross-site report is based in part on the reports from qualitative researchers from the five sites. We want to acknowledge and thank these members of our Qualitative Research Team for their thorough work in putting together the individual site reports and for their help in planning and conceptualizing this research. The five site reports are:

The At Home/Chez Soi Project: Year Two Project Implementation at the Vancouver, BC Site (May, 2012) by Michelle Patterson, Faculty of Health Sciences, Simon Fraser University.

At Home/Chez Soi: Winnipeg Site Later Implementation Evaluation Report (August, 2012) by Scott McCullough and Matthew Havens with Corinne Isaak and Tracy Deboer, Institute of Urban Studies, University of Winnipeg.

At Home/Chez Soi Follow-up Implementation Evaluation: Toronto Site Report (January, 2013) by Vicky Stergiopoulos, Stephen Hwang, Patricia O'Campo, Jeyagobi Jeyaratnam, and Katherine Kruk, Centre for Research in Inner City Health, St. Michael's Hospital.

Final Report on the Findings of the Second Implementation Evaluation for the Moncton Site of the At Home/Chez Soi Project (November, 2012) by Tim Aubry, Stephanie Yamin, John Ecker, Jonathan Jetté, Hélène Albert, Danielle Nolin, & John Sylvestre.

Projet Chez Soi - Montréal : Projet de recherche et de démonstration sur la santé mentale et l'itinérance - Second rapport d'implantation du projet (novembre 2010 - août 2012) : Rapport intérimaire - Mars 2013 (2013, mars) par C. Vallée, M.-J. Fleury, et R. Hurtubise.

Additionally, this report is based on 10 fidelity assessment reports conducted by an external Quality Assurance (QA) team and on interviews with eight members of the QA team and the Mental Health Commission of Canada that were conducted by members of the National Qualitative Research team.

Thanks also to each of the sites and to Cameron Keller and Catharine Hume for reviewing and providing feedback on an earlier draft of this report, and to Julianna Walker, Sue Goodfellow, and Jijian Voronka for their assistance with the fidelity assessments.

¹ For more information please refer to: <http://www.mentalhealthcommission.ca>

² For more information on past Advisory Committees please refer to: <http://www.mentalhealthcommission.ca>

INTRODUCTION

This report presents findings regarding the implementation of the At Home/Chez Soi project.¹ This pan-Canadian project was funded by the Mental Health Commission of Canada (MHCC).² It was a five-year research demonstration project exploring ways to help the growing number of people who are homeless and have a mental illness. At Home/Chez Soi built on existing evidence and knowledge and applied it in Canadian settings to learn about what housing, service and system interventions can best help people across Canada who are living with mental health issues and who have been homeless. The At Home/Chez Soi project was implemented in five cities across Canada: Moncton, Montréal, Toronto, Winnipeg and Vancouver. A more detailed description of the project's structure and the five sites is provided in Appendix 1.

This report focuses on the implementation of the project during its second and third years of operation. A previous report focused on the first year of implementation (Nelson et al., 2012). The At Home/Chez Soi project was a randomized controlled trial (RCT) of Housing First vs. Treatment as Usual (TAU) (Goering et al., 2011; Nelson, Goering, & Tsemberis, 2012; Tsemberis, Gulcur, & Nakae, 2004). Nested within each of these two experimental conditions were two groups of participants: those with high needs, who received support from Assertive Community Treatment (ACT) teams in the Housing First condition, and those with moderate needs, who received support from Intensive Case Management (ICM) programs in the Housing First condition. Additionally, sites had the option of developing a “third arm,” or an intervention condition that was tailor-made to local conditions and needs, and most sites did develop a third arm. More information on the principles of Housing First can be found in Appendix 2. Interim findings on one-year outcomes have been described in another report (Goering et al., 2012).

Using a mixed methods approach (Macnaughton, Goering, & Nelson, 2012), a one-year follow-up fidelity and implementation evaluation of the At Home/Chez Soi project was undertaken. It is often argued that programs change, adapt and improve over time, and that program staff members are more proud of their programs as they gain experience in implementing them (Patton, 2008, 2011). The purpose of this evaluation is to examine changes in program fidelity, as well as to better understand the reasons behind continued and emerging strengths and challenges in the implementation of the At Home/Chez Soi project over a period of roughly one year. Early fidelity and implementation conducted during the participant recruitment phase of the research (August 2010 to April 2011) are compared with later fidelity and implementation (November 2011 to July 2012). We also examined stakeholder perceptions of the program's theory of change (Mowbray, Holter, Teague, & Bybee, 2003), landlord/caretaker perspectives on the project and stakeholder perspectives on sustainability issues. There are five main objectives of this research:

1. **to determine changes in fidelity ratings from early to later implementation;**
2. **to examine the reasons for implementation challenges and strengths;**
3. **to better understand staff perspectives on the theory of change of Housing First;**
4. **to understand caretaker and landlords' experiences with the programs; and**
5. **to learn about issues regarding program sustainability.**

¹The origins of the At Home/Chez Soi project and the selection of the five demonstration sites are detailed in the Qualitative Research Team's report, *Conception of the Mental Health Commission of Canada's At Home/Chez Soi Project* (Macnaughton, Nelson, Piat, Eckerle Curwood, & Egalité, 2010), and the planning process for the sites is described in the cross-site report, *Planning and proposal development of the Mental Health Commission of Canada's At Home/Chez Soi Project* (Nelson, Macnaughton, Eckerle Curwood, Egalité, Piat, & Goering, 2011).

²The Mental Health Commission of Canada (MHCC) is a catalyst for improving the mental health system and changing the attitudes and behaviours of Canadians around mental health issues. Through its unique mandate from Health Canada, the MHCC brings together leaders and organizations from across the country to accelerate these changes. The MHCC is funded by Health Canada and has a 10-year mandate (2007-2017). Among its initiatives, the MHCC's work includes the country's first mental health strategy, working to reduce stigma, advancing knowledge exchange in mental health, and examining how best to help people who are homeless and living with mental health problems.

Corresponding to the five objectives of the mixed methods research noted above, there were five sets of research questions:

1. FIDELITY EVALUATION QUESTIONS

- a. Are there changes from early to later implementation in the fidelity ratings of programs as determined by the fidelity assessment tools implemented by the Quality Assurance (QA) team?
- b. What are the current areas of strength in fidelity?
- c. What are the current areas of challenge in fidelity?

2. DEVELOPMENTAL EVALUATION QUESTIONS (PATTON, 2008, 2011)

- a. What are the reasons for issues that continue to represent implementation fidelity strengths?
- b. What are the reasons for emerging implementation fidelity strengths?
- c. What are the reasons for issues that have emerged as apparent challenges to implementation fidelity?
- d. What are the reasons for issues that continue to present an apparent challenge to implementation fidelity over time?
- e. How is implementation proceeding with respect to challenges identified in first round fidelity reports or implementation evaluation reports? (delays in housing placement, barriers to location choice, challenges with rehousing, challenges with involving participants and persons with lived experience in program operations and research, staff burnout and retention)

3. HOUSING FIRST THEORY OF CHANGE QUESTIONS

- a. What outcomes are seen during the first year and what outcomes are seen during the second year of the intervention?
- b. What are the characteristics of those participants who benefit most from Housing First and those who benefit least?
- c. What are the most important ingredients of the Housing First program at different time periods and for different groups of participants?

4. QUESTIONS ABOUT LANDLORD/CARETAKER EXPERIENCES

- a. What are landlord/caretakers' perceptions about what is working well with the programs?
- b. What are landlord/caretakers' perceptions about what is not working well with the programs?

5. SUSTAINABILITY ISSUE QUESTIONS

- a. How are the concerns of the participants about the stability of their housing and program support being addressed?
- b. What are participants' concerns about sustainability and how are they addressed at the sites?
- c. What are participants' views about the legacy of the project and the lessons that have been learned?

BRIEF METHODOLOGY³

MIXED METHODS APPROACH

A mixed methods approach (Padgett, 2012; Palinkas et al., 2011) to the evaluation of fidelity and implementation was conducted by an external Quality Assurance (QA) team and by local site qualitative researchers. The QA team examined *program fidelity*, a quantitative assessment of the degree to which the implementation of Housing First adheres to the core principles of Housing First. The qualitative implementation evaluation focused on process factors that helped or hindered the achievement of program fidelity as the programs developed over time, *developmental evaluation* (Patton, 2008, 2011), as well as perceptions about the Housing First theory of change, landlord issues and sustainability issues.

FIDELITY EVALUATION

The Pathways Housing First Fidelity Scale was used to assess program implementation along 38 items within five broader domains (Housing Choice and Structure, Separation of Housing and Services, Service Philosophy, Service Array and Program Structure) identified as critical to Housing First (Tsemberis, 2011). See Appendix 2 for Housing First Principles, Appendix 3 for the Housing First Logic Model, Appendix 4 for a more detailed description of the methodology, and Appendix 5 for the fidelity evaluation tools. Items for the fidelity evaluation tool were adopted from several sources (SAMHSA, 2008, 2010; Monroe-DeVita, Teague, & Moser, 2011; Williams, Banks, Robbins, Oakley, & Dean, 2001).

Fidelity assessments of each Housing First program were conducted by an eight-member multi-disciplinary QA team consisting of clinicians, researchers and a person with lived experience representative, with four to six team members per site visit. Because the programs used two different models of service delivery that varied in intensity, two versions of the Pathways Housing First Fidelity Scale were developed – one for teams using ACT and one for those using ICM. There was a great deal of overlap between these two versions with the most noticeable difference that ACT teams were assessed on the degree to which they directly provided an array of services, whereas ICM teams were assessed on the degree to which they were able to broker these same services. For this report, third arm programs were not included. Each of the 38 items was rated by the QA team on a four-point scale (with a high score indicating a high level of fidelity), and each item was benchmarked with concrete indicators.

The fidelity assessment consisted of a full-day visit to each of the five program sites and included program meeting observations, staff interviews, consumer chart reviews and consumer focus groups. Approximately 4-12 staff members were interviewed at each program and interviewees included frontline staff with specialties (e.g., substance use specialist), general service-providers/clinicians (e.g., case manager), management staff (e.g., team leader), and members of the local housing team. Interviews were semi-structured and lasted approximately 45 minutes, with the interviewers taking notes. The consumer focus groups were co-facilitated by two individuals – one a member of the QA team and the other a local consumer representative – and lasted approximately one and a half hours. For the chart review, the fidelity team reviewed a stratified random sample of 10 charts per site, including progress notes for the past month as well as most recent treatment plan and assessments. The visits were conducted between December 2011 and May 2012. The total sample included 89 staff interviews, 11 consumer focus groups and 102 chart reviews.

The QA team triangulated these various sources of data to describe how each program was implementing housing and support services and to rate each program on the extent to which it demonstrated fidelity to the Housing First model on the 38 items. Ratings for each item were developed through discussion and team consensus. At the end of each visit, the

³ A more detailed description of the methodology can be found in Appendix 4.

fidelity team conducted a debriefing session with each program to discuss preliminary findings. At these meetings, the program could also clarify any misconceptions, offer additional information and provide feedback. Following each visit, the QA team prepared brief reports, which described program implementation and operation, program strengths and challenges, and made recommendations in areas where there was potential for improvement. The 10 reports were first sent out as drafts to the programs, soliciting their input and feedback with respect to content, and they were revised based on program input and sent back to the programs as final versions.

QUALITATIVE EVALUATION OF IMPLEMENTATION

Sampling and sample. Sampling was purposeful: individuals who were identified as having played a key role in program implementation were selected and interviewed individually as key informants. Frontline project staff, most of whom participated directly in the programs, were interviewed in focus groups. In all, 17 focus groups with 99 participants, 36 key informant interviews and 57 landlord interviews were conducted by site researchers between January 2012 and July 2012. In addition, eight key informant members of the QA team were interviewed by members of the National Qualitative Research Team. The total sample consisted of 192 participants.

Data collection. Common key informant and focus group protocols were used across the sites that focused on fidelity

Table 1

Number of Participants for Qualitative Research on Implementation

SITE	FOCUS GROUPS WITH STAFF	KEY INFORMANT INTERVIEWS WITH STAFF	LANDLORD INTERVIEWS
Vancouver	3 (n=18)	n=2	n=2
Winnipeg	3 (n=20)	n=5	n=12
Toronto	4 (n=19)	n=9	n=16
Montréal	5 (n=35)	n=8	n=15
Moncton	2 (n=8)	n=4	n=12
QA Team	-	n=8	
All Sites	17 (n=100)	n=36	n=57

issues, the program's theory of change, landlord/caretaker issues and sustainability issues. Key informant interviews and focus groups were conducted, in either English or in French, at the participants' workplaces or at the site offices. The QA team interviews focused on fidelity issues, the program's theory of change and sustainability issues (see Appendices 6 and 7 for the information letters, consent forms and interview guides). All interviews were audio recorded and transcribed verbatim (see Appendix 8 for the transcription protocols). Qualitative site researchers also reviewed relevant project implementation documents, including the initial and follow-up fidelity reports. Finally, qualitative site researchers took field notes on the QA team's feedback meetings with the program staff.

Data analysis. The approach to data analysis at each of the sites involved thematic analysis (Morse & Field, 1995). Site researchers sought and identified common threads throughout the data, drawing out significant concepts that emerged from individual interviews along with concepts that linked interviews together. Each site went through a process of member-checking with people who were interviewed for the site reports to establish the trustworthiness of the data. Qualitative researchers at each of the sites produced site reports on the implementation process (Aubry, Yamin, Ecker, Jetté, Albert, Nolin, & Sylvestre, 2012; McCullough, Havens, Isaak, & Deboer, 2012; Patterson, 2012; Stergiopoulos, Hwang, O'Campo, Jeyaratnam, & Kruk, 2012; Vallée, Fleury, & Hurtubise, 2013). This cross-site report relied on the QA team interviews and the site reports as the source of data, rather than reviewing transcripts or other data from each site. For

the cross-site analysis, members of the National Qualitative Research Team read the five qualitative implementation site reports and the five ACT and five ICM fidelity reports. Matrix displays were constructed using the main topics covered in the site reports and were populated with data from each site report.

Researchers from the sites were involved in a process of review wherein the National Qualitative Research Team and the QA team shared the first draft of this cross-site report with site researchers, invited them to read it over along with their teams, and solicited their comments and suggestions. Comments from the sites were incorporated into the final version of this report.

FINDINGS

PROGRAM FIDELITY

Strengths. Overall, 71 per cent of the fidelity scale items at T1 and 78 per cent of the items at T2 are rated as higher than three on a four-point scale (see Table 9.1 in Appendix 9). This indicates both a high level of fidelity to the Housing First model at both time periods and improvement in fidelity from T1 to T2. The strongest fidelity ratings were reported for the domain of Separation of Housing and Services. For the domain of Housing Choice and Structure, the items of permanent housing tenure, affordable housing, integrated housing and privacy are all rated a four at all of the sites at both time periods. The majority of items of the Service Philosophy domain are also rated quite high, as is housing support for the Service Array domain. Most of the items for the Program Structure domain are also rated quite high.

Challenges. As is depicted in Table 9.1 in Appendix 9, several implementation challenges were noted across the five sites. Housing availability was a problem in all five sites, and housing choice was a challenge in some of the sites. In the domain of Service Philosophy, person-centred planning and motivational interviewing were challenges for several sites, and assertive engagement was a challenge for two of the sites. For the domain of Program Structure, participant representation in the programs was a challenge at all of the sites, and contact with participants emerged as a problem at T2 for three of the sites.

By far, the most challenges were observed for the Service Array domain. The items of psychiatric services, substance abuse treatment, employment and educational services, nursing/medical care, social integration, 24-hour coverage and staff involvement regarding discharge from inpatient treatment were challenges for the majority of sites. Moreover, as is shown in Table 9.2 in Appendix 9, these Service Array issues were more of a problem for the ICM teams than for the ACT teams. The fidelity scores are higher for ACT teams on the vast majority of items that were challenges; the scores were higher for ICM teams on only two of the items. This is likely because ICM teams do not have control over whether there is an array of services in the community that they can broker for consumer participants. Finally, most of the improvement for the fidelity ratings from T1 to T2 occurred in the Service Array and Program Structure domains (see Table 9.3 in Appendix 9).

DEVELOPMENTAL EVALUATION ISSUES

Maintained and emerging strengths. Across sites, there were three common themes regarding maintained and emerging strengths: *partnerships and collaboration, housing and re-housing, and the presence of dedicated specialists and professionals on housing and service teams.*

Partnerships and collaboration between service teams, and with participants, community organizations and professionals were important strengths. The Vancouver site was particularly strong in its level of internal communication between service and housing teams and in developing key partnerships with community professionals such as lawyers and medical specialists familiar with health and addiction issues. They formed strong collaborations

with community and governmental organizations that help navigate health care, social services, and criminal justice systems. One respondent stated:

“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 the changes we’ve seen in our clients.”
(Vancouver report, p. 19)

Key informants and staff members at the Moncton site attributed some of the increased program capacity to the creation of partnerships with community organizations. The Winnipeg site formed multiple positive working relationships between service teams, with individual participants, as well as with participants’ Employment Insurance workers. The Toronto site reported similar findings, in addition to an emergent collaboration with external agencies, such as Ontario Works and Ontario Disability Support Program.

Despite low vacancy rates and lack of affordable housing in every city, all of the sites reported maintained or emerging success with specific aspects of *housing and rehousing* participants. The Vancouver site reported successful, high quality housing procurement as a result of: (1) creatively matching participants with housing units and (2) forming collaborative relationships with landlords and property management companies. Providing consistent support for landlords, including prompt responses to issues, offering to pay any unit damages and guaranteed rent were strong incentives for landlords. A team member stated that:

“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.”
(Vancouver report, p. 17)

The Moncton, Winnipeg and Montréal sites emphasized their dedication and success in creatively rehousing participants by working through their difficulties, learning from past experiences, achieving stability and planning preventative strategies to avoid future rehousing incidents. Toronto maintained strength in initially housing participants and housing retention rates between fidelity assessments.

Another cross-site theme reported was the importance of having dedicated specialists and professionals on housing and service teams. The Moncton site reported that the additions of a home economist, psychiatric consultant and vocational specialist to their ACT team was extremely beneficial to program delivery and support. Winnipeg indicated the benefits of having a housing specialist on the team in contributing to building sustainable connections with landlords. Toronto reported that its strong service provision could be attributed to the high level of clinical expertise, through which they had direct access to clinical perspectives from the team leaders and psychiatrists, reviewing challenges in service delivery and supporting problem solving in joint team meetings.

Recurrent challenges or trouble spots. Regarding challenges or trouble spots, there were five themes: *staffing*, the *scattered-site model of housing*, *participant feelings of isolation and loneliness*, *peer support*, and *documentation*.

Across sites, issues around *staffing* were reported. The Vancouver and Montréal sites reported having difficulties maintaining stable staffing levels on service teams, due to substantial staff turnover. Toronto faced challenges around staff retention rates as well. Between its second and third years, positions had been vacated due to heavy workloads, pressure to meet project timelines and concerns about job security. Moncton communicated challenges in staffing as well, providing specific cases in which they believed service array had been particularly affected by staffing issues. For example, the need for one of the two psychiatrists involved with the program to see participants only at her hospital office rather than in-house, and the desire for some staff to work during specific hours and not others, was a challenge. While staff turnover was noted as a challenge, it should also be noted that this is a common problem in this sector and not something that was unique or unusual about the At Home/Chez Soi project.

A trouble spot was found with respect to the *scattered-site model of housing* being the sole model of housing for the project. Vancouver, Winnipeg, Montréal and Moncton faced recurrent challenges in trying to maintain engagement in services for a small group of participants, particularly people with more complex physical and mental health problems.

The Moncton site suggested that the nature of certain mental health problems, as well as severe substance use during vulnerable stages of change, might contribute to a lack of engagement. The service teams found some participants required much greater levels of care than others, and suggested that the *scattered-site model of housing* may not be the best fit for all participants. Winnipeg suggested that congregate-type settings may be an alternative for those who do not find success in a scattered-site model, and Vancouver introduced the idea of offering a range of “step-up, step-down” options (Vancouver report, p. 20). Moncton opened a transitional apartment building to better support those experiencing multiple evictions, with an end goal of independent living (Moncton report, p. 20).

A recurrent challenge in implementation for Vancouver was the need to address consistent feelings of *isolation and loneliness* experienced by many participants. In spite of feelings of isolation, very few participants in Vancouver left scattered-site housing to return to their old neighbourhoods. Also, it is important to note that isolation is a broader social issue, which is more acute with this population. A key informant in Montréal described the challenge participants faced from being homeless to being a tenant as: “C’est comme une immigration. Tu n’es plus ce que tu étais, tu n’es pas ce que tu risques de devenir.” The Moncton service teams faced similar challenges when working with participants. They attributed these difficult feelings experienced by participants to their changing social networks, leaving friends behind, and vast lifestyle and living arrangement changes. A key informant from Moncton stated that:

“...the person that is addicted lives a life of loneliness... You can’t be around your friends, so the drug is your best friend..... An agency has to make sure that you can be there to complement that..... until they have been able and have had time to build new friends.” (Moncton report, p. 14)

Another recurrent challenge for Moncton was the integration of *peer support* into the program. The Moncton site identified multiple participants as potential peer specialists since the first fidelity assessment and had begun the process of providing three peers with training so they could become integrated into and support the work of the ACT team.

The Winnipeg site also identified a need to provide additional opportunities for participant input in service delivery. Staff in the Moncton and Winnipeg sites had concerns about appropriately defining and clarifying the roles that peer support workers should play on service teams. For example, the Winnipeg site found that peer support worker roles had evolved into adopting the responsibilities of other team members (e.g., case workers).

One final cross-site challenge included issues of *documentation*. Vancouver recognized its need to more clearly document teams’ work in their case notes. Moncton appeared to experience implementation challenges around their service philosophy in terms of “assertive engagement.” However, after further investigation, they found that the problem was that while their teams were making significant efforts to engage participants, very few team members had documented these efforts in their case notes. Similarly, Winnipeg and Toronto reported that low implementation fidelity for certain criteria could be attributed to inconsistent record and chart-keeping by team members, which led to inconsistent reflections of the actual work being done.

Emerging challenges or trouble spots. Across sites, two common themes were evident with regards to emerging challenges or trouble spots: *housing* trouble spots and challenges around *vocational and educational goal supports*.

Even though *housing and rehousing* were common themes cited as maintained or emerging strengths across sites between fidelity assessments, most of the sites also identified some emerging trouble spots regarding *housing* experienced between its second and third years. The Vancouver site reported challenges around finding good quality, affordable housing in areas in which participants desired to live. Moreover, low vacancy rates of many co-op buildings and supported housing units became a challenge. Next, many units employed smoke-free and pet-free environments, which further limited options for participants. Finally, the Vancouver service teams found that between its second and third years, while housing options diminished, many participants still tended to choose the first apartment they saw, even if alternatives were available. The Winnipeg site reported emerging challenges around housing procurement between its second and third years, slowing their process of housing and rehousing participants. Low vacancy rates, desirability, quality of upkeep, as well as limited subsidy funding and slow access to damage deposits were alluded to

by the site. In Toronto, while initial housing and housing retention rates were strong, issues of *tenancy management*, *relationships between housing teams and participants*, *dealing with unit damage*, as well as *rehousing participants* emerged as trouble spots in housing. With respect to *tenancy management*, the housing team in Toronto had minimal contact with participants. One housing team member indicated that this could have been a problem:

“So sometime the only interaction we had with the clients was when there was chaos, when there was a real problem that was going on... I mean the landlords are calling us and complaining... but we have no idea who the person is so that was a disadvantage to me that’s going forward.” (Toronto report, p. 25)

With respect to *relationships between housing teams and participants*, both the Montréal and Toronto sites reported that with the project being structured to separate housing and service delivery teams, when landlords contacted housing teams in crisis situations, it was very difficult for housing teams to intervene effectively. Without forming trusting relationships with participants, housing team members struggled to find feasible solutions. *Unit damage* emerged as a challenge similar to that reported by Winnipeg, in that access to damage deposits became a very slow process. Finally, *re-housing* participants became more difficult in Toronto, due to fewer housing choices, and with the end of the project in sight, landlords had been hesitant to sign year-long lease agreements with participants.

Vocational and educational goal supports emerged as a challenge in Vancouver. The site reported that initially engaging and/or re-engaging participants in work, volunteer and educational endeavours had become difficult. While Vancouver’s ACT team employed a vocational specialist, they usually had to tend to emergency crises rather than develop more proactive, long-term goals with participants. Similarly, Toronto found limited variety and availability of educational and employment opportunities and programs available for clients within the community. Opportunities that were available often fell short of providing participants with tangible education or employment positions following training.

Other emerging issues. Other emerging issues were reported across a few of the sites. With respect to service array, both Moncton and Winnipeg sites reported emerging challenges around *harm reduction approaches*. With respect to service delivery, both Winnipeg and Toronto sites reported emerging issues around *frequency of visits* to participants’ homes.

Winnipeg reported that significant turnover in staffing led to varying degrees of understanding of harm reduction strategies. Moncton reported that while they were increasing the number of staff being trained in the harm reduction model and staff were working on integrating the approach in their work with participants, they found many staff members still emphasizing detoxification and abstinence models to participants before they were ready. In addition, a key informant suggested Moncton needed to increase information and engagement strategies with landlords to educate them about harm reduction approaches.

“In terms of harm reduction, ...the thing is you have to get [into] a little bit of a bind from the landlords as well... in terms of harm reduction in the apartments themselves, you’re going to, you know promote harm reduction. Then you have to get landlords on board that... they [participants] can do injections in their houses as long as they keep their needles and sharps in a safe place and ...I’m not sure that we’ve really worked hard on that... but we don’t have a good spectrum of opportunity so I don’t think we’ve done that harm reduction approach with our landlords too much...” (Moncton report, p. 18)

In terms of service delivery, Montréal, Winnipeg and Toronto sites found emerging challenges around determining *frequency of visits* with participants. The Winnipeg and Montréal sites reported that their ACT/ICM teams needed to be mindful around understanding when participants could transition to lower levels of service and higher levels of independence. The Toronto site found that the requirements of the program model for caseworkers to meet with participants weekly may have been an impediment to recovery processes for some. Service team members expressed a reluctance to visit some participants who had jobs or schooling commitments and did not want to be seen with caseworkers in their community. A respondent from Toronto spoke to this issue, stating:

"I think that staff are cognizant to the fact that, sometimes when you give somebody too much service, you're potentially contributing to the problem. So, I think that, in those situations, they're very quick to consult with the program manager and come up with some strategies to kind of even out the level of support." (Toronto report, p. 20)

In Montréal a respondent described the weekly visits as:

"J'ai l'impression que pour les participants, les services, c'est comme un prix à payer pour le logement. Mais dans le fond leur motivation, c'est le logement."

Issues identified from first implementation and fidelity reports. Some of the challenges identified in the first round of fidelity and implementation evaluation reports included: delays in housing placement, barriers to location choice, rehousing, involving participants with lived experience in the program operations and research, and staff burnout and retention. The issues identified and directions taken to address program challenges have been discussed in earlier sections of this report.

HOUSING FIRST PROGRAM THEORY OF CHANGE

The timing of different outcomes. The Housing First logic model, which is depicted in Appendix 3, is a graphic representation of the causal theory implicit in At Home/Chez Soi (Tsemberis & Asmussen, 1999). The model begins with outreach to identify individuals eligible for Housing First services. All individuals are offered scattered-site apartments, as well as support services, enrolling in either ACT or ICM depending on the individual's initial needs assessment. Upon intake, a care plan is prepared by an ACT team or case managers. Immediate changes in five areas believed to be critical in the recovery of people who experience chronic homelessness are as follows: (1) immediate assistance in applying for public assistance and organizing the client's financial affairs to meet apartment lease eligibility requirements and to help the client prepare and manage household income; (2) an immediate working alliance connection between service coordinators and the clients to help the client identify his or her own treatment goals; (3) assistance in identifying and accessing community health services for acute and chronic conditions; (4) assistance in understanding job interests and job acquisition goals; and (5) assistance in helping the client establish family, social and spiritual connections, as desired by the client.

These immediate interventions are predicted to result in participation in addictions and mental health treatment, and reduced contact with non-supportive social contacts within six months. Subsequently, participation in addictions treatment and reduction of contact with non-supportive social contacts is predicted to result in less abuse of alcohol or substances. Similarly, access to community health services is predicted to result in increased participation in illness management and self-care, and access to client-centred job interests and development is predicted to result in increased participation in desired activities and employment search. Assistance in identifying and pursuing client-centred family, social and spiritual connections is predicted to result in increased social support and community integration. Overall, recovery is believed to be associated with reduced use of emergency response service calls, use of the emergency room for primary care, reduced number of arrests, maintenance of stable housing, reduced number of hospitalizations and a general increase in physical health and quality of life.

Reports from the sites both corresponded to and differed from the chronology of change predicted by the above noted model. Across sites, reduced contact with non-supportive social contacts did not appear to be a short-term program outcome. In Toronto, for example, ending these relationships tended to happen in the second year. Interestingly, reunification with family and significant social contacts tended to happen in the second year and earlier in the chronology of change predicted by the above model. It might be that there is a relationship between the dissolution of non-supportive social contacts and reunification with significant social contacts that takes place around the second year of intervention. Respondents in the Toronto and Winnipeg sites suggested that the process of reunification with family and significant social contacts marked an important hurdle in the recovery process. Across sites it was reported – in line with the predicted theory of change – that participants became more willing to participate in treatment in

the second year, whether because of trusting relationships with program staff (Winnipeg) or more relevant program activities (Moncton). This participation was associated with better problem-solving (Winnipeg), a better understanding of the tenancy process (Winnipeg, Toronto), fewer missed appointments and more independence (Moncton).

Additionally, respondents across sites corroborated the predicted model in which vocational concerns emerged following engagement with treatment. Across sites it was reported that participants during the second year began engaging with employment, vocational training, education and volunteering. In Moncton, a work program aided participants in the employment process. In Toronto, increases in vocational engagement were accompanied by decreases in hospital and jail time, corresponding closely to the predicted chronology of change outlined above. One area of the theory of change model that was difficult to compare was in regards to patterns of substance use. In Winnipeg, patterns of reduced substance use were not specified with regard to the chronology of change. In Toronto, abstinence occurred in the first year for some participants but substance use patterns appeared varied in the second year. In Moncton, Montréal and Vancouver, it was not clear what the chronology of change might be with regard to substance use.

Perceptions about who benefits most from Housing First and ACT or ICM. There were commonalities across sites with regard to perceptions about participants who benefited the most from Housing First and ACT or ICM. Attitudinal indicators were frequently mentioned across sites where participants who were “wanting to make positive changes” (Winnipeg), “really wanted housing” (Toronto) or were “committed to changing their lives attitudinally” (Moncton) tended to benefit more from the intervention. Toronto and Moncton in particular emphasized these personal or attitudinal facets of participants who benefited the most including *the readiness and willingness to address or own addiction and mental health issues*, as well as goal setting and appreciation of the program. Winnipeg and Toronto respondents indicated that *service utilization patterns* are an important dimension of those who benefited most from the intervention. In Winnipeg, those participants who were diagnosed by a psychiatrist and prescribed the appropriate medication tended to do better, while in Toronto those participants who had a good match with their caseworker and developed trust tended to do well. Finally, in the Toronto and Montréal sites, clinical characteristics of participants who benefited the most were identified as salient, with participants with serious mental illness and concurrent addiction and mental health issues tending to benefit the most, which was associated with the lack of preconditions for housing.

Critical ingredients as viewed by participants. Across sites there were clear convergences and divergences regarding the critical ingredients of the Housing First theory of change. Staffing was a key component of the theory of change. Acceptance – or the ability of caseworkers to meet clients in their current circumstances – was foregrounded as an important dimension of staffing. Respondents at the Vancouver and Montréal sites believed that hiring individuals who identified with the value orientation of Housing First – right to housing, consumer choice and recovery orientation – were crucial to acceptance. Respondents at the Vancouver site believed that hiring individuals who identified with the normative dimensions of Housing First were crucial to acceptance. Respondents at the Winnipeg and Montréal sites tended to aggregate staffing as a crucial component of the program model in terms of attitudinal factors such as kindness, respect, unconditional acceptance and a nonjudgmental disposition, commitment and participant focus. Moncton and Vancouver stressed the importance of effective communication amongst program staff, while Moncton highlighted the importance of multidisciplinary teams in making nuanced decisions. Montréal respondents stressed the importance of having a housing team, dedicated to housing procurement. Finally, Toronto and Moncton respondents cited the inclusion of people with lived experience as a key component of staffing.

Across sites, participants highlighted *consumer choice* as a critical ingredient of the theory of change model. In Vancouver, respondents foregrounded the importance of choice in housing, suggesting that program participants who got housing in line with their preferences were more likely to commit to their unit. In Winnipeg, respondents believed that choice was a crucial component of program participants taking responsibility for their specific life circumstances, while Toronto respondents framed choice as a key to client-centred service provision. *Rehousing* was identified as a key component of the theory of change across sites. Respondents at the Vancouver site framed rehousing as integral to the Housing First philosophy and stated a commitment to no discharge criteria, while respondents in Winnipeg suggested

that rehousing was important in the process of housing learnings, noting that the majority of participants did not need to be rehoused more than once. Toronto site respondents indicated that rehousing was a crucial juncture for the continued support of program participants.

There were a few areas of divergence between project sites in regard to key components of the theory of change. Respondents at the Toronto site identified resources as a key component. Resources included things like public transit tokens, access to medical personnel and services, appropriate rent supplements relative to the housing market and resources that supported the building of social networks to counter experiences of isolation that accompanied housing for some participants. Moncton site respondents suggested that participants must be given time and opportunity to engage their own processes of recovery. Respondents at the Moncton site also identified transitional housing as an important program component in that it smoothed the process of rehousing for some program participants.

LANDLORD/CARETAKER ISSUES

What worked well from the perspective of landlords. Across sites there were clear themes regarding what worked well for landlords in their participation in At Home/Chez Soi. One prominent theme across sites was *relationships between landlords and housing and clinical teams as well as relationships between landlords and program tenants*. In Toronto, landlords talked about positive relationships with housing and clinical teams, whom landlords experienced as professional and capable, as well as positive relationships with tenants. In Moncton, landlords stated that program tenants were, in many instances, as good or better than other tenants. Landlords in Vancouver had positive experiences with the “fit” of tenants in their buildings. In Winnipeg, relationships with landlords were more challenging, which stemmed from unique challenges of implementation clustering around colonial histories of Aboriginal participants, racism, substance use and low vacancy rates. Positively, landlords in Winnipeg talked about having good relationships with the housing team despite considerable tenancy challenges.

Across sites, there were common themes regarding strategies adopted by project sites to appease landlords and smooth implementation when problems with participants as tenants were encountered. Landlords responded to these strategies favourably. Some common strategies included *cleaning and repairs to damaged units*. This strategy served to intercede between the rights of landlords to property and the responsibility of tenants to maintain property. A certain amount of learning was to be expected as program participants were learning new roles as tenants. Landlords in Moncton and Winnipeg talked very positively about this facet of the program while landlords in Toronto had mixed experiences with damages. The mixed experiences of these landlords likely were related to participation in other programs, particularly head lease programs, where housing teams had a more involved role in tenancies. A second important strategy mentioned across sites was the *cooperation of housing and clinical teams with relocations or transfers*. Landlords valued the intercession of project staff in tenancies that were not working. This cooperation was important, from the vantage point of landlords, in avoiding time-consuming and costly eviction proceedings. There were also instances of unique *site-specific strategies* designed to smooth implementation. In Winnipeg, for example, a roundtable with landlords was established that included both a feedback mechanism and an educational component with which landlords reported having positive experiences. In Toronto and Montréal, the housing teams began attending meetings with clinical teams, in part, to close information gaps between the program and landlords, and, most critically, between the staff of the teams.

Across sites there appeared to be attitudinal factors that influenced landlords’ willingness to participate, as well as their experiences of the program. In Toronto and Winnipeg in particular, these attitudinal factors were foregrounded. Interestingly, these project sites were likely two of the most difficult sites to house participants because of low vacancy rates. In Toronto, many landlords talked about their concerns for participants and their health issues, and a strong desire to give back to the community. Similarly, in Winnipeg some landlords presented a strong desire to make it work, reflecting positive attitudes towards both the program and program tenants. These attitudinal factors are likely important in understanding the decision of landlords to participate in the program, their orientation towards program tenants and their understanding of participants’ unique challenges.

What worked less well from the perspective of landlords. Across sites there were clear challenges regarding dimensions of the project. Many of these common challenges across sites were issues regarding the *behaviour of tenants* resulting from the transition from street life to tenancy. These challenges included visitors, traffic in buildings, property damage and drug use. In Winnipeg there were marked challenges with unit takeovers and solvent use, reflecting the unique challenges of implementation at that site. In Moncton, landlords complained about smoking in units. These challenges likely reflected the transition from homelessness to housing and the process of learning about tenancy. While these complaints were serious concerns for landlords that merited consideration, they represent a barometer of program success in the degree to which program participants were interacting with landlords and becoming increasingly involved in the mainstream housing market – a novel facet of the supported housing model.

There were *challenges with rents and payment across sites*. There were two dimensions to this challenge. On the one hand, at sites with low vacancy rates like Winnipeg and Toronto, the guaranteed payment of rent was, at times, inconsequential to landlords' decisions to participate since vacancy was a non-issue. On the other hand, there were difficulties with non-payment of program tenant portions of rent money in some sites. Toronto in particular mentioned instances in which program tenants were not paying rent. In Toronto, this was cited as a reason for landlords to request a unit transfer. It should be noted the nature of non-payment of portions was complex. In some instances there were simple issues of non-payment. In other instances, non-payment might have constituted changes to disability benefits where rents were raised and program tenants' disability insurance body was not notified. Subsequently, their portion of rent may have fallen marginally below the total price, landing them in arrears that could have been problematic to landlords, particularly those who were part of large housing corporations.

A substantive challenge from the perspective of landlords across sites was *communication*. There were two dimensions to this challenge: (1) communication in the buildings between landlords and program tenants and program tenants and other tenants; and (2) communication between landlords and housing and clinical teams. In the first instance, landlords in Vancouver reported that program tenants required direction about their relationship with other tenants and took longer than other tenants to fit in with the norms of the building. In Toronto and Moncton, landlords relayed instances in which noise and behaviour disturbed the enjoyment of other tenants. Landlords across sites had issues with communication with housing and clinical teams. Across sites, getting in touch with housing and clinical teams was a concern. At times landlords believed that the program was unresponsive to their needs as well as the support needs of tenants. There seemed to be a degree of confusion, for some landlords, about who should be contacted for what in addition to confusion about reaching both clinical supports and housing teams by phone. A landlord in Toronto suggested that it would be helpful to be provided with a list of numbers particular to a program participant's housing and clinical contacts. The data suggested this might be an area in which concerns of landlords could be easily assuaged through the development of a communication protocol that includes the regular dissemination of clinical and housing contacts for program participants. Additionally, landlords in Toronto indicated a desire for more frequent and regular check-ins with housing and clinical teams.

ISSUES REGARDING SUSTAINABILITY AND THE FUTURE OF THE PROJECT

How sites, with national-level support, addressed sustainability concerns of participants. Concerns regarding sustainability arose during the first round implementation report, and the nature and impact of these concerns came increasingly to the fore during the second round fidelity visits. During these visits, key informants spoke of the increasing mental health impact on participants, as well as the anxiety-producing effect on staff. Thus, there was a realization that a consistent national approach to communication was needed that was based on transparency, or at least as transparent a message as was possible given the fundamental uncertainty of the situation. Prior to developing such a strategy, however, there was an information void, and in some cases, inaccurate understandings were spread, such as the belief that services would not continue in any form. With the development of a strategy, participants and staff were assured that concerted efforts were being made to ensure the continuity of their current housing and support, but that a Plan B (or transitional plan) was being mapped out, which would entail both support

and housing. However, given the uncertainty of housing subsidies continuing beyond the formal end of the project, an acknowledgment was made that it would not be possible to guarantee that participants would be able to keep their current housing. The fears of staff turned out to be well-founded as some of the staff in two sites lost their jobs when the programs in which they worked were no longer funded.

Despite assurances that people would not be left without housing, the perspective of participants was that they nonetheless still could be losing their home. While the federal government decided to provide one more year of funding for the rent subsidies at the five sites, some participants did have to move and more could lose their current housing after the funding for rent supplements expires after one year. There was also a realization that the project risked losing the hard-won trust of participants, for whom the threat of loss could represent yet another betrayal. At the same time, site reports and key informants suggested that the anxiety of staff was a significant concern, which hindered the sites' ability to retain and recruit new staff, and hindered the housing teams' efforts to rehouse some participants. Staff anxiety may thus have been projected into the messages they conveyed to participants. At the time of the interviews, respondents believed that the project at both the national level and site level was doing a reasonable job of messaging the sustainability situation, that the situation was manageable and that staff were getting a handle on their own anxiety and projecting that less into their communications with participants. However, the continued uncertainty surrounding transitional and sustainable long-term funding was moving the issue towards becoming an overriding concern for all concerned.

Sustainability strategies: national and site level. One aspect of the sustainability strategy was the contracting with government relations experts to help with knowledge translation efforts and to raise awareness of the project within both political and civil service arenas at each of the sites. At the national level, some heavy hitters were called upon to raise awareness of the project and its value with federal decision makers. At the same time, project and MHCC staff at the national and site levels met with a number of decision makers at both federal and provincial levels. The more general knowledge exchange activities at each site occurred partly by osmosis, as the wider mental health system inevitably learned about the project and was able to see the tangible benefits that it was able to achieve. Knowledge exchange was also happening more intentionally at each site, in conjunction with the release of the project's Interim Findings report. In some sites, the release was accompanied by media attention, which also raised public awareness about the sustainability concerns surrounding the project.

Another sustainability strategy adopted by some sites (e.g., Moncton) was to attempt to "mainstream" the project and its funding within the regular system from the outset. Other sites, however, were concerned about situating the project too closely within the formal system, given their sense that an organizational culture more conducive to successful implementation, and thus to sustainability, would be found within the NGO sector. One key informant, however, was adamant that mainstreaming the funding was key to sustainability. This informant also suggested that knowledge exchange should not overly focus on the results of the Interim Report, but should emphasize what is already known about the efficacy of Housing First, and that it has been successfully implemented in Canada.

Other key informants believed that sustainability would look different in each of the sites, and that the basic aspects of the support would be continued, although perhaps in some cases taken on by a different agency. There was a concern that remaining teams might drift from the original model. One strategy for addressing sustainability at the site level suggested by one key informant was for a third-party monitoring function to be established at each of the sites, so that following the project's formal end, the sites could, in effect, internalize the function of the fidelity team and continue to monitor implementation in the future.

CROSS-CUTTING THEMES AND LESSONS LEARNED

Sites reported general agreement that the At Home/Chez Soi project was a success – attesting to the utility of the Housing First model, the importance of adapting to the local context, and the power of housing as “a basic need and one of the first steps to recovery” (Toronto report, p. 28). One service staff member at the Winnipeg site said, “I’ve worked in programs for 25 years and helped develop programs in many cities, and I’ve never seen a program as successful as this one” (Winnipeg report, p. 20). Further, Vancouver reported that over the last year, key informants, focus groups and staff expressed feelings of reduced stress and increased positivity regarding project progress; and Moncton noted that results of the second fidelity assessment “reflect program development in the direction of improved fidelity in a number of areas, particularly as it related to the breadth of services offered to participants” (Moncton report, p. 36). With these successes in mind, sites pointed to cross-cutting themes and lessons learned that help us understand these successes, as well as increase the likelihood of continued programmatic success in the future by providing suggestions for addressing remaining implementation and sustainability challenges.

Maturing of the teams. The growing maturity of the teams was a common observation in site reports and in national-level key informant interviews. This had to do with team members, individually and collectively, developing a sense of confidence and expertise in implementing the model, and a growing sense of resilience that was gradually replacing the fragility described earlier in the project. This maturity was related to getting over the hump of recruitment, when the unpredictable caseloads of that phase were compounded by learning curve issues associated with adopting the model without having a base of expertise upon which to build (e.g., having two or three people who already knew the model).

Gaining confidence also had to do with knowing what one could and couldn’t do and learning what it takes to achieve results with the model. Seeing the benefits of Housing First, especially with participants who may have been written off in the past, was a particularly powerful force that enabled staff to buy in to an approach that may have initially been met with skepticism. Watching participants benefit also helped staff to unlearn previous attitudes and approaches that came out of working unsuccessfully with similar participants in the past. The maturing of the teams was also related to a growing sense of cohesion or gelling, which consisted of developing a shared sense of understanding and commitment to the model and a clearer understanding of who did what, when. Increased cohesion also allowed the teams to promote self-care and to harness diverse perspectives and expertise to solve complex problems that had previously stymied individual team members. The teams also developed better judgment about difficult situations that required balancing competing principles, such as choice and assertive engagement, and learning how to negotiate with participants with multiple rehousing who requested additional moves, but who may have benefited from help reflecting on the reasons for previous moves. As one key informant stated: “the teams have moved from implementing the model to thinking of themselves as experts.”

Improved team capacity for addressing needs and impacting key outcomes. Overall, respondents talked about how the model itself, and staff’s growing proficiency in the model, were associated with significant gains in wellbeing for project participants. The housing and support provided enabled participants to achieve both clinical and housing stability. Further, by accessing specialist resources and developing and sharing their skills, the teams collectively became better at addressing the complex needs of participants (e.g., concurrent or multiple disorders, trauma, etc.). To deal with the particular challenge of meeting a broad array of needs within a brokerage model, ICM teams became more ACT-like in certain respects, such as securing sessional resources of physicians and taking an increasingly team-oriented approach to case management. Finally, the teams also became more able to address the recovery-oriented needs of participants, supporting them to achieve vocational goals or pursue other forms of meaningful activity. They also were able to support community integration, by developing group-based programs, facilitating family reunification and orienting participants to their new neighbourhoods.

Enhancing staff capacity. Despite this sense of growing maturity, expertise and staff proficiency in the Housing First model, sites nonetheless acknowledged the need to continue to address staff capacity challenges. In retrospect, the challenging experience of the recruitment suggests the importance of being strategic about this phase to limit the

burden on teams. In this regard, sites suggested strategies such as limiting the intake rate to a certain cap (Toronto); scattering housing referrals more broadly at the beginning, as opposed to clustering these into specific buildings (Vancouver); and helping teams anticipate the possibility of the need for early rehosings (Winnipeg). Moving forward, Vancouver and Montréal suggested creating more opportunities for small staff groups or mini-teams to meet and engage in problem-solving around specific issues rather than waiting for larger meetings that focused more on general operations. Respondents on the Vancouver team also suggested having staff training and education be more focused on practical issues, such as dealing with pests in apartments, hoarding, charting systems and Residential Tenancy Act. Given the loss of skills represented by staff turnover, formal training for new staff rather than a “learn-as-you-go” model was also recommended. Key informants also noted, however, that staff turnover could sometimes be an opportunity to replace staff, including team leaders, who were not well suited to the Housing First model.

Although multiple sites noted that it had been less stressful on staff between the second and third years due to enrollment completion, some staff were still experiencing issues related to burnout. A staff member on the Vancouver team stated the following:

“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.” (Vancouver report, p. 30).

Attending to diverse needs and characteristics of participants. Despite improvement, some challenges remained. First of all, sites were challenged to find solutions for the small number of participants who hadn’t yet achieved housing stability within scattered-site apartments. Toronto suggested increasing the range of choices including seeking a “midway option between independent and completely supportive” (Toronto report, p. 29). Moncton experimented with providing step-up or step-down transitional housing options for participants with multiple evictions. Project sites also identified gaps in implementing basic aspects of the model, as well as providing for a more comprehensive array of supports tailored to participants’ unique and complex needs. For instance, Moncton noted the addition of peer specialists to the ACT team only after the completion of the second implementation evaluation and the need for more psychiatric consultation, perhaps via home visits, for some participants. The Moncton site report also noted the need to implement “integrated dual diagnosis treatment strategies, an evidence-based approach that combines mental health and substance abuse services in one setting” (SAMHSA, 2010a; Moncton report, p. 37). National key informants suggested that adequately meeting participants’ vocational needs would require a dedicated employment specialist, working within an evidence-based supported employment model, such as the Individual Placement and Support model. Winnipeg reported perceived shortcomings in taking into account the unique effect of generations of complex trauma on Aboriginal participants, noting that the timeline of the project was insufficient for fully addressing such traumas. Finally, Toronto acknowledged that the project did not have the capacity to deal effectively with people who had a history of violence and who were threatening violence.

Emerging sense of commitment, ownership and belonging. Another common theme is the emerging sense of ownership of the project felt by people both within and outside of the initiative itself, and the related feeling that the project belonged within the community. Participants’ comments also suggested the importance of these themes for successful implementation and for the sustainability of the project. A national-level key informant suggested that a sense of ownership and belonging to the program existed within the participants themselves. Key informants further noted the remarkable sense of dedication to the project that continued within the project’s staff, despite the difficulty and complexity of the work. Respondents also suggested that there was a growing sense of joint commitment to the model of the various teams within each site, and by agencies and individuals within the wider mental health and social services system who worked with and benefited from the project, such as income assistance and employment workers.

There was also a sense that the project as a whole was valued and achieved a sense of belonging within a wider group of stakeholders, such as the landlords who rented to participants, and the police and criminal justice system professionals who appreciated how the support provided to participants alleviated some of their work. This sense of commitment to and ownership of the project by those who were closely involved, and the sense of belonging the

project earned within the wider community, translated into improved program capacity in the short run, and greater ability to meet the needs of participants. In the long run, the sense of integration in the wider community improved the prospects for sustainability.

Focusing on relationship development. In accordance with the themes noted above, key informants discussed the critical importance of relationship development to program success, noting that beginning these processes early on is advisable. Vancouver, Moncton, Montréal and Winnipeg reflected on difficulties associated with external partners, including mental health teams, housing services, hospital, landlords and Aboriginal organizations. In Montréal, respondents emphasized how the current organization of mental health services made it very difficult to access psychiatrists and primary care professionals. Site key informants acknowledged that these challenges also led to program successes (e.g., greater cooperation and knowledge exchange within the service community), but the general consensus was that building relationships and clarifying expectations earlier on would have been beneficial.

Importance of organizational context for implementation and sustainability. Site reports and national key informants suggested that organizational context and its importance for implementation could be understood as a series of concentric circles. At the innermost circle, the findings attest to the importance not only of team leadership, but of the host agency leadership. Stable and strong host agency leadership helped with the logistical aspects of implementation, and could help teams withstand turnover of team leaders. A congruent host agency culture was also instrumental for ensuring that the philosophical aspects of the model were implemented and maintained. Moving beyond the team environment, respondents noted the importance of having a strong Site Coordinator, especially one who could “hold the space” necessary for bringing in the multiple players, helping them negotiate differences and creating a shared vision. One national key informant, however, strongly emphasized the need for protocols that made lines of authority clear, acknowledging that this could be accomplished from the bottom up through the consensus-building skills of the Site Coordinator. This informant stated that clear accountability structures were necessary because consensus-building was not always possible. The overarching context of the central project leadership and resources was also acknowledged as instrumental to implementation. National key informants in particular suggested that the fidelity process and the feedback and training that came out of it (and was taken up by the teams) was an essential part of the teams’ continued improvement.

Views about project legacies. For some respondents, the legacy of the project had to do with the adaptations that were made and successfully integrated into the original Pathways model. For instance, a key learning mentioned by one respondent is that the ICM model can be successfully adapted and used as a viable model of support in the Housing First approach, particularly when it adopts some features of ACT, such as team-based case management and the capturing of some specialist resources. For others, a key learning had to do with the emerging salience of previously tacit aspects of the model, such as the importance of developing a close, clearly defined relationship between the housing and clinical teams. The difficulty of achieving this when teams are located in different agencies was a related learning.

A number of respondents suggested that a main legacy of the project has been to show that Housing First is possible to implement in various Canadian contexts, that it works and that it is possible to house the most marginalized people using a scattered-site housing model. For several key informants, a main learning from the Pathways model, as opposed to Housing First, in general, which had been previously implemented in Canada, is that the housing subsidy is crucial and is what allows the participant to leapfrog ahead and thrive in an environment that really is of their choosing. Some key informants also commented that another main legacy was the organizational shift in culture and values that the project promoted within the mental health systems and the agencies that hosted it. Housing people who are homeless and have mental illness is possible provided that there is ongoing training, follow-up and teamwork among partners. The rich legacy of partnerships, including that between the landlords and teams that have been created and drawn upon into the fight against poverty and homelessness was noted. Key informants observed that such legacies do not require extra money to implement.

Another legacy that was mentioned by a number of key informants was for individuals who are homeless to be treated like a human being.

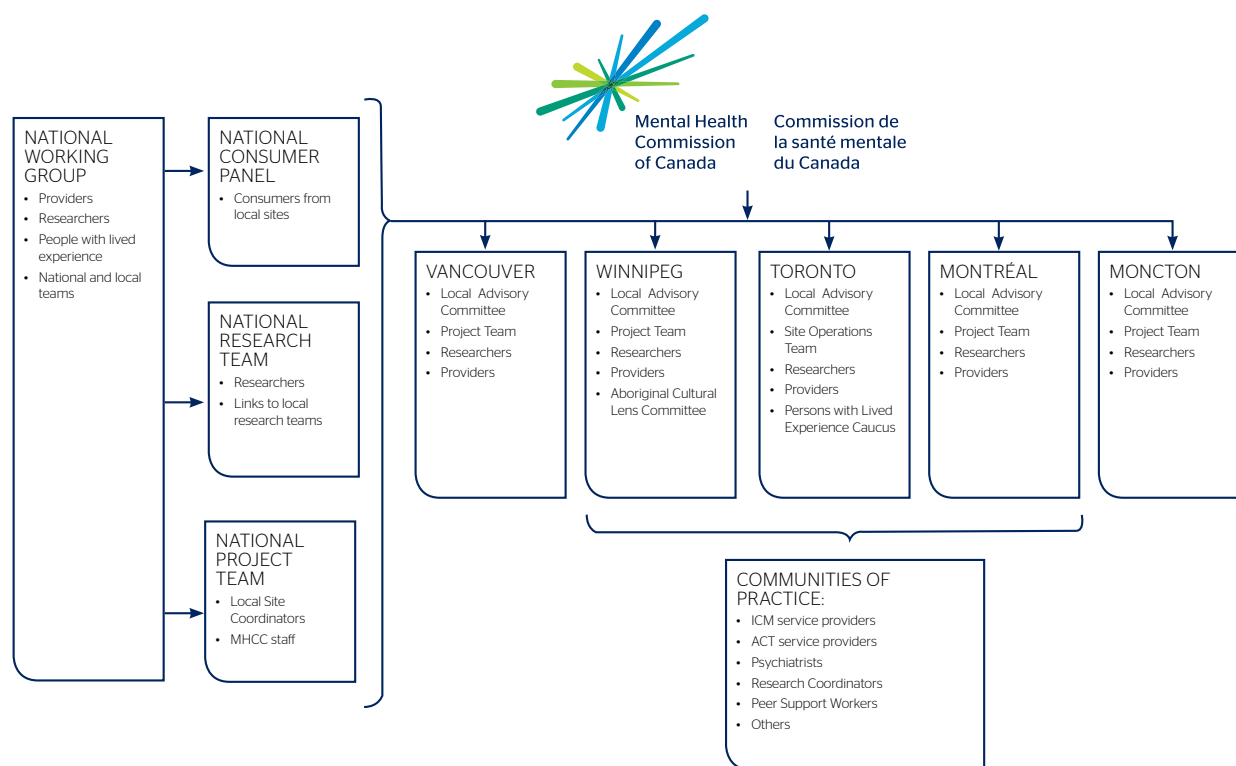
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PROJECT STRUCTURE AND DESCRIPTION OF THE FIVE AT HOME/CHEZ SOI PROJECT SITES

FIGURE 1:
Structure of the National Research Demonstration Project in Mental Health and Homelessness



VANCOUVER

Located on Canada's west coast, Metropolitan Vancouver is Canada's third largest urban area with a population of roughly two million. While Vancouver boasts a reputation as one of the most livable cities in the world, the overlap between mental disorders, substance use and homelessness has become a civic crisis. When compared to the rest of British Columbia and Canada, the city is unique in terms of the heterogeneity, multimorbidity and concentration of its homeless population. The extent of chronic medical conditions, including infectious disease, has been well-documented among Vancouver's homeless population (Acorn, 1993; Wood, Kerr et al., 2003). Furthermore, many individuals who are experiencing homelessness 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. This number represents a 23 per cent increase since 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.

Vancouver is home to the Downtown East Side (DTES) community (approximately 16,000 individuals) where homelessness, drug addiction and other health and psychosocial problems are rampant and highly visible. Many individuals in the DTES are homeless or live in unstable housing conditions, resulting in high rates of health and social service needs. 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. 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.

Although estimates of the clinical, social and housing service needs within the population of people who are homeless with mental disorders vary widely, it is clear that the variability and severity of need within the homeless population requires interventions that respond to individuals with both high and moderate levels of need. However, while Provincial ACT Standards have been developed and a Provincial Advisory Committee has been established to initiate ACT province-wide, there is currently only one ACT team in Vancouver (initiated in 2009), and only three province-wide. Thus, a critical element of context in Vancouver is the lack of basic service components (i.e., Housing First, ACT, ICM). This dearth of services may help explain the magnitude of complexity and tension in 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 high demand for low income housing is evidenced by the 0.5 percent 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 for a bachelor apartment is \$736/month, almost double the \$375 monthly shelter allowance. In general, housing in Vancouver for people with multiple barriers due to substance use and other mental disorders has been in congregate settings, and this trend is continuing 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, Vancouver's Mayor struck 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 & 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 activities and commitments fulfill their promise, they will significantly improve the standard of “usual care” for people who are homeless with mental disorders in Vancouver.

Sources:

The At Home/Chez Soi Project: A Review of the Proposal Development and Planning Phase in Vancouver, BC (September, 2010) by Michelle Patterson, Diane Schmidt, and Denise Zabkiewicz, Faculty of Health Sciences, Simon Fraser University.

The At Home/Chez Soi Project: Project Implementation at the Vancouver, BC Site (May, 2011) by Diane Schmidt and Michelle Patterson, Faculty of Health Sciences, Simon Fraser University.

WINNIPEG

With a population of more than 600,000, Winnipeg is the capital and largest city in the province of Manitoba, which is in the prairies of Western Canada. Winnipeg is home to the largest urban Aboriginal population, with roughly 7,000 people of First Nations ancestry residing in Winnipeg. Estimates of the homeless population in Winnipeg range from a minimum of 350 living on the streets, with a further 1,915 making use of shelters on a short-term or crisis basis (Ford 2009). One challenge associated with the Winnipeg demonstration project is that there was never a comprehensive and coordinated homeless count. However, past efforts and discussions with emergency shelter staff indicate that the average person without shelter in Winnipeg is most likely male (70 per cent) and of Aboriginal descent (70 per cent).

Low vacancy rates for rental property in Winnipeg – 1.1 per cent as of October 2009 – in both the public and private housing market have contributed to long waiting lists for those seeking affordable shelter. Approximately 40 per cent of the rental housing stock is located within Winnipeg’s inner city where housing is older and increasingly in need of major repair. Winnipeg’s housing rental stock is decreasing while rents increase, eroding both affordability and availability. As a result, prospective landowners and managers in the public market have the power to be particular in tenant selection. Some property owners and managers may avoid renting to tenants who are considered marginalized due to perceived drug and alcohol use and mental health issues, or as a function of systemic discrimination. Racism and stigma are major obstacles to housing Aboriginal people with mental illness and/or addictions.

According to a 2009 report from Canada Mortgage and Housing, the average rent for a bachelor apartment was \$447, \$615 for a one-bedroom and \$809 for a two-bedroom. With the average rent this high, a single person on Employment and Income Assistance (EIA) with a budget of \$320 per month to rent an apartment (or \$300 per month for accommodations in a rooming house) would have great difficulty obtaining shelter in Winnipeg. For a bachelor suite, this represents a shortfall of \$147 per month for shelter costs, which must inevitably be taken from other household budget areas. A key issue in Winnipeg is the high demand for subsidized housing. The Manitoba Urban Native Housing Association reports that there is an overwhelming shortage of housing, with 2,300 persons on their wait lists (Distasio & Mulligan 2005). There are an estimated 5,000 tenants in 1,000 rooming houses (Distasio, Dudley & Maunder 2002). Meanwhile, close to 1,000 persons live in residential hotels along the Main Street area of downtown Winnipeg (Distasio & Mulligan 2005).

The standard form of shelter for those experiencing homelessness in Winnipeg falls under the category of Crisis and Transitional Housing. In addition, there are emergency and transitional shelters geared towards providing services to particular populations, such as women or youth needing protection from dangerous home environments. Winnipeg currently has the capacity for 500 shelter beds during the winter months. Adult males represent a constituency of high need that are frequent users of emergency shelter, and who often have addictions issues. Moreover, Aboriginal males experiencing mental illness often seek emergency, transitional and supportive housing in contrast to permanent housing (2001 Community Plan on Homelessness and Housing). While overall shelter beds have increased over the past several years, there remains no Aboriginal-owned and operated shelter. The last shelter operated by the Aboriginal community was the Neeginan Emergency Shelter.

To some extent, housing is integrated into the delivery of mental health services in Winnipeg. But while there are general services, some supportive housing (with live-in staff) and supported housing (with case management) programs available for people with mental illness, the Housing First approach was not implemented on a widespread basis until the At Home/Chez Soi project. In terms of mental health services, Winnipeg has only recently developed its first ACT program. Moreover, there was little to no history of collaboration between mental health service-providers and organizations serving the Aboriginal population.

Although a large majority of project participants is of Aboriginal descent, it is a very diverse population of individuals with unique circumstances and needs. The existing housing system in the city has not dealt effectively with this population in the past. Many of the participants have had lengthy experience with the social services system, some not positive.

Sources:

Report on Proposal Development at the Winnipeg Site: The Mental Health Commission of Canada's At Home/Chez Soi Project (September, 2010) by Michael Dudley with the assistance of Fereshteh Moradzadeh, Institute of Urban Studies, University of Winnipeg.

Winnipeg Site Implementation Report (July, 2011) by Michael Dudley and Matthew Havens, Institute of Urban Studies, University of Winnipeg.

TORONTO

With a population of 2.7 million people, Toronto is the largest city in Canada and is known as one of the world's most multicultural centers. Half of the city's population was born outside of Canada and 47 per cent of its residents describe themselves as belonging to a visible minority. Almost half of Toronto's population are immigrants (Statistics Canada, 2001), and this group has been identified as vulnerable to homelessness and in need of targeted support services (Toronto Shelter Support and Housing Administration, 2009; City of Toronto, 2000).

Homelessness in Toronto remains a significant social issue. Based on the Street Needs Assessment conducted by the City of Toronto in 2006, at any given night, there are more than 5,000 people experiencing homelessness in Toronto. About 79 per cent of them are living in shelters, 8 per cent on the street, 4 per cent in health care or treatment facilities, and 6 per cent in correctional facilities (Toronto Shelter Support and Housing Administration, 2009). Between one fourth to one third of individuals who are homeless in Toronto have a serious mental health problem such as schizophrenia, major depressive disorder or bipolar affective disorder. A 2007 survey by Street Health found that about 35 per cent of people experiencing homelessness in Toronto reported a prior diagnosis of a mental health condition and 25 per cent reported a combination of mental health and substance use problems (i.e. a concurrent disorder).

The unmet need for specialized mental health services among individuals who are homeless in the Toronto area is significant and a large proportion of people with mental health problems who are homeless do not receive the proper level of care. It is estimated that only 25 to 50 per cent of those eligible for services actually receive them. Furthermore, immigrants, who make up about one third of people experiencing homelessness in Toronto, in particular face significant barriers (e.g. racism, language barriers and stigma) to accessing mental health services (Access Alliance Multicultural Community Health Centre, 2005).

There is a large pool of longstanding services available to individuals experiencing homelessness in Toronto, including supportive and alternative housing, emergency shelters, drop-ins, integrated street outreach services, housing help and eviction prevention services, and meal programs funded through three levels of government and the charitable sector. Three downtown Community Health Centres – Parkdale in West Downtown, Queen West in Central Toronto and Regent Park in Southeast Toronto – are given six million dollars a year in addition to their annual funding to hire staff (doctors, nurses, nurse practitioners, social workers, outreach workers), to work specifically with people who are homeless, and to coordinate services for people who are homeless between CHCs in the city.

Also included in the homelessness service landscape is the City of Toronto's Streets to Homes program, which began in 2005 and focuses on moving individuals who are homeless and living outdoors into permanent housing (Toronto Shelter Support and Housing Administration, 2009). A sizeable mental health service network serves individuals who are homeless and housed in Toronto; clients living with serious mental health problems and homelessness access the treatment system in Toronto through many different entry points.

Despite this, people who are homeless and living with mental health issues often face barriers to service access and end up using emergency room and inpatient hospitalizations for their care (Canadian Institutes of Health Research. Reducing Health Disparities & Promoting Equity for Vulnerable Populations. 2002). Existing mental health services often lack the resources or are unable to combine the basket of services and supports needed to address their needs, especially at higher levels of care (Stergiopoulos, Dewa, Durbin, Chau, Svoboda, 2010). A few larger drop-in centres in Toronto have the resources to provide more extensive medical and case management supports to their clients who are homeless and living with serious mental health problems. However, most drop-ins have very limited resources for providing psychiatric or medical supports and those resources can be very precarious. Service fragmentation and lack of options for consumer choice often make it difficult to engage those with the most complex needs. There are ongoing efforts to develop a centralized access point for certain community services including case management, ACT and supportive housing.

There are approximately 4,405 supportive housing units in Toronto specifically designated for individuals with serious mental health problems. The great majority of these are permanent housing with anything from an hour a week to 24 hours a day of support. The supportive housing providers' tenants are diverse with low incomes. They are predominantly single adults, have similar social or health issues affecting housing stability, but they must have a mental health diagnosis and may also live with addictions. In some instances, supportive housing providers also house couples and families with children as long as one member of the household meets the mental health/diagnosis criterion. Additionally, there are many units available through what is referred to as the "alternative housing providers," a group of providers who house individuals with a variety of health and social issues. The alternative housing providers' tenants are also diverse, but are predominantly single adults with low incomes who may live with mental health problems or addictions, or other social or health issues which present barriers to finding and maintaining stable housing. Although several initiatives developed and funded by the Ministry of Health and Long-Term Care have had an impact on homeless populations, the permanent nature of the housing creates capacity issues once the units are filled.

Sources:

At Home/Chez Soi Project Planning and Proposal Development Toronto Site Report (November, 2010) by Maritt Kirst, Erin Christine Plenert, Deborah Wise Harris, Bonnie Kirsh, Stephen Hwang, Patricia O'Campo, and Vicky Stergiopoulos, Centre for Inner City Health, St. Michael's Hospital.

At Home/Chez Soi Implementation Evaluation Toronto Site Report (August, 2011) by Vicky Stergiopoulos, Stephen Hwang, Patricia O'Campo, and Jeyagobi Jeyaratnam, Centre for Inner City Health, St. Michael's Hospital.

MONCTON

The Greater Moncton region of the province of New Brunswick includes the cities of Moncton, Dieppe and the town of Riverview. The Greater Moncton area population is approximately 130,000 with it having experienced a growth of 6.5 per cent between 2001 and 2006. The language composition of the population is approximately 62 per cent Anglophone and 35 per cent Francophone (City of Moncton, 2011). The location of the rural arm of the Moncton site study is in the southeast region of the province of New Brunswick. The southeast region is within a 60 minute drive of Greater Moncton and covers a region stretching over 2,000 square kilometers. 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 individuals experiencing homelessness who received services from shelters in the Greater Moncton area in 2006 is 946 (Human Resources and Social Development Canada, 2007). This outcome reflects the annual number of individuals served by the two largest shelters in the city (689 male adults, 177 female adults and 80 children). In 2010, a total of 682 clients, representing 425 different individuals, had stays at the House of Nazareth shelter in Moncton (Greater Moncton Homelessness Steering Committee, 2011). In contrast, a total of 737 clients had stays at the House of Nazareth in 2009. The average length of stay for consumers at the House of Nazareth was a little over six days in both years. Overall, a total of 4,259 beds at the House of Nazareth were used in 2010 and 4,550 beds in 2009 representing a small drop in shelter use.

Approximately 70 per cent of dwellings in the Greater Moncton region are owned with the remaining 30 per cent being rental units. The Community Plan Assessment Framework (2007) identified approximately 15,500 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. On average, approximately 30 per cent of disposable income for renters is used to cover housing costs. In contrast, those living in rental situations identified as “in core housing need” spend approximately 45-50 per cent of their income on housing-related expenses. There is a relatively high vacancy rate in Moncton and a long waiting list for social housing. Nevertheless, there have been some small, incremental financial increases in income assistance and minimum wage. One of the significant gaps in policy that continues to affect the living conditions of many renters in New Brunswick is the absence of provincial standards to regulate the safety and suitability of rooming and boarding houses.

Services and supports available in the community include the range of longer-term services available through community mental health centres (CMHCs) such as case management, community support and rehabilitation as well as the community supports provided by other settings such as reintegration services, transitional and housing programs, and outreach services. CMHCs are the main source of services delivered in the community and these are organized under three core programs: (1) Acute services (i.e., 24-hour crisis intervention, short-term therapy prevention, consultation and service delivery coordination), (2) child and adolescent services (i.e., individualized assessment and treatment, service provision for all family members), and (3) adult long-term services (i.e., treatment, monitoring, psycho-social rehabilitation) (Health Systems Research and Consulting Unit, 2009). Publicly-funded mental health services are delivered in Moncton and in the adjoining rural region through CMHCs, tertiary and secondary facilities, and psychiatrists in private practice. The tertiary and secondary facilities and psychiatrists in private practice are located in Moncton. In addition, there are three rural service providers located out of the mental health clinic in Shediac. Addiction services available in Greater Moncton include a detoxification centre, outpatient counselling, health promotion, and wellness activities and school-based youth support services.

Relative to the other sites participating in the At Home/Chez Soi project, Moncton was the most resource deprived in terms of housing and community mental health services. There are two organizations in Moncton providing long-term supportive housing: (1) Alternative Residences Inc. which offers 30 units for mental health consumers that can accommodate up to 76 individuals; twenty-six of the 30 units are apartments and the other four are 24-hour supervised residences; the maximum stay is set at two years; and (2) Future Horizons Housing Inc. which has 12 units (three two-bedrooms & nine 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.

¹A household is said to be in core housing need if its housing falls below standards in terms of adequacy, suitability or affordability and it would have to spend more than 30 per cent of its before-tax income to pay the median rent of alternative local housing that meets all three standards. (Cooperative Housing Federation of Canada, 2007).

Sources:

Rapport de recherche: Phase I - Planification et développement du projet Chez-soi/At Home Moncton et volet rural (September, 2010) by Charles Gaucher, Lindsay Flowers, Natasha Prévost, and Wiebke Tinney.

Implementation Evaluation Report for the Mental Health Commission of Canada's At Home/Chez Soi Project: Moncton Site (June, 2011) by Tim Aubry, Rebecca Cherner, John Ecker, Jonathan Jetté, and Keith Philander.

MONTRÉAL

Located in the province of Québec, Montréal is Canada's second largest metropolitan area with roughly 3.8 million people. It also has the second largest Francophone population in the world, after Paris. Montréal has a significant problem of homelessness and mental illness.

At last count, carried out in 1998 by Institut de la Statistique du Québec (Québec institute of statistics), 28,214 people had at one time used a shelter, a soup kitchen or day centre. Of this number, 12,666 had been homeless over the course of the past year (MSSS, 2008). For 2005, the number of people in Montréal who were homeless at least part of the year, was estimated at 30,000 ("Cadre canadien en matière de logement 2005," in RAPSIM, 2008). The profile of homelessness has undergone a major transformation (Roy & Hurtubise, 2007).

There are more and more youths, women, seniors and Natives living in the street. This population also faces major concurrent health problems. In particular, from 30-50 per cent of people who are homeless have mental health problems, and 10 per cent live with severe mental health problems. Over half of adults living with homelessness and mental health problems may also have an addiction problem (Weinrebet al., 2005). In addition, an increasing number of people who are homeless have problems with the law (Bellot, 2008). The multiplicity of problems affecting this population makes it increasingly complex to implement adequate responses to homelessness.

Existing housing programs for people with mental illness include social housing (a congregate program for low-income living), hostels, foster families, group homes, supervised apartments and rooming homes. Moreover, although provincial policy has called for the implementation of ACT and ICM teams across the province since 2005, when the At Home/Chez Soi project started, access to such programs was still relatively limited. The beginning of the At Home/Chez Soi project coincided with provincial initiatives to address the growing problem of homelessness in Québec.

[In 2008], the government of Québec established a parliamentary commission on homelessness. Over 145 submissions were made and 104 persons or groups provided testimonials. A document titled *L'itinérance au Québec - Cadre de référence* (Homelessness in Québec: A Reference Framework) was issued a few months later. It targeted four priority objectives at the provincial, regional, and local levels to respond to the needs of the homeless population: (1) enhance prevention; (2) respond to emergency situations; (3) intensify intervention and social reintegration; and (4) improve knowledge, research and training (MSSS, 2008). The reference framework is the basis for the *Plan d'action interministériel en itinérance 2010-2013* (interministerial action plan on homelessness, 2010-2013) made public in December 2009, which recommends identifying best practices in the fight against homelessness.

It is worth noting that the action plan identifies the Housing First model as a promising avenue of exploration for persons facing chronic homelessness and mental health problems (*Plan d'action interministériel en itinérance 2010-2013*, 2009). The *Plan d'action en santé mentale 2005-2010* (mental health care action plan, 2005-2010), tabled in 2005, recommends consolidation of community services to help persons with mental health problems and to facilitate their social reintegration (MSSS, 2005). The action plan also presents specific targets for housing services with support from Assertive Community Treatment (ACT) teams and Intensive Case Management (ICM) teams.

Source:

Projet Chez Soi Montréal - Projet de recherche et de démonstration sur la santé mentale et l'itinérance: Rapport d'évaluation de la planification et du développement du projet (été 2008 - automne 2009) (July, 2010) by Marie-Josée Fleury, Catherine Vallée, Roch Hurtubise, and Guy Grenier.

PRINCIPLES OF HOUSING FIRST

HOUSING FIRST MODEL

- Recovery-oriented culture
- Based on consumer choice for all services
- Only requirements: income paid directly as rent; visited at a minimum once a week for pre-determined periods of follow-up supports
- Rent supplements for clients in private market: participants pay 30 per cent or less of their income or the shelter portion of welfare
- Treatment and support services voluntary – clinicians/providers based off site
- Legal rights to tenancy (no head leases)
- No conditions on housing readiness
- Program facilitates access to housing stock
- Apartments are independent living settings primarily in scattered sites
- Services individualized, including cultural adaptations
- Reduce the negative consequences of substance use
- Availability of furniture and possibly maintenance services
- Tenancy not tied to engagement in treatment

Sources:

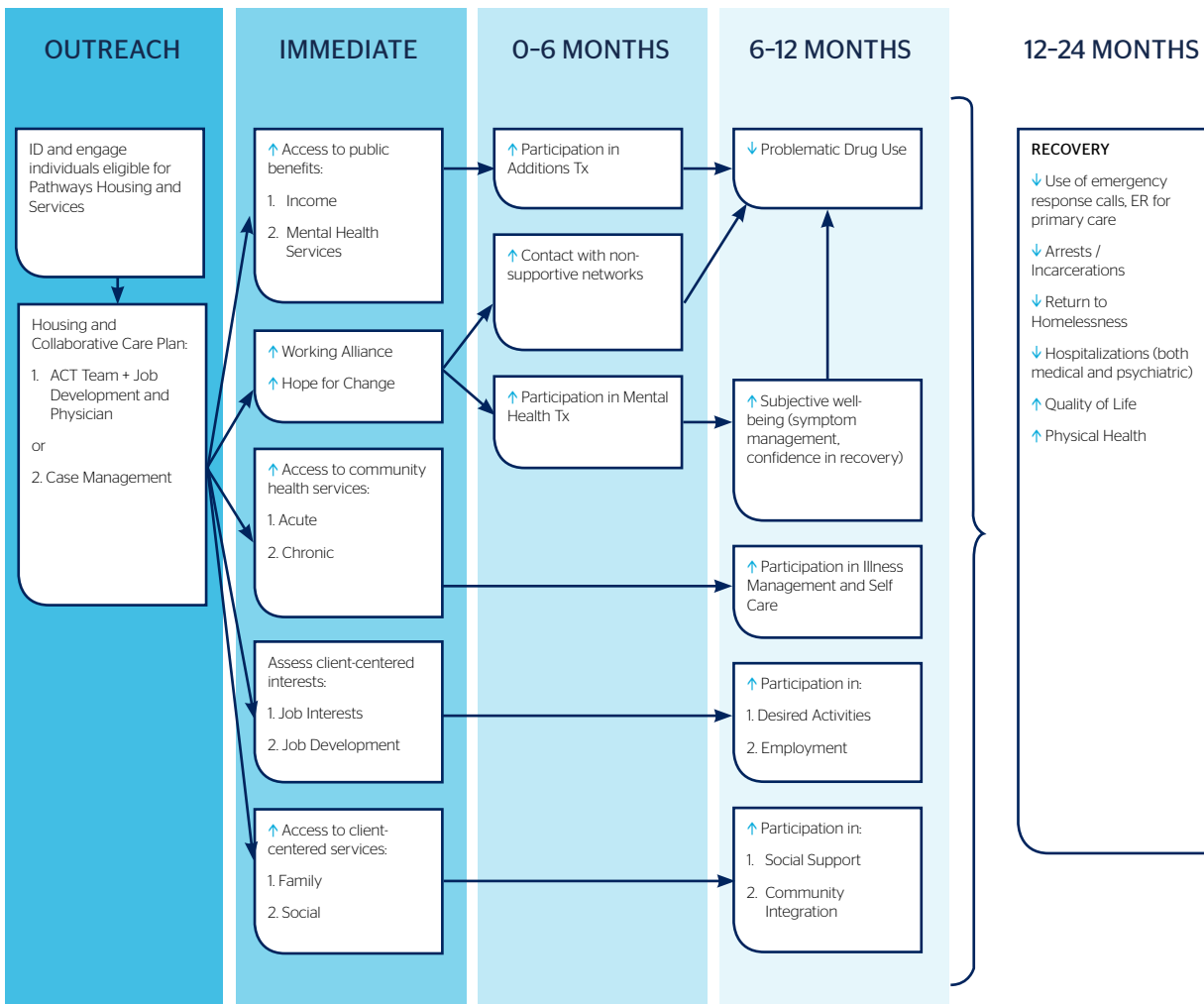
Tsemberis S. (1999). From streets to homes: An innovative approach to supported housing for homeless adults with psychiatric disabilities. *Journal of Community Psychology, 27*, 225-241.

Tsemberis, S., & Eisenberg R.F. (2000). Pathways to housing: Supported housing for street-dwelling homeless individuals. *Psychiatric Services, 51*, 487-493

As outlined in *Request for Applications MHCC Research Demonstration Projects in Mental Health and Homelessness, 2009*.

FIGURE 2:
Pathways Housing First Consumer Interventions and Outcomes

DRAFT June 8, 2009



DETAILED METHODOLOGY

MIXED METHODS APPROACH

A mixed methods approach (Padgett, 2012; Palinkas et al., 2011) to fidelity and implementation evaluation of the At Home/Chez Soi project was undertaken. In this context, program fidelity refers to a quantitative assessment of the degree to which the implementation of Housing First adheres to the core principles and ingredients of the Housing First logic model (Mowbray, Holter, Teague, & Bybee, 2003). Implementation evaluation can include a quantitative evaluation of fidelity, but it can also include formative evaluation (Patton, 2008), qualitative data on the process of implementation and factors that help or hinder the achievement of program fidelity, and developmental evaluation (Patton, 2011), the influence of contextual factors on implementation and how programs change and adapt to such influences. In this mixed methods evaluation, qualitative methods were used as a complement to the quantitative evaluation of fidelity (Padgett, 1998; Patton, 2008, 2011). Qualitative methods are particularly well suited to understand the dynamics of program implementation in context and to understand how and why numerical ratings of program fidelity show more or less adherence to the Housing First model.

FIDELITY EVALUATION

The Pathways Housing First Fidelity Scale was used to assess program implementation along 38 items within five broader domains (Housing Choice and Structure, Separation of Housing and Services, Service Philosophy, Service Array and Program Structure) identified as critical to Housing First (Tsemberis, 2011). See Appendix 2 for Housing First Principles, Appendix 3 for the Housing First Logic Model, Appendix 4 for a more detailed description of the methodology, and Appendix 5 for the fidelity evaluation tools. Items for the fidelity evaluation tool were adopted from several sources (SAMHSA, 2008, 2010; Teague, Moser, & Monroe-DeVita, 2011; Williams, Banks, Robbins, Oakley, & Dean, 2001).

Fidelity assessments of each Housing First program were conducted by a five to six-member multidisciplinary Quality Assurance (QA) team consisting of clinicians, researchers, service providers and a consumer representative. The purpose of the fidelity assessment was to: (1) contribute to the process evaluation by describing program fidelity on the 38-item scale and (2) identify program challenges or areas of low fidelity so that technical assistance could be targeted to areas of greatest need for each program. Additionally, the fidelity assessment yielded information on program modifications for various subgroups and different locales, as well as effective implementation strategies that could be replicated across programs. This was the second fidelity assessment for each program. The first assessment occurred approximately one year into program implementation after a certain threshold of participants had been enrolled and staff had some experience on the job. This second assessment was conducted one year later. Because the programs used two different models of service delivery that varied in intensity, two versions of the Pathways Housing First Fidelity Scale were developed – one for teams using an Assertive Community Treatment (ACT) model and one for those using Intensive Case Management (ICM). Overall, there was a great amount of overlap between the two scale versions; the most significant difference, however, was that ACT teams were assessed on the degree to which they directly provided an array of services, whereas ICM teams were assessed on the degree to which they were able to broker these same services. Each of the 38 items was rated by the QA team on a four-point scale (with a high score indicating a high level of fidelity), and each item was benchmarked.

The fidelity assessment consisted of a full-day site visit to each program and included program meeting observations, staff interviews, consumer chart reviews and a consumer focus group. Approximately 6-12 staff were interviewed at each program and interviewees included frontline staff with specialties (e.g., substance use specialist, psychiatrist, nurse, peer specialist), general service providers/clinicians (e.g., case manager), management staff (e.g., team leader, program director), at least two members of the local housing team. Interviews were semi-structured and

lasted approximately 45 minutes, with interviewers taking notes. The consumer focus group was cofacilitated by two individuals – one a member of the fidelity team and the other a local consumer representative – and lasted approximately one and a half hours with 4-12 participants. For the chart review, the fidelity team reviewed a stratified random sample of 10 charts, including progress notes for the past month as well as most recent treatment plan and assessments. The site visits were conducted between December 2011 and April 2012. The total sample for the fidelity assessment included 89 staff interviews, 10 consumer focus groups and 102 chart reviews.

Table of the Samples for the Fidelity Evaluation of Implementation

TEAMS	VANCOUVER	MONCTON	WINNIPEG	TORONTO	MONTRÉAL
ACT	ACT and housing staff (n=11) Chart reviews (n=10)	ACT and housing staff (n=12) Consumers (k=2) Chart reviews (n=12)	ACT and housing staff (n=8) Consumers (k=1) Chart reviews (n=10)	ACT and housing staff (n=10) Consumers (k=1) Chart reviews (n=10)	ACT and housing staff (n=9) Consumers (k=1) Chart reviews (n=10)
ICM	ICM and housing staff (n=9) Consumers (k=1) Chart reviews (n=10)	-	ICM and housing staff (n=4) Consumers (k=1) Chart reviews (n=10)	ICM and housing staff (n=9) Consumers (k=1) Chart reviews (n=10)	ICM and housing staff (n=17) Consumers (k=2) Chart reviews (n=20)

The fidelity team triangulated these various sources of data to describe how each program was implementing housing and support services and to rate each program on the extent to which it demonstrated fidelity to the Housing First model on the 38 items. Ratings for each item were developed through discussion and team consensus. In advance of the visit, the fidelity team also collected and reviewed information from each program related to housing and clinical service policies and procedures, population served and program operations. At the end of each visit, the fidelity team conducted a debrief session with each program to discuss preliminary findings. Debrief sessions were structured as a dialogue with program staff, such that the fidelity team could report initial observations and recommendations, but the program could also clarify any misconceptions, offer additional information, and provide feedback. After each visit, the fidelity team prepared a brief report, with additional appendices, which described program implementation and operation, program strengths and challenges, and made recommendations in areas where there was potential for improvement. Reports were first sent out as drafts to programs, soliciting their input and feedback with respect to content. Reports were then edited based on program input and sent back to the programs as final versions.

QUALITATIVE EVALUATION OF IMPLEMENTATION

Sampling and sample. Sampling was purposeful: individuals who were identified as having played a key role in program implementation were selected and interviewed individually as key informants. Frontline project staff and consumers, most of whom participated directly in the programs, were interviewed in focus groups. In all, 80 key informant interviews and 17 focus groups with 99 participants were conducted by site researchers between January 2012 and July 2012. In addition, eight key informants who played a key role in the fidelity site visits were interviewed by members of the National Qualitative Research Team. Additionally, eight key informants who either conducted the fidelity site visits or who provided administrative, training and technical assistance to the sites were interviewed by members of the National Qualitative Research Team. These interviews were conducted between January 2011 and April 2011

and were designed to obtain another perspective on issues of fidelity and implementation. All participants provided informed consent to participate in the research (See Appendix 6 for sample information letters and consent forms). The total sample size for the qualitative evaluation of implementation was $n = 192$. See the following table for a complete breakdown of participants for this research.

Table of the Samples for the Qualitative Evaluation of Implementation

VANCOUVER	MONCTON	WINNIPEG
Focus groups with staff from the three clinical teams ($k=3$, $n=18$)	Focus groups with ACT staff ($k=2$, $n=8$)	Focus groups with staff from the three clinical teams ($k=3$, $n=20$)
Key informant interviews with Housing Procurement Coordinator and Site Coordinator ($n=2$)	Key informant interviews with Physician Clinical Director, ACT Team Manager, Housing Lead, and the MHCC Site Coordinator ($n=4$)	Key informant interviews with Housing Team and Site Coordinator ($n=5$)
Landlord interviews ($n=2$)	Landlord interviews ($n=12$)	Landlord interviews ($n=12$)
(Total $n = 22$)	(Total $n = 28$)	(Total $n = 37$)
TORONTO	MONTRÉAL	NATIONAL
Interviews with Toronto Site Coordinator, representative from the City of Toronto, the Housing Connections Lead, Directors Team Leads from the ACT, ICM, and Ethno-racial ICM ($n=9$)	Focus groups with staff from the three clinical teams, the housing team and the consumer group ($k=5$, $n=34$)	Key informant interviews ($n=8$) with fidelity evaluation site team members and leadership staff from the Mental Health Commission
Landlord interviews ($n=16$)	Key informant interviews with Site Coordinator, Directors, Team Leaders, Clinical Consultant ($n=8$)	
(Total $n = 44$)	Landlord interviews ($n=15$)	
	(Total $n = 57$)	

Data collection. Common key informant and focus group protocols were used across the sites. Key informant interviews and focus groups were conducted, in either English or in French, at the participants' workplaces or at the site offices. The national-level interviews focused on activities to strengthen fidelity (e.g., training, technical assistance, management/administrative assistance), as well as the process of conducting the fidelity evaluation visits (see Appendix 7 for the interview guides). All interviews were audio recorded and transcribed verbatim (see Appendix 8 for the transcription protocols). Qualitative site researchers also reviewed relevant project implementation documents. Finally, the qualitative site researchers also took field notes on the QA team feedback meetings with program staff (see Appendix 7).

Data analysis. The approach to data analysis at each of the sites involved thematic analysis (Morse & Field, 1995). Site researchers sought and identified common threads throughout the data, drawing out significant concepts that emerged from individual interviews along with concepts that linked interviews together. They also used the constant comparative method of making comparisons during each stage of the analysis to further develop themes (Charmaz, 2006). Each site went through a process of member-checking with people who were interviewed for the site reports to establish the trustworthiness of the data. Qualitative researchers at each of the sites produced site reports on the implementation process (Aubry, Yamin, Ecker, Jetté, Albert, Nolin, & Sylvestre, 2012; McCullough, Havens, Isaac, & Deboer, 2012; Patterson, 2012; Stergiopoulos, Hwang, O'Campo, Kruk, & Jeyaratnam, 2012). This cross-site report relied

on the national-level interviews and the site reports as the source of data, rather than reviewing transcripts or other data from each site. Not working directly with the transcripts constituted a limitation in undertaking this secondary analysis. Nevertheless, it provided the National Qualitative Research Team with the opportunity to check back with the sites; this serves as a strength for member-checking and validating the accuracy and completeness of these results.

For the cross-site analysis, members of the National Qualitative Research Team read the five qualitative implementation site reports and the five ACT and five ICM fidelity reports. Analysis of the cross-site data focused on the main sections of the reports: (1) development of evaluation issues regarding fidelity strengths and challenges, (2) the Housing First program theory of change, (3) landlord/caretaker experiences with implementation, and (4) sustainability issue questions. For the qualitative data, matrix displays were constructed with sites as one dimension and the four topics of analysis as the other dimension. Relevant data from each of the site reports were coded and included in the cells of these matrices. Additional data gathered from the interviews with the QA team were inserted into the analysis.

Researchers from the sites were involved in a process of review wherein the National Qualitative Research Team and the QA team shared the first draft of this cross-site report with site researchers, invited them to read it over along with their teams, and solicited their comments and suggestions. Comments from every site were incorporated into the final version of this report.

PATHWAYS FIDELITY EVALUATION TOOLS

HOUSING FIRST AND ACT

ITEM	CRITERION	1	2	3	4
HOUSING CHOICE & STRUCTURE					
1.	Housing Choice. Program participants choose the location and other features of their housing.	Participants have no choice in the location, decorating, furnishing, or other features of their housing and are assigned a unit.	Participants have little choice in location, decorating, and furnishing, and other features of their housing.	Participants have some choice in location, decorating, furnishing, and other features of their housing.	Participants much choice in location, decorating, furnishing, and other features of their housing.
2.	Housing Availability. Extent to which program helps participants move quickly into units of their choosing.	Less than 55% of program participants move into a unit of their choosing within 3 months. <i>Program does not have access to housing subsidies and does not facilitate access to housing subsidies.</i>	55 - 69% of program participants move into a unit of their choosing within 3 months.	70 - 84% of program participants move into a unit of their choosing within 3 months.	85% of program participants move into a unit of their choosing within 3 months.
3.	Permanent Housing Tenure. Extent to which housing tenure is assumed to be permanent with no actual or expected time limits, other than those defined under a standard lease or occupancy agreement.	There are rigid time limits on the length of stay in housing such that participants are expected to move by a certain date or the housing is considered emergency, short-term, or transitional.	There are standardized time limits on housing tenure, such that participants are expected to move when standardized criteria are met.	There are individualized time limits on housing tenure, such that participants can stay as long as necessary, but are expected to move when certain criteria are met.	There are no expected time limits on housing tenure, although the lease agreement may need to be renewed periodically.
4.	Affordable Housing. Extent to which participants pay a reasonable amount of their income for housing costs.	Participants pay 61% or more of their income for housing costs.	Participants pay 46 - 60% or less of their income for housing costs.	Participants pay 31- 45% or less of their income for housing costs.	Participants pay 30% or less of their income for housing costs.
5.	Integrated Housing. Extent to which program participants live in scatter- site private market housing which is otherwise available to people without psychiatric or other disabilities.	Participants do not live in private market housing, access is determined by disability and 100% of the units in a building are leased by the program.	Participants live in private market housing where may or may not be determined by disability, and more than 40% of the units in a building are leased by the program.	Participants live in private market housing where access is not determined by disability and 21- 40% of the units in a building are leased by the program.	Participants live in private market housing where access is not determined by disability and less than 20% of the units in a building are leased by the program.

ITEM	CRITERION	1	2	3	4
6.	Privacy. Extent to which program participants are expected to share living spaces, such as bathroom, kitchen, or dining room with other tenants.	Participants are expected to share all living areas with other tenants, including a bedroom	Participants have their own bedroom, but are expected to share living areas such as bathroom, kitchen, dining room, and living room with other tenants.	Participants have their own bedroom and bathroom, but are expected to share living areas such as a kitchen, dining room, and living room with other tenants.	Participants are not expected to share any living areas with other tenants.
SEPARATION OF HOUSING & SERVICES					
7.	No Housing Readiness. Extent to which program participants are not required to demonstrate housing readiness to gain access to housing units.	Participants have access to housing only if they have successfully completed a period of time in transitional housing or outpatient/inpatient/residential treatment.	Participants have access to housing only if they meet many readiness requirements such as sobriety, abstinence from drugs, medication compliance, symptom stability, or no history of violent behavior or involvement in the criminal justice system.	Participants have access to housing with minimal readiness requirements, such as willingness to comply with program rules or a treatment plan that addresses sobriety, abstinence, and medication compliance.	Participants have access to housing with no requirements to demonstrate readiness, other than agreeing to meet with staff face-to-face once a week.
8.	No Program Contingencies of Tenancy. Extent to which continued tenancy is not linked in any way with adherence to clinical, treatment, or service provisions.	Participants can keep housing only by meeting many requirements for continued tenancy, such as sobriety, abstinence from drugs, medication compliance, symptom stability, no violent behavior, or involvement in the criminal justice system.	Participants can keep housing with some requirements for continued tenancy such as compliance with their treatment plan and meeting individual clinical or behavioral standards.	Participants can keep housing with minimal requirements for continued tenancy, such as participation in formal services or treatment activities (attending groups, seeing a psychiatrist).	Participants can keep their housing with no requirements for continued tenancy, other than adhering to a standard lease and seeing staff for a face-to-face visit once a week.
9.	Standard Tenant Agreement. Extent to which program participants have legal rights to the unit with no special provisions added to the lease or occupancy agreement.	Participants have no written agreement specifying the rights and responsibilities of tenancy and have no legal recourse if asked to leave their housing.	Participants have a written agreement (such as a lease or occupancy agreement) which specifies the rights and responsibilities of tenancy, but contains special provisions regarding adherence to clinical provisions (e.g., medication compliance, sobriety, treatment plan).	Participants have a written agreement (such as a lease or occupancy agreement) which specifies the rights and responsibilities of tenancy, but contains special provisions regarding adherence to program rules (e.g., requirements for being in housing at certain times, no overnight visitors).	Participants have a written agreement (such as a lease or occupancy agreement) which specifies the rights and responsibilities of typical tenants in the community and contains no special provisions other than agreeing to meet with staff face-to-face once a week.

ITEM	CRITERION	1	2	3	4
10.	Commitment to Re- House. Extent to which the program offers participants who have lost their housing access to a new housing unit.	Program does not offer participants who have lost their housing a new housing unit nor assist with finding housing outside the program.	Program does not offer participants who have lost housing a new unit, but assists them to find housing outside the program.	Program offers participants who have lost their housing a new unit, but only if they meet readiness requirements, complete a period of time in more supervised housing, or the program has set limits on the number of relocations.	Program offers participants who have lost their housing a new unit without requiring them to demonstrate readiness and has no set limits on the number of possible relocations.
11.	Services Continue Through Housing Loss. Extent to which program participants continue receiving services even if they lose housing.	Participants are discharged from program services if they lose housing for any reason. (Services are contingent on staying in housing)	Participants are discharged from services if they lose housing, but there are explicit criteria specifying options for re- enrollment, such as completing a period of time in inpatient treatment.	Participants continue to receive program services if they lose housing, but may be discharged if they do not meet "housing readiness" criteria.	Participants continue to receive program services even if they lose housing due to eviction, short- term inpatient treatment, although there may be a service hiatus during institutional stays.
12.	Off-site, Mobile Services. Extent to which social and clinical service providers are not located at participant's residences and are mobile.	Social and clinical service providers are based on-site 24/7, and have limited or no mobility to deliver services at locations of participants' choosing.	Social and clinical service providers are based off-site or on-site during the day and have limited mobility to deliver services at locations of participants' choosing.	Social and clinical service providers are based off-site, but maintain an office on-site, and are capable of providing mobile services to locations of participants' choosing.	Social and clinical service providers are based off- site, do not maintain an office on-site, but are capable of providing mobile services to locations of participants' choosing.
SERVICE PHILOSOPHY					
13.	Service choice. Extent to which program participants choose the type, sequence, and intensity of services on an ongoing basis.	Services are chosen by the service provider with no input from the participant.	Participants have little say in choosing, modifying, or refusing services.	Participants have some say in choosing, modifying, or refusing services and supports, but program staff determinations usually prevail.	Participants have the right to choose, modify, or refuse services and supports at any time, except one face-to-face visit with staff a week.
14.	No requirements for participation in psychiatric treatment. Extent to which program participants with psychiatric disabilities are not required to take medication or participate in psychiatric treatment.	All participants with psychiatric disabilities are required to take medication and participate in psychiatric treatment.	Participants with psychiatric disabilities are required to participate in mental health treatment such as attending groups or seeing a psychiatrist and are required to take medication but exceptions are made.	Participants with psychiatric disabilities who have not achieved a specified period of symptom stability are required to participate in mental health treatment, such as attending groups or seeing a psychiatrist.	Participants with psychiatric disabilities are not required to take medication or participate in formal treatment activities.

ITEM	CRITERION	1	2	3	4
15.	No requirements for participation in substance use treatment. Extent to which participants with substance use disorders are not required to participate in treatment.	All participants with substance use disorders, regardless of current use or abstinence, are required to participate in substance use treatment (e.g., inpatient treatment, attend groups or counseling with a substance use specialist).	Participants who are using substances or who have not achieved a specified period of abstinence must participate in substance use treatment.	Participants with substance use disorders whose use has surpassed a threshold of severity must participate in substance use treatment.	Participants with substance use disorders are not required to participate in substance use treatment.
16.	Harm Reduction Approach. Extent to which program utilizes a harm reduction approach to substance use.	Participants are required to abstain from alcohol and/or drugs at all times and lose rights, privileges, or services if abstinence is not maintained.	Participants are required to abstain from alcohol and/or drugs while they are on-site in their residence or participants lose rights, privileges, or other services if abstinence is not maintained.	Participants are not required to abstain from alcohol and/or drugs, but staff work with participants to achieve abstinence not recognizing other alternatives that reduce harm.	Participants are not required to abstain from alcohol and/or drugs and staff work with participants to reduce the negative consequences of use according to principles of harm reduction.
17.	Motivational Interviewing. Extent to which program staff use motivational interviewing in all aspects of interaction with program participants.	Program staff are not at all familiar with motivational interviewing.	Program staff are somewhat familiar with principles of motivational interviewing.	Program staff are very familiar with principles of motivational interviewing, but it is not used consistently in daily practice.	Program staff are very familiar with principles of motivational interviewing and it is used consistently in daily practice.
18.	Assertive Engagement. Program uses an array of techniques to engage consumers who are difficult to engage, including (1) motivational interventions to engage consumers in a more collaborative manner, and (2) therapeutic limit-setting interventions where necessary, with a focus on instilling autonomy as quickly as possible. In addition to applying this range of interventions, (3) the program has a thoughtful process for identifying the need for	Team only uses #1 OR #2.	A more limited array of assertive engagement strategies are used for engagement (partial #1 and #2). Systematic identification is lacking (#3 absent).	Team uses #1 and #2. Team does not systematically identify the need for various types of engagement strategies (#3 absent).	Team systematically uses assertive engagement strategies by applying all 3 principles (see under definition)

ITEM	CRITERION	1	2	3	4
	assertive engagement, measuring the effectiveness of these techniques, and modifying approach where necessary.				
19.	Absence of Coercion. Extent to which the program does not engage in coercive activities towards participants.	Program routinely uses coercive activities with participants such as leveraging housing or services to promote adherence to clinical provisions or having excessive intrusive surveillance of participants.	Program sometimes uses coercive activities with participants and there is no acknowledgment that these practices conflict with participant autonomy and principles of recovery.	Program sometimes uses coercive activities with participants, but staff acknowledge that these practices may conflict with participant autonomy and principles of recovery.	Program does not use coercive activities such as leveraging housing or services to promote adherence to clinical provisions or having excessive intrusive surveillance with participants.
20.	Person-Centered Planning. Program conducts person-centered planning, including: 1) development of formative treatment plan ideas based on discussions driven by the participant's goals and preferences, 2) conducting regularly scheduled treatment planning meetings, 3) actual practices reflect strengths and resources identified in the assessment	Less than 55% of treatment plans and updates satisfy all 3 criteria.	55 - 69% of treatment plans and updates satisfy all 3 criteria.	70 - 84% of treatment plans and updates satisfy all 3 criteria.	At least 85% of treatment plans and updates satisfy all 3 criteria.
21	Interventions Target a Broad Range of Life Goals. The program systematically delivers specific interventions to address a range of life areas (e.g., physical health, employment, education, housing satisfaction, social support, spirituality, recreation & leisure, etc.)	Interventions do not target a range of life areas.	Program is not systematic in delivering interventions that target a range of life areas.	Program delivers interventions that target a range of life areas but in a less systematic manner.	Program systematically delivers interventions that target a range of life areas.
22	Participant Self-Determination and Independence. Program increases participants' independence and	Program directs participants decisions and manages day-to-day activities to a great extent that clearly undermines	Program provides a high level of supervision and participants' day-to-day choices are not very meaningful.	Program generally promotes participants' self-determination and independence.	Program is a strong advocate for participants' self-determination and independence in day-to-day activities.

ITEM	CRITERION	1	2	3	4
	self-determination by giving them choices and honoring day-to-day choices as much as possible (i.e., there is a recognition of the varying needs and functioning levels of participants, but level of oversight and care is commensurate with need, in light of the goal of enhancing self-determination).	promoting participant self-determination and independence OR program does not actively work with participants to enhance self-determination, nor do they provide monitoring or supervision.			
SERVICE ARRAY					
23.	Housing Support. Extent to which program offers services to help participants maintain housing, such as offering assistance with neighborhood orientation, landlord relations, budgeting and shopping.	Program does not offer any housing support services.	Program offers some housing support services during move-in, such as neighborhood orientation, shopping, but no follow-up or ongoing services are available.	Program offers some ongoing housing support services including assistance with neighborhood orientation, landlord relations, budgeting, and shopping but does not offer any property management services, assistance with rent payment, and co-signing of leases.	Program offers ongoing housing support services including assistance with neighborhood orientation, landlord relations, budgeting, shopping, property management services, assistance with rent payment, and co-signing of leases.
24.	Psychiatric Services. Psychiatric services are directly provided by the program.	Less than 55% of consumers have a psychiatric prescriber on staff complete at least monthly assessment of consumers' symptoms and response to medications, including side effects (5 in 6 months)	55 - 69% of consumer have a psychiatric prescriber on staff complete at least monthly assessment of consumers' symptoms and response to medications, including side effects (5 in 6 months)	70 - 84% of consumers have a psychiatric prescriber on staff complete at least monthly assessment of consumers' symptoms and response to medications, including side effects (5 in 6 months)	85% or more of consumers have a psychiatric prescriber on staff complete at least monthly assessment of consumers' symptoms and response to medications, including side effects (at least 5 in 6 months)
25.	Integrated, Stage-wise Substance Use Treatment. Integrated, stage-wise substance use treatment is directly provided by the program. Core services include: (1) systematic and integrated screening and assessment; interventions tailored to those in (2) early stages of change readiness (e.g.,	Less than 55% of consumers in need of treatment are receiving them from the team.	55 - 69% of consumers in need of treatment are receiving them from the team.	70 - 84% of consumers in need of treatment are receiving them from the team.	85% or more of consumers in need of substance abuse treatment are receiving team integrated, stage-wise treatment; both 1 & 2 or 1 & 3 from the following: (1) systematic and integrated screening and assessment; interventions tailored to those in (2) early stages of change readiness (e.g., outreach,

ITEM	CRITERION	1	2	3	4
	outreach, motivational interviewing) and (3) later stages of change readiness (e.g., CBT, relapse- prevention).				motivational interviewing) and (3) later stages of change readiness (e.g., CBT, relapse-prevention).
26.	Supported Employment Services. Extent to which supported employment services are provided directly by the program. Core services include: (1) engagement and vocational assessment; (2) rapid job search and placement based on participants' preferences (including going back to	Less than 55% of consumers in need of services are receiving them from the team. (receiving 1 & 2 or 1 & 3)	55- 69% of consumers in need of services are receiving them from the team. (receiving 1 & 2 or 1 & 3)	70 - 84% of consumers in need of services are receiving them from the team. (receiving 1 & 2 or 1 & 3)	85% or more of consumers in need of services received supported employment services. (receiving 1 & 2 or 1 & 3)
27.	Nursing Services. Extent to which nursing services are provided directly by the program. Core services include: (1) managing participants' medication, administering & documents medication treatment; (2) screening consumers for medical problems/ side effects; (3) communicating & coordinating services with other medical providers; (4) engaging in health promotion, prevention, & education activities (i.e., assess for risky behaviors & attempt behavior change)	Less than 55% of consumers in need of services are receiving them from the team. (At least 3 services)	55 - 69% of consumers in need of services are receiving them from the team. (At least 3 services)	70 - 84% of consumers in need of services are receiving them from the team. (At least 3 services)	85% or more of consumers in need of nursing services are receiving them from the program. (At least 3 services)
28.	Social Integration. Extent to which services supporting social integration are provided directly by the program. 1) Facilitating access to and helping participants develop valued social roles	Less than 55% of consumers in need of services are receiving support for social integration. (At least 2 services)	55- 69% of consumers in need of services are receiving support for social integration. (At least 2 services)	70- 84% of consumers in need of services are receiving support for social integration. (At least 2 services)	85% of consumers in need of services are receiving support for social integration. (At least 2 services)

ITEM	CRITERION	1	2	3	4
	and networks within and outside the program, 2) helping participants develop social competencies to successfully negotiate social relationships, 3) enhancing citizenship and participation in social and political venues.				
29.	24-hour Coverage. Extent to which program responds to psychiatric or other crises 24-hours a day.	Program has no responsibility for handling crises after hours and offers no linkages to emergency services.	Program does not respond during off-hours by phone, but links participants to emergency services for coverage.	Program responds during off-hours by phone, but less than 24 hours a day, and links participants to emergency services as necessary.	Program responds 24-hours a day by phone directly and links participants to emergency services as necessary.
30.	Involved in In-Patient Treatment. Program is involved in inpatient treatment admissions and works with inpatient staff to ensure proper discharge.	Program is involved in less than 55% of inpatient admissions and discharges.	Program is involved in 55 - 69% of inpatient admissions and discharges.	Program is involved in 70 - 84% of inpatient admissions and discharges.	Program is involved in 85% or more of inpatient admissions and discharges.
PROGRAM STRUCTURE					
31.	Priority Enrollment for Individuals with Obstacles to Housing Stability. Extent to which program prioritizes enrollment for individuals who experience multiple obstacles to housing stability.	Program has many rigid participant exclusion criteria such as substance use, symptomatology, criminal justice involvement, and behavioral difficulties, and there are no exceptions made.	Program has many participant exclusion criteria such as substance use, symptomatology, criminal justice involvement, and behavioral difficulties, but exceptions are possible.	Program selects participants with multiple disabling conditions, but has some minimal exclusion criteria.	Program selects participants who fulfill criteria of multiple disabling conditions including 1) homelessness, 2) severe mental illness and 3) substance use.
32.	Contact with Participants. Extent to which program has a minimal threshold of non-treatment related contact with participants.	Program meets with less than 60% of participants 4 times a month face-to-face.	Program meets with 60 - 74% of participants 4 times a month face-to-face.	Program meets with 75 - 89% of participants at least 4 times a month face-to-face.	Program meets with 90% of participants at least 4 times a month face-to-face.
33.	Low Participant/ Staff Ratio. Extent to which program consistently maintains a low participant/ staff ratio, excluding the psychiatrist & administrative support.	36 or more participants per 1 FTE staff.	21-35 participants per 1 FTE staff.	11-20 participants per 1 FTE staff.	10 or fewer participants per 1 FTE staff.

ITEM	CRITERION	1	2	3	4
34.	Team Approach. Extent to which program staff function as a multidisciplinary team; clinicians know and work with all program participants.	Fewer than 20% of participants have face-to-face contacts with at least 3 staff members in 4 weeks.	20 - 49% of participants have face-to-face contacts with at least 3 staff members in 4 weeks.	50 - 79% of participants have face-to-face contacts with at least 3 staff members in 4 weeks.	80% or more of participants have face-to-face contacts with at least 3 staff members in 4 weeks.
35.	Frequent Meetings. Extent to which program staff meet frequently to plan and review services for each program participant.	Program meets less than once a week.	Program meets 1 day per week.	Program meets 2 - 3 days per week.	Program meets at least 4 days per week and reviews each participant each time, even if only briefly.
36.	Daily Meeting (Quality): The program uses its daily organizational program meeting to: (1) Conduct a brief, but clinically-relevant review of all participants & contacts in the past 24 hours AND (2) record status of all participants. Program develops a daily staff schedule based on: (3) Weekly Consumer Schedules; (4) emerging needs, AND (5) need for proactive contacts to prevent future crises; (6) Staff are held accountable for follow-through.	Meeting fully serves 3 of the functions.	Meeting fully serves 4 of the functions.	Meeting fully serves 5 of the functions.	Daily team meeting fully serves all 6 functions (see under definition).
37.	Peer Specialist on Staff. The program has at least 1.0 FTE staff member who meets local standards for certification as a peer specialist. If peer certification is unavailable locally, minimal qualifications include the following: (1) self-identifies as an individual with a serious mental illness who is currently or formerly a recipient of mental health services; (2) is in the	0.25 FTE to 0.49 FTE peer specialist who meets minimal qualifications.	0.50 FTE to 0.74 FTE peer specialist who meets minimal qualifications OR at least 1.0 FTE peer specialist with inadequate qualifications OR more than 2 peer specialists fill the 1.0 FTE.	0.75 FTE to 0.99 FTE peer specialist who meets minimal qualifications. No more than 2 Peer Specialists fill the 1.0 FTE.	At least 1.0 FTE peer specialist who meets minimal qualifications and has full professional status on the team. No more than 2 Peer Specialists fill the 1.0 FTE.

HOUSING FIRST AND ACM

ITEM	CRITERION	1	2	3	4
	process of his/her own recovery; and (3) has successfully completed training in wellness and recovery interventions. Peer specialist has full professional status on the team.				
38.	Participant Representation in Program. Extent to which participants are represented in program operations and have input into policy.	Program does not offer any opportunities for participant input into the program (0 modalities).	Program offers few opportunities for participant input into the program (1 modality for input).	Program offers some opportunities for participant input into the program (2 modalities for input).	Program offers opportunities for participant input, including on committees, as peer advocates, and on governing bodies (3 modalities).
HOUSING CHOICE & STRUCTURE					
1.	Housing Choice. Program participants choose the location and other features of their housing.	Participants have no choice in the location, decorating, furnishing, or other features of their housing and are assigned a unit.	Participants have little choice in location, decorating, and furnishing, and other features of their housing.	Participants have some choice in location, decorating, furnishing, and other features of their housing.	Participants much choice in location, decorating, furnishing, and other features of their housing.
2.	Housing Availability. Extent to which program helps participants move quickly into units of their choosing.	Less than 54% of program participants move into a unit of their choosing within 3 months.	55 - 69% of program participants move into a unit of their choosing within 3 months.	70 - 84% of program participants move into a unit of their choosing within 3 months.	85% of program participants move into a unit of their choosing within 3 months.
3.	Permanent Housing Tenure. Extent to which housing tenure is assumed to be permanent with no actual or expected time limits, other than those defined under a standard lease or occupancy	There are rigid time limits on the length of stay in housing such that participants are expected to move by a certain date or the housing is considered emergency, short-term, or transitional.	There are standardized time limits on housing tenure, such that participants are expected to move when standardized criteria are met.	There are individualized time limits on housing tenure, such that participants can stay as long as necessary, but are expected to move when certain criteria are met.	There are no expected time limits on housing tenure, although the lease agreement may need to be renewed periodically.
4.	Affordable Housing. Extent to which participants pay a reasonable amount of their income for housing costs.	Participants pay 61% or more of their income for housing costs.	Participants pay 46-60% or less of their income for housing costs.	Participants pay 31-45% or less of their income for housing costs.	Participants pay 30% or less of their income for housing costs.

ITEM	CRITERION	1	2	3	4
5.	Integrated Housing. Extent to which program participants live in scatter-site private market housing which is otherwise available to people without psychiatric or other disabilities.	Participants do not live in private market housing, access is determined by disability and 100% of the units in a building are leased by the program.	Participants live in private market housing where may or may not be determined by disability, and more than 40% of the units in a building are leased by the program.	Participants live in private market housing where access is not determined by disability and 21 - 40% of the units in a building are leased by the program.	Participants live in private market housing where access is not determined by disability and less than 20% of the units in a building are leased by the program.
6.	Privacy. Extent to which program participants are expected to share living spaces, such as bathroom, kitchen, or dining room with other tenants.	Participants are expected to share all living areas with other tenants, including a bedroom.	Participants have their own bedroom, but are expected to share living areas such as bathroom, kitchen, dining room, and living room with other tenants.	Participants have their own bedroom and bathroom, but are expected to share living areas such as a kitchen, dining room, and living room with other tenants.	Participants are not expected to share any living areas with other tenants.
SEPARATION OF HOUSING & SERVICES					
7.	No Housing Readiness. Extent to which program participants are not required to demonstrate housing readiness to gain access to housing units.	Participants have access to housing only if they have successfully completed a period of time in transitional housing or outpatient/inpatient/residential treatment.	Participants have access to housing only if they meet many readiness requirements such as sobriety, abstinence from drugs, medication compliance, symptom stability, or no history of violent behavior or involvement in the criminal justice system.	Participants have access to housing with minimal readiness requirements, such as willingness to comply with program rules or a treatment plan that addresses sobriety, abstinence, and medication compliance.	Participants have access to housing with no requirements to demonstrate readiness, other than agreeing to meet with staff face-to-face three times a month.
8.	No Program Contingencies of Tenancy. Extent to which continued tenancy is not linked in any way with adherence to clinical, treatment, or service provisions.	Participants can keep housing only by meeting many requirements for continued tenancy, such as sobriety, abstinence from drugs, medication compliance, symptom stability, no violent behavior, or involvement in the criminal justice system.	Participants can keep housing with some requirements for continued tenancy such as compliance with their treatment plan and meeting individual clinical or behavioral standards.	Participants can keep housing with minimal requirements for continued tenancy, such as participation in formal services or treatment activities (attending groups, seeing a psychiatrist).	Participants can keep their housing with no requirements for continued tenancy, other than adhering to a standard lease and seeing staff for a face-to-face visit 3 times a month.
9.	Standard Tenant Agreement. Extent to which program participants have legal rights to the unit with no special provisions added to the lease or occupancy agreement.	Participants have no written agreement specifying the rights and responsibilities of tenancy and have no legal recourse if asked to leave their housing.	Participants have a written agreement (such as a lease or occupancy agreement) which specifies the rights and responsibilities of tenancy, but contains special provisions regarding adherence	Participants have a written agreement (such as a lease or occupancy agreement) which specifies the rights and responsibilities of tenancy, but contains special provisions regarding adherence	Participants have a written agreement (such as a lease or occupancy agreement) which specifies the rights and responsibilities of typical tenants in the community and contains no special provisions other than

ITEM	CRITERION	1	2	3	4
			to clinical provisions (e.g., medication compliance, sobriety, treatment plan).	to program rules (e.g., requirements for being in housing at certain times, no overnight visitors).	agreeing to meet with staff three times a month.
10.	Commitment to Re- House. Extent to which the program offers participants who have lost their housing access to a new housing unit.	Program does not offer participants who have lost their housing a new housing unit nor assist with finding housing outside the program.	Program does not offer participants who have lost housing a new unit, but assists them to find housing outside the program.	Program offers participants who have lost their housing a new unit, but only if they meet readiness requirements, complete a period of time in more supervised housing, or the program has set limits on the number of relocations.	Program offers participants who have lost their housing a new unit without requiring them to demonstrate readiness and has no set limits on the number of possible relocations.
11.	Services Continue Through Housing Loss. Extent to which program participants continue receiving services even if they lose housing.	Participants are discharged from program services if they lose housing for any reason. (Services are contingent on staying in housing)	Participants are discharged from services if they lose housing, but there are explicit criteria specifying options for re- enrollment, such as completing a period of time in inpatient treatment.	Participants continue to receive program services if they lose housing, but may be discharged if they do not meet "housing readiness" criteria.	Participants continue to receive program services even if they lose housing due to eviction, short- term inpatient treatment, although there may be a service hiatus during institutional stays.
12.	Off-site, Mobile Services. Extent to which social and clinical service providers are not located at participant's residences and are mobile.	Social and clinical service providers are based on- site 24/7, and have limited or no mobility to deliver services at locations of participants' choosing.	Social and clinical service providers are based off- site or on-site during the day and have limited mobility to deliver services at locations of participants' choosing.	Social and clinical service providers are based off- site, but maintain an office on-site, and are capable of providing mobile services to locations of participants' choosing.	Social and clinical service providers are based off- site, do not maintain an office on-site, but are capable of providing mobile services to locations of participants' choosing.
SERVICE PHILOSOPHY					
13.	Service choice. Extent to which program participants choose the type, sequence, and intensity of services on an ongoing basis.	Services are chosen by the service provider with no input from the participant.	Participants have little say in choosing, modifying, or refusing services.	Participants have some say in choosing, modifying, or refusing services and supports, but program staff determinations usually prevail.	Participants have the right to choose, modify, or refuse services and supports at any time, except three face-to-face visits with staff a month.
14.	No requirements for participation in psychiatric treatment. Extent to which program participants with psychiatric disabilities are not required to take medication or participate in psychiatric treatment.	All participants with psychiatric disabilities are required to take medication and participate in psychiatric treatment.	Participants with psychiatric disabilities are required to participate in mental health treatment such as attending groups or seeing a psychiatrist and are required to take medication but exceptions are made.	Participants with psychiatric disabilities who have not achieved a specified period of symptom stability are required to participate in mental health treatment, such as attending groups or seeing a psychiatrist.	Participants with psychiatric disabilities are not required to take medication or participate in formal treatment activities.

ITEM	CRITERION	1	2	3	4
15.	No requirements for participation in substance use treatment. Extent to which participants with substance use disorders are not required to participate in treatment.	All participants with substance use disorders, regardless of current use or abstinence, are required to participate in substance use treatment (e.g., inpatient treatment, attend groups or counseling with a substance use specialist).	Participants who are using substances or who have not achieved a specified period of abstinence must participate in substance use treatment.	Participants with substance use disorders whose use has surpassed a threshold of severity must participate in substance use treatment.	Participants with substance use disorders are not required to participate in substance use treatment.
16.	Harm Reduction Approach. Extent to which program utilizes a harm reduction approach to substance use.	Participants are required to abstain from alcohol and/or drugs at all times and lose rights, privileges, or services if abstinence is not maintained.	Participants are required to abstain from alcohol and/or drugs while they are on-site in their residence or participants lose rights, privileges, or other services if abstinence is not maintained.	Participants are not required to abstain from alcohol and/or drugs, but staff work with participants to achieve abstinence not recognizing other alternatives that reduce harm.	Participants are not required to abstain from alcohol and/or drugs and staff work with participants to reduce the negative consequences of use according to principles of harm reduction.
17.	Motivational Interviewing. Extent to which program staff use motivational interviewing in all aspects of interaction with program participants.	Program staff are not at all familiar with motivational interviewing.	Program staff are somewhat familiar with principles of motivational interviewing.	Program staff are very familiar with principles of motivational interviewing, but it is not used consistently in daily practice.	Program staff are very familiar with principles of motivational interviewing and it is used consistently in daily practice.
18.	Assertive Engagement. Program uses an array of techniques to engage difficult-to-treat consumers, including (1) motivational interventions to engage consumers in a more collaborative manner, and (2) therapeutic limit-setting interventions where necessary, with a focus on instilling autonomy as quickly as possible. In addition to applying this range of interventions, (3) the program has a thoughtful process for identifying the need for assertive engagement,	Team only uses #1 OR #2.	A more limited array of assertive engagement strategies are used for engagement (partial #1 and #2). Systematic identification is lacking (#3 absent).	Team uses #1 and #2. Team does not systematically identify the need for various types of engagement strategies (#3 absent).	Team systematically uses assertive engagement strategies by applying all 3 principles (see under definition)

ITEM	CRITERION	1	2	3	4
	measuring the effectiveness of these techniques, and modifying approach where necessary.				
19.	Absence of Coercion. Extent to which the program does not engage in coercive activities towards participants.	Program routinely uses coercive activities with participants such as leveraging housing or services to promote adherence to clinical provisions or having excessive intrusive surveillance of participants.	Program sometimes uses coercive activities with participants and there is no acknowledgment that these practices conflict with participant autonomy and principles of recovery.	Program sometimes uses coercive activities with participants, but staff acknowledge that these practices may conflict with participant autonomy and principles of recovery.	Program does not use coercive activities such as leveraging housing or services to promote adherence to clinical provisions or having excessive intrusive surveillance with participants.
20.	Person-Centered Planning. Program conducts person-centered planning, including: 1) development of formative treatment plan ideas based on discussions driven by the participant's goals and preferences, 2) conducting regularly scheduled treatment planning meetings, 3) actual practices reflect strengths and resources identified in the assessment	Less than 54% of treatment plans and updates satisfy all 3 criteria.	55 - 69% of treatment plans and updates satisfy all 3 criteria.	70 - 84% of treatment plans and updates satisfy all 3 criteria.	At least 85% of treatment plans and updates satisfy all 3 criteria.
21.	Interventions Target a Broad Range of Life Goals. The program systematically delivers or brokers specific interventions to address a range of life areas (e.g., physical health, employment, education, housing satisfaction, social support, spirituality, recreation & leisure, etc.)	Delivered or brokered interventions do not target a range of life areas.	Program is not systematic in delivering or brokering interventions that target a range of life areas.	Program delivers or brokers interventions that target a range of life areas but in a less systematic manner.	Program systematically delivers or brokers interventions that target a range of life areas.

ITEM	CRITERION	1	2	3	4
22.	<p>Participant Self-Determination and Independence. Program increases participants' independence and self-determination by giving them choices and honoring day-to-day choices as much as possible (i.e., there is a recognition of the varying needs and functioning levels of participants, but level of oversight and care is commensurate with need, in light of the goal of enhancing self-determination).</p>	<p>Program directs participants decisions and manages day-to-day activities to a great extent that clearly undermines promoting participant self-determination and independence</p> <p>OR</p> <p>program does not actively work with participants to enhance self-determination, nor do they provide monitoring or supervision.</p>	<p>Program provides a high level of supervision and participants' day-to-day choices are not very meaningful.</p>	<p>Program generally promotes participants' self-determination and independence.</p>	<p>Program is a strong advocate for participants' self-determination and independence in day-to-day activities.</p>
SERVICE ARRAY					
23.	<p>Housing Support Extent to which program offers services to help participants maintain housing, such as offering assistance with neighborhood orientation, landlord relations, budgeting and shopping.</p>	<p>Program does not offer any housing support services.</p>	<p>Program offers some housing support services during move-in, such as neighborhood orientation, shopping, but no follow-up or ongoing services are available.</p>	<p>Program offers some ongoing housing support services including assistance with neighborhood orientation, landlord relations, budgeting, and shopping but does not offer any property management services, assistance with rent payment, and co-signing of leases.</p>	<p>Program offers ongoing housing support services including assistance with neighborhood orientation, landlord relations, budgeting, shopping, property management services, assistance with rent payment, and co-signing of leases.</p>
24.	<p>Psychiatric Services. Program successfully links participants who need psychiatric support with a psychiatrist in the community. (documentation evidences participant received services or program routinely attempted engagement within the last 6 months)</p>	<p>Program successfully links less than 54% of participants who need psychiatric support with a psychiatrist.</p>	<p>Program successfully links 55 - 69% of participants who need psychiatric support with a psychiatrist.</p>	<p>Program successfully links 70 - 84% of participants who need psychiatric support with a psychiatrist.</p>	<p>Program successfully links 85% or more of participants who need psychiatric support with a psychiatrist.</p>
25.	<p>Integrated, Stage-wise Substance Use Treatment. Program successfully links participants who need substance use</p>	<p>Program successfully links less than 54% of consumers in need of substance abuse treatment with agencies that provide</p>	<p>Program successfully link 55 - 69% of consumers in need of substance abuse treatment</p>	<p>Program successfully links 70 - 84% or more of consumers in need of substance abuse treatment with agencies that provide</p>	<p>Program successfully links 85% or more of consumers in need of substance abuse treatment with agencies that provide such</p>

ITEM	CRITERION	1	2	3	4
	treatment with such treatment community. (documentation evidences participant received services or program routinely attempted engagement within the last 6 months)	such treatment.		such treatment.	treatment.
26.	Supported Employment Services. Supported employment services are provided directly or brokered by the program. Core services include: (1) engagement and vocational assessment; (2) rapid job search and placement based on participants' preferences (including going back to school, classes); & (3) job coaching & follow-along supports (including supports in academic settings).	Less than 30% of consumers in need of services are receiving them from the team (receiving 1 & 2 or 1 & 3).	30 - 44% of consumers in need of services are receiving them from the team (receiving 1 & 2 or 1 & 3).	45 - 59% of consumers in need of services are receiving them from the team (receiving 1 & 2 or 1 & 3).	60% or more of consumers in need of services received supported employment services (receiving 1 & 2 or 1 & 3).
27.	Nursing/Medical care. Program successfully links participants who need medical care with a physician or clinic in the community. (documentation clearly evidences participant received services or program routinely attempted engagement within the last 6 months)	Program successfully links less than 54% of participants who need medical care with a physician or clinic.	Program successfully links 55-69% of participants who need medical care with a physician or clinic.	Program successfully links 70 - 84% of participants who need medical care with a physician or clinic.	Program successfully links 85% or more of participants who need medical care with a physician or clinic.
28.	Social Integration. Extent to which services supporting social integration are provided directly by the program. 1) Facilitating access to and helping participants develop valued social roles and networks within and outside the	Less than 54% of consumers in need of services are receiving support for social integration. (At least 1 service)	55 - 69% of consumers in need of services are receiving support for social integration. (At least 1 service)	70 - 84% of consumers in need of services are receiving support for social integration. (At least 1 service)	85% of consumers in need of services are receiving support for social integration. (At least 1 service)

ITEM	CRITERION	1	2	3	4
	program, 2) helping participants develop social competencies to successfully negotiate social relationships, 3) enhancing citizenship and participation in social and political venues.				
29.	24-hour Coverage. Extent to which program responds to psychiatric or other crises 24-hours a day.	Program has no responsibility for handling crises after hours and offers no linkages to emergency services.	Program does not respond during off-hours by phone, but links participants to emergency services for coverage.	Program responds during off-hours by phone, but less than 24 hours a day, and links participants to emergency services as necessary.	Program responds 24- hours a day by phone directly and links participants to emergency services as necessary.
30.	Involved in In-Patient Treatment. Program is involved in inpatient treatment admissions and works with inpatient staff to ensure proper discharge.	Program is involved in less than 55% of inpatient admissions and discharges.	Program is involved in 55 - 69% of inpatient admissions and discharges.	Program is involved in 70 - 84% of inpatient admissions and discharges.	Program is involved in 85% or more of inpatient admissions and discharges.
30A.	Professional Networking. Program successfully builds professional connections with a range of institutions and providers to facilitate access to treatment and services.	Program has no established relationships with agencies or staff are not knowledgeable as to what community resources are available to their participants.	Program has few established relationships with agencies and/or referrals are very infrequent.	Program has established relationships with agencies but does not routinely make referrals.	Program has established relationships with agencies that provide a vast array of services and routinely makes referrals.
PROGRAM STRUCTURE					
31.	Priority Enrollment for Individuals with Obstacles to Housing Stability. Extent to which program prioritizes enrollment for individuals who experience multiple obstacles to housing stability.	Program has many rigid participant exclusion criteria such as substance use, symptomatology, criminal justice involvement, and behavioral difficulties, and there are no exceptions made.	Program has many participant exclusion criteria such as substance use, symptomatology, criminal justice involvement, and behavioral difficulties, but exceptions are possible.	Program selects participants with multiple disabling conditions, but has some minimal exclusion criteria.	Program selects participants who fulfill criteria of multiple disabling conditions including 1) homelessness, 2) severe mental illness and 3) substance use.
32.	Low Participant/ Staff Ratio. Extent to which program consistently maintains a low participant/ staff ratio, excluding the psychiatrist & administrative support.	50 or more participants per 1 FTE staff.	36-49 participants per 1 FTE staff.	21-35 participants per 1 FTE staff.	20 or fewer participants per 1 FTE staff.

ITEM	CRITERION	1	2	3	4
33.	Contact with Participants. Extent to which program has a minimal threshold of non-treatment related contact with participants.	Program meets with less than 60% of participants 3 times a month face-to-face.	Program meets with 60 - 74% of participants 3 times a month face-to-face.	Program meets with 75 - 89% of participants at least 3 times a month face-to-face.	Program meets with 90% of participants at least 3 times a month face-to-face.
34.	Team Approach. Extent to which program staff function as a multidisciplinary team; clinicians know and work with all program participants.	N/A	N/A	N/A	N/A
35.	Frequent Meetings. Extent to which program staff meet frequently to plan and review services for each program participant.	Program meets at least once every two weeks but does not review each participant each time, or meets less than once a week.	Program meets at least once every two weeks and reviews each participant each time, and conducts case conferences.	Program meets at least once a week, but does not review each participant each time, and conducts case conferences monthly.	Program meets at least once a week and reviews each participant each time, even if only briefly, and conducts case conferences monthly.
36.	Weekly Meeting (Quality): The program uses its weekly organizational program meeting to: (1) Conduct a high level overview of each participant, where they are at and next steps (2) a detailed review of participants who are not doing well in meeting their goals (3) review of one success from the past week and (4) program updates and (5) discuss health and safety issues and strategies	Meeting fully serves 3 of the functions.	Meeting fully serves 4 of the functions.	Meeting fully serves 5 of the functions.	Weekly team meeting fully serves all 6 functions (see under definition).
37.	Peer Specialist on Staff. The program has at least 1.0 FTE staff member who meets local standards for certification as a peer specialist.	N/A	N/A	N/A	N/A
38.	Participant Representation in Program. Extent to which participants are represented in program operations and have input into policy.	Program does not offer any opportunities for participant input into the program (0 modalities).	Program offers few opportunities for participant input into the program (1 modality for input).	Program offers some opportunities for participant input into the program (2 modalities for input).	Program offers opportunities for participant input, including on committees, as peer advocates, and on governing bodies (3 modalities).

At Home/Chez Soi Fidelity Visits - Consumer Focus Group Facilitator Guide

CRITERION SECTION	OPENING PROBE	FOLLOW-UP	CRITERION
Housing Choice and Structure	How did you decide where you would live?	<ol style="list-style-type: none"> 1. How quickly did you find an apartment 2. What is your apartment like 3. How long can you stay in your present apartment 4. How affordable is the rent 	<ul style="list-style-type: none"> • Housing Choice • Housing Availability - program helps participants to move quickly • Housing Availability - move in 4 weeks of receiving a housing voucher • Permanent Housing Tenure • Affordable Housing • Integrated housing • Privacy - shared space or self-contained unit
Separation of Housing and Services	What did you have to do in order to get your housing?	<ol style="list-style-type: none"> 1. Who has read their lease 2. Who has had more than one apartment since they joined the program 3. Where do you meet with staff 	<ul style="list-style-type: none"> • No housing readiness • No program contingencies of continued tenancy • Standard tenant agreement - no special provisions added to the lease • Commitment to re-house • Services continue through housing loss • Off-site mobile services
Service Philosophy	How did you decide what to work on in the program?	<ol style="list-style-type: none"> 1. What are you working on 2. What does the program do if staff do not like the choices you make 3. How do you work with the psychiatrist 4. How do decide where you will meet with staff 	<ul style="list-style-type: none"> • Service choice • No requirements for part. in psych. treatment • No requirements for participation in substance use treatment • Harm reduction approach • Assertive engagement • Absence of coercion • Person-centred planning • Interventions target a broad range of life goals • Participant self-determination and independence
Service Array	How does the program help you to create a successful tenancy?	<ol style="list-style-type: none"> 1. What help are you given in your relationships with family, friends and neighbours 2. How do staff respond when you want to drink and/or use street drugs 3. How are staff available if you need them 4. How are you looking for work 	<ul style="list-style-type: none"> • Housing support • Psychiatric services • Integrated, stage wise substance use treatment • Supported employment services • Nursing services • Social integration • 24-hour coverage • Involved in in-patient treatment
Program Structure	What opportunities are there for you to give advice and feedback into the program?	<ol style="list-style-type: none"> 1. How often do you see staff, what's it like 2. Who works with you 	<ul style="list-style-type: none"> • Contact with participants • Team approach • Participant Representation in Program

HOUSING FIRST FIDELITY PROPOSED PROTOCOL SUMMARY: DRAFT

Please note that, generally, all items below apply to both ACT and ICM programs, unless specified "For ACT" or "For ICM".

I. Prior to Site Visit

Programs will be asked to provide the following materials, as available, related to general program information two weeks prior to the fidelity visit:

- Program Mission Statement
- Program Housing Procedures Manual or related document
- Program Clinical Procedures Manual or related document
- Sample Lease Agreement for each type of housing offered
- Sample Client Program Orientation Materials
- Sample Treatment Plan or Sample Service Plan
- Sample Progress Note
- Sample Client Contact Log
- Sample Client Weekly/Monthly Schedule
- Any other documents that describe the program, housing, or clinical services.

Programs will be asked to provide the following data two weeks prior to the fidelity visit:

- Roster of Staff (including psychiatrist) with roles and full-time equivalents, and positions that are not currently filled
- List of clients (initials only) that have terminated from the program since start-up and general reason for leaving:
 - Graduated (left because of significant improvement or reduced need for services)
 - Transferred to a more restrictive service setting (e.g., hospital, nursing home)
 - Left geographic area (indicate whether the client left with or without good referrals/linkages elsewhere)
 - Case close because they refused services or team cannot find them
 - Deceased
 - Other (explain)
- List of clients (initials only) who have changed housing since entering the program (e.g., moved after having received their first unit in the program)
- A list of 10 clients (initials only) who represent the last 10 inpatient psychiatric or substance abuse treatment admissions or discharges
- Roster of All Active Clients (initials only) with the following information:
 - Date of Intake into Program and Date of Move-In
 - Housing Type (e.g., single-site apartment, scatter-site apartment, board and care, etc.)
 - Diagnosis of Substance Use disorder and whether currently using substances
 - For ACT only, whether client is receiving services outside the ACT team (e.g., day treatment)

- For ICM only, list of agencies/programs to which they refer clients for:
 - Mental Health / Psychiatric Treatment
 - Substance Abuse Treatment
 - Nursing / Medical Services
 - Vocational / Employment Services
 - Social Support / Social Integration Services

II. Day of Fidelity Site Visit

Fidelity Overview (20-30 minutes)

- Program staff and fidelity personnel introductions Brief overview of fidelity visit
- Opportunity for program staff Q & A

Observe Team / Program Meeting (60 minutes)

- ACT: Fidelity staff will observe a daily team meeting.
- ICM: Fidelity staff will observe a weekly program meeting and ask staff to include a brief discussion of the 10 clients who were chosen for a chart review.

Team Leader / Program Supervisor Interview (60 minutes)

- This interview will cover all aspects of the program's housing, services, and structure.

Substance Abuse Specialist Interview (ACT) / Case Manager 1 Interview (ICM) (20-30 minutes)

- ACT: This interview will cover the program's approach to substance use and secondarily address other topics related to program services and supports.
- ICM: This interview will cover various topics related to program services and supports.

Supported Employment Interview (ACT) / Case Manager 2 Interview (ICM) (20-30 minutes)

- ACT: This interview will cover the program's approach to supported employment and secondarily address other topics related to program services and supports.
- ICM: This interview will cover various topics related to program services and supports.

Housing Specialist Interview (20-30 minutes)

- This interview will cover issues related to client housing and housing services provided by the program.

Chart Review (120 minutes)

- Fidelity staff will review the program's documentation for 10 clients (who have been admitted for at least 30 days) who will be chosen at random. For the clients chosen, we will need to see: Last 2 Treatment Plans / Service Plans and Progress Notes for the past 2 months.

Client Focus Groups (60-90 minutes)

- Fidelity staff will ask the program to schedule a focus group of approximately 6-8 clients. Clients will be asked to talk about their experiences with the program with respect to housing and services,

Team Leader Brief Follow-up (30 minutes)

- Fidelity staff will address any outstanding issues and inquire about any discrepancies.

IIA. If there is time

Observe Treatment Planning / Service Planning Meeting (30 minutes, would need to be scheduled in advance)

- Fidelity staff will observe a meeting with a client during which a treatment plan / service plan is updated or developed.

Shadow 1-2 Visits to Clients in the Community (90 minutes)

- Fidelity staff will accompany program staff on home visits to 1-2 clients to observe the housing and services delivered.

Shadow 1-2 Client Visits in the Office (30 minutes)

- Fidelity staff will observe program staff delivering services to 1-2 clients in the office.

Interview with Psychiatrist (20 minutes)

- If Psychiatrist is available, fidelity staff will conduct an interview about mental health treatment services.

III. After the Fidelity Visit

- Fidelity staff will follow up to obtain any missing data.
- Fidelity staff will provide detailed feedback report.

SAMPLE INFORMATION LETTERS AND CONSENT FORMS FOR QUALITATIVE IMPLEMENTATION EVALUATION

1. Information Letter and Consent Form for Implementation Evaluation Key Informant Interviews / Focus Groups (Site Coordinators, ACT & ICM Leads and Team Members)

Informed Consent Statement

You are invited to participate in a research study on the implementation of the Mental Health Commission of Canada Research Demonstration Project in Mental Health and Homelessness in [site name]. The purpose of this research is to understand the story of the implementation of the MHCC Homelessness and Mental Health Project in [site name], as you see it. The findings of this research will be used to inform other jurisdictions that are interested in implementing similar initiatives. The Principal Investigator for the local site is [insert name] and the Principal Investigator for the national research team is Dr. Paula Goering of the Centre for Addiction and Mental Health in Toronto. Altogether, about 100 people who were involved in implementing the “At Home” project across the five demonstration sites will participate in interviews or focus groups for this research. This includes approximately 20 people who were involved in the implementation of the [site name] initiative.

INFORMATION

This research is part of the Mental Health Commission of Canada Research Demonstration Projects in Mental Health and Homelessness, which you have been involved with in [site name]. This aspect of the research involves participation in an individual interview or a focus group with others (approximately 5-10 people) who have been involved in implementing the “At Home” project in [site name]. The interview or focus group will be conducted by a member of the local site research team. The interview will be arranged at a time and place that is convenient for you.

During the interview, the Site Researcher will ask you a number of questions about the implementation of the MHCC Homelessness and Mental Health Project in [site name]. We will give you the questions in advance so you have a chance to think about them. You are free not to answer any question or to pass on any question that is asked. Individual interviews will last for approximately one hour, and focus groups will last for approximately one and one-half to two hours. With your consent, the Site Researcher will audio record the interview. There is no deception involved in this research.

RISKS

We do not believe that you will experience any significant risks to your well-being by participating in this interview. It is possible that if involvement in implementing the project was a challenging or emotionally intense experience for you, you may find yourself recalling such challenges and emotions.

BENEFITS

We do envision significant benefits to your participation in this study. You may benefit from the opportunity to reflect on your participation in implementing the MHCC demonstration project in [site name]. Your perspectives on this project may be beneficial to other jurisdictions that are interested in implementing similar initiatives. Finally, the results of this study will make a contribution to the research literature on the ways in which Housing First programs have been conceived, planned, and implemented in different community contexts.

CONFIDENTIALITY

Your responses to the interview/focus group questions will be held confidential by the researcher. That is, your name will not be associated with anything you say during the interview or focus group. We will keep everything you say

confidential and private, and your name will not be associated in any way with your responses. A transcription of the interview or focus group will be identified by code number and stored in a locked filing cabinet to protect the confidentiality of your responses. Should you consent to the use of quotations, they may be used in write-ups and/or presentations on this research; however, the quotations will not contain any information that allows you to be identified.

All audio files of digitally recorded interviews and focus groups will be stored on a secure (password protected) server provided by the vendor Health Diaries, which is accessible only to members of the local site research team and the national research team. Transcriptions of the interviews and focus groups will be stored in a locked filing cabinet [add location - probably the office of the site researcher]. All audio files will be deleted and paper transcripts destroyed by December 31, 2016.

COMPENSATION

No compensation will be provided for your participation in the interview or focus group.

CONTACT

If you have questions at any time about the study or the procedures, or if you experience adverse effects as a result of participating in this study, you may contact the Site Researcher, [insert name and contact information]. This project has been reviewed and approved by the Research Ethics Board at [university name]. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact [insert name and contact information for local REB].

PARTICIPATION

Your participation in this study is purely voluntary and you have the right to decide that you do not want to take part in the research. Your decision to take part or to not take part will in no way affect your relationship to the MHCC Research Demonstration Projects in Mental Health and Homelessness. If you withdraw from the study, we will not transcribe any of your responses. You have the right to omit or withdraw your response to any question or procedure without penalty.

FEEDBACK AND PUBLICATION

A summary of the results of this research will be sent to you when the data have been analyzed, no later than [date]. Information from this research will be used to inform reports on the implementation of the “At Home” initiative at each of the five demonstration sites, as well as a cross-site report developed by the national research team. Additionally, we plan to present the results of the research at professional and scientific conferences and to publish the findings in professional and scientific journals.

WHERE CAN I GET ADDITIONAL HELP OR RESOURCES IF I NEED THEM?

If you have any questions concerning the collection of this information, please contact: [Site Researcher name and contact information] or [REB name and contact information for local university]

MHCC AT HOME/CHEZ SOI PROJECT RESEARCH CONSENT FORM

I have received a copy of the INFORMED CONSENT STATEMENT. I have read it or had it read to me and understand it. It describes my involvement in the research and the information to be collected from me.

I agree to participate in an interview or focus group for this research.

- Yes
- No

I agree to have the interview or focus group tape-recorded.

- Yes
- No

I understand and agree that my quotations may appear in published reports.

- Yes
- No

Participant's signature

Date

Researcher's signature

Date

2. Information Letter and Consent Form for Mental Health Commission of Canada Homelessness & Mental Health Demonstration Project – Conception Phase Research Part II

Dr. Geoffrey Nelson, Wilfrid Laurier University; Dr. Myra Piat, McGill University

Informed Consent Statement

You are invited to participate in a second part of the research study, “Mental Health Commission of Canada Homelessness & Mental Health Demonstration Project – Conception Phase Research”. The purpose of this phase of the research is to understand the perspective of the national team regarding issues related to the fidelity of programs for the MHCC At Home/Chez Soi project. The findings of this research will be used to inform other jurisdictions that are interested in planning similar initiatives. The principal researchers for this project are Dr. Geoffrey Nelson, of the Psychology Department at Wilfrid Laurier University, and Dr. Myra Piat, of the Department of Psychiatry at McGill University. Approximately 8 people who participated in the first conception phase research interview, and also conducted fidelity visits to one or more sites, will be interviewed for this research. Dr. Paula Goering of the Centre for Addiction and Mental Health in Toronto, who is the Principal Investigator of this project, suggested that you would be a key person to invite to participate in this research. Please see the attached Information Letter for further details about the study.

INFORMATION

This research is part of the Mental Health Commission of Canada Research Demonstration Projects in Mental Health and Homelessness, for which you have participated in one or more site fidelity visits. This aspect of the research involves participation in an individual interview. The interview will be conducted by a member of the project’s National Research Team. The interview will be arranged at a time and place that is convenient for you, and may be conducted via telephone.

During the interview, the researcher will ask you a number of questions about actions that were undertaken by the National Team to strengthen fidelity and the process of conducting the fidelity site visits for the MHCC Homelessness and Mental Health Project, which is being implemented in Vancouver, Winnipeg, Toronto, Montreal, and Moncton. We will give you the questions in advance so you have a chance to think about them. You are free not to answer any question or to pass on any question that is asked. The interview will last for approximately one to one-and-one-half hours. With your consent, the researcher will audio record the interview. We will not be able to interview you if you do not consent to the audio recording. There is no deception involved in the research.

RISKS

We do not believe that you will experience any significant risks to your well-being by participating in this interview. It is possible that if involvement in the fidelity visits for the project was a challenging or emotionally intense experience for you, you may find yourself recalling such challenges and emotions.

BENEFITS

We do envision significant benefits to your participation in this study. You may benefit from the opportunity to reflect on your participation in the conception phase and fidelity visits for the MHCC demonstration project. Your perspectives on the fidelity visits may be beneficial to other jurisdictions that are interested in planning similar initiatives. Finally, the results of this study will make a contribution to the research literature on the ways in which Housing First programs have been conceived, planned, and implemented in different community contexts.

CONFIDENTIALITY

Your responses to the interview questions will be held confidential by the researcher. That is, your name will not be associated with anything you say during the interview. We will keep everything you say confidential and private, and

your name will not be associated in any way with your responses. However, due to the small number of individuals being interviewed for this research, and the fact that only a few individuals conducted fidelity visits for the MHCC project, it may not be possible to present your quotations in such a way as to preserve your anonymity from people who are familiar with the project or the groups and individuals involved. We will not associate your name with any quotes from the interviews, unless you consent to having your name associated with your quotes. While you can choose not to have quotes associated with your name, we will not be able to use your interview if you do not consent to allowing us to quote you anonymously.

All audio files of digitally recorded interviews will be stored on a secure (password protected) server provided by the vendor Health Diary, which is accessible only to the following members of the National Research Team: Dr. Geoffrey Nelson, Dr. Myra Piat, Dr. Eric MacNaughton, Mr. Tim Macleod, and Ms. Rachel Caplan. Transcriptions of the interviews will be stored in a locked filing cabinet in the office of Dr. Geoffrey Nelson. All audio files will be deleted and paper transcripts destroyed by December 31, 2016.

COMPENSATION

No compensation will be provided for your participation in the interview.

CONTACT

If you have questions at any time about the study or the procedures, or if you experience adverse effects as a result of participating in this study, you may contact Dr. Myra Piat of McGill University at (514) 761-6131, extension 2521 or Dr. Geoffrey Nelson of Wilfrid Laurier University at (519) 884-0710, extension 3314. This project has been reviewed and approved by the Wilfrid Laurier University Research Ethics Board. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr. Bob Basso, Chair, rbasso@wlu.ca, University Research Ethics Board, Wilfrid Laurier University, (519) 884-0710, extension 5225.

PARTICIPATION

Your participation in this study is purely voluntary and you have the right to decide that you do not want to take part in the research. Your decision to take part or to not take part will in no way affect your relationship to the MHCC Research Demonstration Projects in Mental Health and Homelessness. If you withdraw from the study, we will not transcribe any of your responses to the interview. You have the right to omit or withdraw your response to any question or procedure without penalty.

FEEDBACK AND PUBLICATION

Information from this research will be used to inform the reports on the planning and proposal development process at each of the five demonstration sites, as well as a cross-site report developed by the national research team. Study results will be disseminated by the MHCC via a written report to participants by December, 2011. Additionally, we plan to present the results of the research at professional and scientific conferences and to publish the findings in professional and scientific journals.

WHERE CAN I GET ADDITIONAL HELP OR RESOURCES IF I NEED THEM?

If you have any questions concerning the collection of this information, please contact one of the following:

Dr. Myra Piat

Department of Psychiatry
McGill University
Verdun, QC H4H 1R3

Tel: 1-514-761-6131 ext. 2521

Email: myra.piat@douglas.mcgill.ca

Dr. Geoffrey Nelson

Department of Psychology
Wilfrid Laurier University
Waterloo, ON N2L 3C5

Tel: 1-519-884-0710, ext. 3314

Email: gnelson@wlu.ca

Dr. Bob Basso

Chair, Research Ethics Board
Wilfrid Laurier University

Tel: 1-519-884-0710 ext. 5225

Email: rbasso@wlu.ca

MENTAL HEALTH COMMISSION OF CANADA RESEARCH DEMONSTRATION PROJECTS IN MENTAL HEALTH AND HOMELESSNESS

Research Consent Form

I have received a copy of the INFORMED CONSENT STATEMENT. I have read it or had it read to me and understand it. It describes my involvement in the research and the information to be collected from me.

I agree to participate in an interview or focus group for this research.

- Yes
- No

I agree to have the interview audio tape-recorded.

- Yes
- No

I understand and agree that my quotations may appear in published reports.

- Yes
- No

I agree to have my name associated with quotations from my interview.

- Yes
- No

Participant's signature

Date

Researcher's signature

Date

PARTICIPANT OBSERVATION PROTOCOL AND INTERVIEW GUIDES FOR QUALITATIVE IMPLEMENTATION EVALUATION

Participant Observation Protocol

1. Have two people take semi-verbatim notes of proceedings (after session, combine notes into one set of field notes)

Note: it may be helpful to develop an identifying short form for each meeting participant (e.g. QA #1, #2 [for QA team members one, two, etc];, LT #1 [local team member #1])
2. Explain purpose of participant observation to meeting participants as part of the mixed methods implementation/ fidelity evaluation, we're conducting participant observation of this particular feedback session (and with the other teams) and we're taking field notes that will help us understand the reasons behind the fidelity ratings, and which will help the qualitative research team to prepare for the sessions that will be conducted with the teams and Site Coordinator in which we will further explore some of the issues that we're observing for today (as per below, we're looking at trouble spots and strengths, and getting a sense of the reasons for these, as well as any differences in perspective on them)
3. In final field notes, make particular note of:
 - Fidelity items identified as trouble spots, areas of improvement or strengths
 - Perspectives regarding why particular fidelity items are viewed as trouble spots or strengths
 - Fidelity items where there is a discrepancy in perspective between QA fidelity team and site participants (or where there is a discrepancy in perspective amongst team members)
 - Reflections on other notable issues
4. Provide copy of field notes to implementation evaluation focus group facilitator(s), and interviewer of Site Coordinator
5. Facilitators and interviewers should also be familiar with contents of the written report provided by the fidelity visit team to the site.

Key Informant Interview Guide For Later Implementation Evaluation

Thank you for attending this interview. As you know, the purpose of this interview is for you to share your knowledge about key program components of the MHCC At Home/Chez Soi project and their implementation. We believe that this is important in defining the key ingredients of this intervention and determining their fidelity. The interview will take less than one hour.

Before we get started let's review the consent form. Then you can decide if you want to participate in the interview. [\[Interviewer reviews the information letter and consent form, which can be adapted from the early qualitative evaluation of implementation, with the participant.\]](#)

What questions do you have before we begin? [\[After questions have been asked and answered, the participant is asked to complete the consent form and give it to the interviewer.\]](#)

I am now going to start the tape recorder.

The purpose of today's interview is to focus on what has changed in the implementation of the MHCC At Home/Chez Soi programs over the past year since the first fidelity/implementation evaluation, to understand the reasons for ongoing and emerging implementation successes and challenges. Also, we would like to understand any discrepancies in perspective between the Quality Assurance (QA) team's ratings, and the team's own self-ratings. A final issue we'd like to explore, is what the project has learned about the logic model of the intervention, in other words, what we're learning about the process of how the intervention is impacting on the lives of participants.

Fidelity Scale Questions

Note to interviewer: the term "trouble spot" as used below refers to a rating which is low and there is agreement between QA team fidelity rating and team self-rating; "notable improvements" are issues where there has been a significant improvement in QA team fidelity ratings between first and second rounds; and a "discrepancy" is where QA team fidelity and self-ratings differ (e.g., something assessed as an apparent trouble spot by the fidelity report, but where the team rating is higher, or vice versa).

In preparation for the discussion for this first section of the interview, the interviewer should examine the participant observation field notes, available ratings from both first and second rounds, and if necessary work with the site to identify the issues that will be explored as trouble spots, notable strengths/improvements and discrepancies.

1. Re: agreed upon trouble spots (maintained from first round and/or emerging):
 - What barriers are getting in the way of implementation? (probe and/or code: for barriers related to structure, resources, relationships, strategy/process, etc.)
 - How would you address these issues moving forward?
2. Re: notable improvements from the first round:
 - to what do you attribute the improvement? (probe and/or code for facilitators related to structure, resources, relationships, strategy/process, etc.)
3. Re: other notable strengths (maintained from the first round and/or emerging in the second round):
 - to what do you attribute this strength? (probe and/or code for facilitators related to structure, resources, relationships, strategy/process, etc.)
4. Re: discrepancies:
 - what accounts for the discrepancy? (probe: is this an adaption to context or an innovation?)

Issues Identified from First Round Implementation Evaluation/Fidelity Assessment

Note to interviewer: The issues listed below may already have emerged in the first section of questions. The interviewer should adjust the questions accordingly. The interviewer should also ask about any issues emerging during the participant observation session which haven't been discussed.

1. Why, if at all, are there delays or barriers to housing some participants?
 - How can (or are) these delays be(ing) addressed moving forward?
2. What are the difficulties or successes in obtaining the types of housing in the locations that participants want?
 - How can (or are) any challenges be addressed moving forward?

3. What are the challenges or successes experienced in rehousing some participants?
 - How can (or are) any challenges be(ing) addressed moving forward?
4. What are the challenges or successes with respect to the developing a coordinated working relationship between the housing and clinical teams?
 - How can (or are) any challenges be(ing) addressed moving forward?
5. What have been the challenges or successes in involving program participants and people with lived experience in the operations and shaping of the service teams, and with research?
 - How can (or are) any challenges be addressed moving forward?
6. What have been the challenges or successes with respect to staffing issues (probe re: leadership, cohesion, staff burnout/self-care, staff retention?)
 - How can any challenges be addressed moving forward?
7. What other challenges or successes would you like to discuss? (e.g. issues identified from participant observation session, issues identified in the first round site implementation evaluation report, other issues arising)
 - How can any challenges be addressed moving forward?

Questions about the Intervention Logic Model

- What has the project learned about the relationship between housing and recovery?
- What has the project site learned about the relationship between other critical ingredients of the intervention and recovery?
- What has the project learned about other barriers and facilitators of recovery?
- Optional: What have the teams learned about the barriers and facilitators of other domains of interest: engagement in care, quality of life, community integration, efficient service usage (e.g., use of hospital services, criminal justice involvement, etc.)?
- What has the project learned about the process of involvement of persons with lived experience and about its impact on the initiative?

Questions about the Organizational Context Surrounding the Project

What have you learned about the impact (positive, negative or otherwise) on implementation of the organizational context surrounding the project, e.g. host service delivery agencies, health authorities, etc. (probe re: leadership, climate/culture, goodness of fit, etc.)

Questions about the Sustainability and the Future of the Project?

- How are the teams addressing the concerns by participants about the sustainability of the project? (probe: to what extent is this an issue? how are teams communicating to participants about this issue?)
- How do you see the project going forward in the future (probe; concerns/strategies re sustainability; perspective on potential legacies of project on the surrounding mental health and housing systems and on strategies for achieving these?)

Ending the Interview

- Are there any other observations about the implementation of programs you haven't had a chance to mention that you would like to add before we finish?
- As I bring this interview to a close I would like to know about your experiences (how you feel, what you are thinking) about having participated in this interview today/tonight.
- Is there anything we could do to improve the interview?
- I am now shutting off the tape recorder. What questions do you have of me?

Key Informant Interview Guide for Later Implementation Evaluation for Members of the Quality Assurance Fidelity Teams (to be done by national team)

Thank you for attending this interview. As you know, the purpose of this interview is for you to share your knowledge about key program components of the MHCC At Home/Chez Soi project and their implementation. We believe that this is important in defining the key ingredients of this intervention and determining their fidelity. The interview will take less than one hour.

Before we get started let's review the consent form. Then you can decide if you want to participate in the interview. [\[Interviewer reviews the information letter and consent form, which can be adapted from the early qualitative evaluation of implementation, with the participant.\]](#)

What questions do you have before we begin? [\[After questions have been asked and answered, the participant is asked to complete the consent form and give it to the interviewer.\]](#)

I am now going to start the tape recorder.

The purpose of today's interview is to focus on what has changed in the implementation of the MHCC At Home/Chez Soi programs over the past year since the first fidelity/implementation evaluation, to understand the reasons for ongoing and emerging implementation successes and challenges. Also, we would like to understand any discrepancies in perspective between the QA team's ratings, and the team's own self-ratings. A final issue we'd like to explore, is what the project has learned about the logic model of the intervention, in other words, what we're learning about the process of how the intervention is impacting on the lives of participants. As part of this exploration, we'd like to understand your own experience, as an expert in Housing First implementation, or as someone with the national perspective on At Home/Chez Soi, about the Housing First logic model.

Fidelity Scale Questions

Note to interviewer: the term "trouble spot" as used below refers to a rating which is low and there is agreement between Quality Assurance (QA) team fidelity rating and team self-rating; "notable improvements" are issues where there has been a significant improvement in QA team fidelity ratings between first and second rounds; and a "discrepancy" is where QA team fidelity and self-ratings differ (e.g., something assessed as an apparent trouble spot by the fidelity report, but where the team rating is higher, or vice versa).

In preparation for the discussion for this first section of the interview, the interviewer should have a general sense of implementation strengths, improvements and trouble spots across the various sites, as well as a general sense of any typical discrepancies in perspective between sites and QA team members.

1. Speaking generally of all the sites, what are the common implementation trouble spots? (probe: issues remaining from first round?; emerging in second round?):
 - What barriers are getting in the way of implementation? (probe and/or code: for barriers related to structure, resources, relationships, strategy/process, etc.)
 - How would you suggest that the project address these issues moving forward?
2. Speaking generally of all the sites, what are the notable improvements in implementation from the first round?
 - to what do you attribute the improvement? (probe and/or code for facilitators related to structure, resources, relationships, strategy/process, etc.)
3. Again, speaking generally of all the sites, what other notable implementation strengths have you observed? (probe: maintained from the first round and/or emerging in the second round)
 - to what do you attribute this strength? (probe and/or code for facilitators related to structure, resources, relationships, strategy/process, etc.)
4. Are there any notable strengths specific to particular sites that the other sites could learn from? (Please describe)
5. Thinking of the comparison between sites' self-ratings and the QA team's fidelity ratings: are there any typical discrepancies between the two perspectives? (what do you think accounts for these?)

Issues Identified from First Round Implementation Evaluation/Fidelity Assessment

Note to interviewer: The issues listed below may already have emerged in the first section of questions. The interviewer should adjust the questions accordingly. The interviewer should also ask about any issues emerging during the participant observation session which haven't been discussed.

1. Why, if at all, are there delays or barriers to housing some consumers?
 - How do you suggest the project address these challenges moving forward?
2. What are the difficulties or successes in obtaining the types of housing in the locations that consumers want?
 - How do you suggest the project address these challenges moving forward?
3. What are the challenges or successes experienced in rehousing some consumers?
 - How do you suggest the project address these challenges moving forward?
4. What have been the challenges or successes in involving program participants and people with lived experience in the operations and shaping of the service teams, and with research?
 - How do you suggest the project address these challenges moving forward?
5. What are the challenges or successes with respect to the developing a coordinated working relationship between the housing and clinical teams?
 - How can (or are) any challenges be(ing) addressed moving forward?

6. What have been the challenges or successes with respect to staffing issues (probe re: leadership, cohesion, staff burnout/self-care, staff retention?)
 - How do you suggest the project address these challenges moving forward?
7. What other challenges or successes would you like to discuss? (e.g. issues identified from participant observation session, issues identified in the first round site implementation evaluation report, other issues arising)
 - How do you suggest the project address these challenges moving forward?

Questions about the Intervention Logic Model

- Thinking about the experience across all the At Home/Chez Soi sites, or about your experience with the Housing First model in general, how do you understand the relationship between housing and recovery?
- Thinking about the experience across all the At Home/Chez Soi sites, or about your experience with the Housing First model in general what is the relationship between other critical ingredients of the Housing First intervention and consumer recovery?
- Thinking about the experience across all the At Home/Chez Soi sites, or about your experience with the Housing First model in general, what are the other barriers and facilitators of consumer recovery?
- Optional: Thinking about the experience across all the At Home/Chez Soi sites, or about your experience with the Housing First model in general, what have you learned about the barriers and facilitators of other domains of interest: engagement in care, quality of life, community integration, efficient service usage (e.g., use of hospital services, criminal justice involvement, etc.)?
- Thinking about the experience across all the At Home/Chez Soi sites, or about your experience with the Housing First model in general, what have you learned about the process of involvement of persons with lived experience in Housing First and about its impact on Housing First programs?

Questions about the Organizational Context Surrounding the Project

- What have you learned about the impact (positive, negative or otherwise) on implementation of the organizational context surrounding the project, e.g. host service delivery agencies, health authorities, etc. (probe re: leadership, climate/culture, goodness of fit, etc.)

Questions about Sustainability and the Future of the Project

- What have you learned about sustainability issues, both in terms of the nature of the concerns and how the project is addressing these?
- What are your views about the future impact of the project (both re its potential legacies and strategies to ensure these?)

Ending the Interview

- Are there any other perceptions about the implementation of programs you haven't had a chance to mention that you would like to add before we finish up?
- As I bring this interview to a close I would like to know about your experiences (how you feel, what you are thinking) about having participated in this interview today/tonight.
- Is there anything we could do to improve the interview?
- I am now shutting off the tape recorder. What questions do you have of me?

Focus Group Interview Guide For Later Implementation Evaluation

Thank you for attending this interview. As you know, the purpose of this interview is for you to share your knowledge about key program components of the MHCC At Home/Chez Soi project and their implementation. We believe that this is important in defining the key ingredients of this intervention and determining their fidelity. The interview will take less than one hour.

Before we get started let's review the consent form. Then you can decide if you want to participate in the interview. [\[Interviewer reviews the information letter and consent form, which can be adapted from the early implementation evaluation, with the participant.\]](#)

What questions do you have before we begin? [\[After questions have been asked and answered, the participant is asked to complete the consent form and give it to the interviewer.\]](#)

I am now going to start the tape recorder.

The purpose of today's interview is to focus on what has changed in the implementation of the MHCC At Home/Chez Soi programs over the past year since the first fidelity/implementation evaluation, to understand the reasons for ongoing and emerging implementation successes and challenges. Also, we would like to understand any discrepancies in perspective between the Quality Assurance (QA) team's ratings, and the team's own self-ratings. A final issue we'd like to explore, is what the project has learned about the logic model of the intervention, in other words, what we're learning about the process of how the intervention is impacting on the lives of participants.

Fidelity Scale Questions

Note to facilitator: the term "trouble spot" as used below refers to a rating which is low and there is agreement between QA team fidelity rating and team self-rating; "notable improvements" are issues where there has been a significant improvement in QA team fidelity ratings between first and second rounds; and a "discrepancy" is where QA team fidelity and self-ratings differ (e.g., something assessed as an apparent trouble spot by the fidelity report, but where the team rating is higher, or vice versa).

In preparation for the discussion for this first section of the focus group, the facilitator should examine the participant observation field notes, available ratings from both first and second rounds, and if necessary work with the teams to identify the issues that will be explored as trouble spots, notable strengths/improvements and discrepancies.

1. Re: agreed upon trouble spots (maintained from first round and/or emerging):
 - What barriers are getting in the way of implementation? (probe and/or code: for barriers related to structure, resources, relationships, strategy/process, etc.)
 - How would you address these issues moving forward?
2. Re: notable improvements from the first round:
 - to what do you attribute the improvement? (probe and/or code for facilitators related to structure, resources, relationships, strategy/process, etc.)
3. Re: other notable strengths (maintained from the first round and/or emerging in the second round):
 - to what do you attribute this strength? (probe and/or code for facilitators related to structure, resources, relationships, strategy/process, etc.)
4. Re: discrepancies:
 - What accounts for the discrepancy? (probe: is this an adaption to context or an innovation?)

Issues Identified from First Round Implementation Evaluation/Fidelity Assessment

Note to facilitator: The issues listed below may already have emerged in the first section of questions. The facilitator should adjust the questions accordingly. The facilitator should also ask about any issues emerging during the participant observation session which haven't been discussed.

1. Why, if at all, are there delays or barriers to housing some consumers?
 - How can (or are) these delays be(ing) addressed moving forward?
2. What are the difficulties or successes in obtaining the types of housing in the locations that consumers want?
 - How can (or are) any challenges be addressed moving forward?
3. What are the challenges or successes experienced in rehousing some consumers?
 - How can (or are) any challenges be(ing) addressed moving forward?
4. What are the challenges or successes with respect to the developing a coordinated working relationship between the housing and clinical teams?
 - How can (or are) any challenges be(ing) addressed moving forward?
5. What have been the challenges or successes in involving program participants and people with lived experience in the operations and shaping of the service teams, and with research?
 - How can (or are) any challenges be addressed moving forward?
6. What have been the challenges or successes with respect to staffing issues (probe re: leadership, cohesion, staff burnout/self-care, staff retention?)
 - How can any challenges be addressed moving forward?
7. What other challenges or successes would you like to discuss? (e.g. issues identified from participant observation session, issues identified in the first round site implementation evaluation report, other issues arising)
 - How can any challenges be addressed moving forward?

Questions about the Intervention Logic Model

- What are the critical ingredients related to housing that promote recovery (or: what has the project learned about the relationship between housing and recovery?)
- What has the project site learned about the relationship between other critical ingredients of the intervention and consumer recovery?
- What has the project learned about other barriers and facilitators of consumer recovery?
- Optional: What have the teams learned about the barriers and facilitators of other domains of interest: engagement in care, quality of life, community integration, efficient service usage, e.g. use of hospital services, criminal justice involvement, etc.?
- What has the project learned about the process of involvement of persons with lived experience and about its impact on the initiative?

Questions about the Sustainability and the Future of the Project?

- How are the teams addressing the concerns by participants about the sustainability of the project? (probe: to what extent is this an issue? how are teams communicating to participants about this issue?)
- How do you see the project going forward in the future (probe; concerns/strategies re sustainability; perspective on potential legacies of project on the surrounding mental health and housing systems and on strategies for achieving these?)

Ending the Interview

- Are there any other perceptions about the implementation of programs you haven't had a chance to mention that you would like to add before we finish up?
- As I bring this interview to a close I would like to know about your experiences (how you feel, what you are thinking) about having participated in this interview today/tonight.
- Is there anything we could do to improve the interview?
- I am now shutting off the tape recorder.
- What questions do you have of me?

TRANSCRIPTION PROTOCOLS FOR QUALITATIVE IMPLEMENTATION EVALUATION: DRAFT 1 - OCTOBER 28, 2009

Key Informant Interviews

- File names should be in the following format: ID # XXX - MHCC Implementation
- Files should be saved in .doc, .docx, or .rtf format.
- The first paragraph of each file should be in the following format: Key informant interview conducted (date) by (facilitator name); transcribed (date transcription completed) by (transcriptionist name). Interviewer's speech in italics. Participant responses in normal text.
- Please use 1 inch (left) and 2 inch (right) margins and Times New Roman 12 pt font.
- Pages and lines should be numbered. Page numbers should be inserted in the top right corner (in Microsoft Word, Insert -> Page Numbers). Line numbering in Microsoft Word can be inserted through Page Layout -> Line Numbers -> Continuous.
- In each section of the interview, please use italics to indicate interviewer speech and plain text to indicate participant speech.
- Please transcribe speech as naturally as possible, including "you knows", "ums", etc.
- Insert paragraph breaks after all obvious changes of topic.
- Other transcription conventions that may prove useful:
 - [descriptor] Descriptors of speech or behaviours in square parentheses e.g., [sarcastically], [laughter], [P# laughs]
 - (2.0) Extended pause (seconds)
 - 'Aw...'
 - Extended sounds shown by colons in proportion to the length of the sound
 - Word Underline shows stress or emphasis
 - Wor- Hyphen indicates that a word or sound is broken off
 - WORD Increase in amplitude is shown by capital letters
 - (word) Parenthesis bound uncertain transcription, the transcriber's "best guess" ((incomp)) Incomprehensible
- File Management: Completed transcripts should be saved to the Health Diaries site in the folder "Site àImplementationàKey Informant Interviews à Transcripts" under the name "ID # XXX - MHCC Implementation"

FOCUS GROUPS: DRAFT 1 - OCTOBER 28, 2009

- File names should be in the following format: Focus Group
- # XXX - MHCC Implementation
- Files should be saved in .doc, .docx, or .rtf format.
- The first paragraph of each file should be in the following format: Focus group conducted (date) by (facilitator name); transcribed (date transcription completed) by (transcriptionist name). Interviewer's speech in italics. Participant responses in normal text.
- Please use 1 inch (left) and 2 inch (right) margins and Times New Roman 12 pt font.
- Pages and lines should be numbered. Page numbers should be inserted in the top right corner (in Microsoft Word, Insert -> Page Numbers). Line numbering in Microsoft Word can be inserted through Page Layout -> Line Numbers -> Continuous.
- In each section of the interview, please use italics to indicate interviewer speech and plain text to indicate participant speech.
- Please transcribe speech as naturally as possible, including "you knows", "ums", etc.
- Insert paragraph breaks after all obvious changes of topic. Insert paragraph breaks between speakers, with the >> character to indicate a change of speaker.
- Other transcription conventions that may prove useful:
 - **[descriptor]** Descriptors of speech or behaviours in square parentheses e.g., [sarcastically], [laughter], [P# laughs]
 - **(2.0)** Extended pause (seconds)
 - **'Aw...'** Extended sounds shown by colons in proportion to the length of the sound
 - **Word** Underline shows stress or emphasis
 - **Wor-** Hyphen indicates that a word or sound is broken off WORD Increase in amplitude is shown by capital letters
 - **(word)** Parenthesis bound uncertain transcription, the transcriber's "best guess" ((incomp))
Incomprehensible
- File Management: Completed transcripts should be saved to the Health Diaries site in the folder "Site à Implementation à Focus Groups à Transcripts" under the name "Focus Group # XXX - MHCC Planning"

TABLES FOR FIDELITY EVALUATION

Table 9.1 Scores on the Fidelity Scale Items by Site Averaged Across ACT and ICM

FIDELITY DOMAINS AND ITEMS	TIME PERIOD	MONCTON	MONTRÉAL	TORONTO	WINNIPEG	VANCOUVER
Housing Choice and Structure						
1. Housing Choice	T1	3.5	3	3.8	3.3	3
	T2	4	3	3.5	3	4
2. Housing Availability	T1	3	1	2	1.9	3
	T2		1.3	1.5	1	2.3
3. Permanent Housing Tenure	T1	4	4	4	4	4
	T2	4	4	4	4	4
4. Affordable Housing	T1	4	4	4	4	4
	T2	4	4	4	4	4
5. Integrated Housing	T1	4	4	4	4	4
	T2	4	4	4	4	4
6. Privacy	T1	4	4	4	4	4
	T2	4	4	4	4	4
Separation of Housing and Services						
7. No Housing Readiness	T1	4	3.8	4	4	4
	T2	4	4	4	4	4
8. No Program Contingencies of Tenancy	T1	4	4	4	4	4
	T2	4	4	4	4	4
9. Standard Tenant Agreement	T1	4	4	4	3.3	4
	T2	4	4	4	4	4
10. Commitment to Re-House	T1	4	4	4	3.5	3.8
	T2	4	4	4	2.5	4
11. Services Continue Through Housing Loss	T1	4	4	4	4	4
	T2	4	4	4	4	4
12a. Off-site Services	T1	4	4	4	4	4
	T2	4	4	4	4	4
12b. Mobile Services	T1	3	3.7	3.3	4	4
	T2	4	4	3.8	4	4

Table 9.1 Scores on the Fidelity Scale Items by Site Averaged Across ACT and ICM

FIDELITY DOMAINS AND ITEMS	TIME PERIOD	MONCTON	MONTRÉAL	TORONTO	WINNIPEG	VANCOUVER
Service Philosophy						
13. Service Choice	T1	4	4	3.5	4	4
	T2	4	4	4	4	4
14. No Requirements for Participation in Psychiatric Treatment	T1	4	4	4	4	4
	T2	4	4	4	4	4
15. No Requirements for Participation in Substance Use Treatment	T1	4	4	4	4	4
	T2	4	4	4	4	4
16. Harm Reduction Approach	T1	4	3.7	3.5	3.5	4
	T2	3	3.5	3.8	3.2	4
17. Motivational Interviewing	T1	2	3.5	3	2.5	3.5
	T2	3	2.8	3.5	3	3.2
18. Assertive Engagement	T1	3	3	3.3	3.3	4
	T2	3	2.8	3.5	3.2	4
19. Absence of Coercion	T1	4	4	4	4	3.3
	T2	4	4	4	4	4
20. Person-Centred Planning	T1	2	2.7	2.5	2.5	4
	T2	2.5	3.3	3	2.5	3.5
21. Interventions Target a Broad Range of Life Goals	T1	4	3.7	2.8	3.5	4
	T2	4	3.7	3.3	3	4
22. Participant Self-Determination and Independence	T1	4	3.7	3.5	4	3
	T2	4	3.7	3.5	4	4
Service Array						
23. Housing Support	T1	4	4	4	4	4
	T2	4	4	4	4	4
24. Psychiatric Services	T1	-	3	3.5	2.5	3
	T2	3	2.8	3.8	2.5	3.5
25. Substance Abuse Treatment	T1	2	3.3	3	2.5	3
	T2	2.5	3.2	3.8	3	3.5
26. Employment and Educational Services	T1	3	2.5	2.5	2.3	2
	T2	3.5	2.8	3.5	2.8	3
27. Nursing/medical Care	T1	3	2.7	3	2.5	3.5
	T2	3.5	3	3.5	2.5	3.8

Table 9.1 Scores on the Fidelity Scale Items by Site Averaged Across ACT and ICM

FIDELITY DOMAINS AND ITEMS	TIME PERIOD	MONCTON	MONTRÉAL	TORONTO	WINNIPEG	VANCOUVER
28. Social Integration	T1	3	2.3	3	2.5	3.5
	T2	3.5	3.2	3.5	3	3.8
29. 24-hour Coverage	T1	3	3	2.5	3	3.5
	T2	3	3	3	3	3.5
30. Involved in Inpatient Treatment	T1	2	3	3.5	4	0
	T2	4	3.5	4	4	4
Program Structure						
31. Priority Enrollment for Individuals with Obstacles to Housing Stability	T1	4	4	4	4	4
	T2	4	4	4	4	4
32. Low Participant/Staff Ratio	T1	4	4	4	4	4
	T2	4	4	4	4	4
33. Contact with Participants	T1	4	3.3	1.5	4	4
	T2	4	2.5	2	3	4
34. Team Approach	T1	4	3	4	4	4
	T2	4	4	4	4	4
35. Frequent Meetings	T1	4	4	4	4	4
	T2	4	4	4	4	4
36. Weekly Meeting/Case Review (Quality)	T1	3	3.3	3	3.5	4
	T2	3	3.7	3.8	3.8	4
37. Peer Specialist on Staff	T1	3	4	4	4	4
	T2	2	4	4	4	4
38. Participant Representation in Program	T1	2	1.7	2	2	2
	T2	3	1.3	2	1.8	3.5

T1 = first year of implementation, T2 = second year of implementation. Team Approach and Peer Specialist on Staff are only rated for ACT programs. Scores are averaged across ACT and ICM programs for all sites except for Moncton, which is based only on ACT program scores. Red highlights represent challenges (scores ≤ 3), while yellow highlights indicate strengths (scores > 3). Note that third arm programs are not included

Table 9.2

Scores on the Fidelity Scale Items Indicating Challenges by ACT and ICM Programs at Time 1 and Time 2

FIDELITY DOMAINS AND ITEMS	TIME PERIOD	ACT	ICM
Housing Choice and Structure			
2. Housing Availability	T1	2	18
	T2		15
Service Philosophy			
17. Motivational Interviewing	T1	3.3	2.8
	T2	3.5	2.6
20. Person-Centred Planning	T1	3	2.6
	T2	3.3	2.8
Service Array			
24. Psychiatric Services	T1	4	2.2
	T2	3.6	2.6
25. Substance Abuse Treatment	T1	2.8	3
	T2	3.4	3.1
26. Employment and Educational Services	T1	2.2	2.6
	T2	2.9	3.2
27. Nursing/Medical Care	T1	3.4	2.4
	T2	3.7	2.7
28. Social Integration	T1	3	2.8
	T2	3.6	3.1
29. 24-hour Coverage	T1	3	3
	T2	3.2	3

T1 = first year of implementation, T2 = second year of implementation. Scores are averaged across sites, so that five ACT and five ICM programs are included. Note that third arm programs are not included.

Table 9.3

Scores on the Fidelity Scale Domains by Site Averaged Across ACT and ICM Programs at Time 1 and Time 2

FIDELITY DOMAINS TOTAL POSSIBLE SCORE	TIME PERIOD	MONCTON	MONTREAL	TORONTO	WINNIPEG	VANCOUVER	AVERAGE ACROSS SITES
Housing Choice and Structure - 24	T1	22.5	20	21.7	22.4	21.1	21.5
	T2		20.3	21.3	20	21.8	
Separation of Housing and Services - 28	T1	27	27.5	27.2	26.8	27.8	27.3
	T2	28	28	27.8	26.5	28	27.7
Service Philosophy - 40	T1	35	36.2	35.6	35.3	37.8	36.0
	T2	35	35.8	36.5	35	38.75	36.2
Service Array - 32	T1	20	22	26.7	22.8	22	22.7
	T2	27	25.5	27	24.8	29	26.7
Program Structure - 32	T1	28	22.7	23.7	24	26	24.9
	T2	28	27.5	27.8	28.5	31.5	28.7

T1 = first year of implementation, T2 = second year of implementation. Scores are averaged across ACT and ICM programs for all sites except for Moncton, which is based only on ACT program scores. Note that third arm programs are not included.



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